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	09/30/2024

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 - 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 closed medical record review, review of skin and wound notes, facility policy review and interview, the facility failed to ensure individualized care planned interventions were developed and followed to prevent Resident #165 from developing in-house pressure ulcers within 30 days of admission and failed to ensure the pressure ulcer was properly treated, and interventions were initiated to promote healing and to prevent Resident #165 from developing an additional full thickness wound to the left buttock from incontinence associated dermatitis. Actual Harm occurred on 09/12/24 when Resident #165, who was at risk for developing pressure ulcers, was dependent on staff for bed mobility and incontinence care, and had in-house acquired Stage III pressure ulcers (full-thickness loss of skin that extended to the subcutaneous tissue, but did not cross the fascia beneath it) on her sacral area, developed a new new full thickness (extend deeper than the skin's epidermis and dermis layers and can reach the subcutaneous tissue, muscle, bone or tendons) wound to the left buttock with a primary etiology of incontinence associated dermatitis (a combination of chemical and physical irritation to the skin from prolonged exposure to urine and/or feces). Resident #165's family voiced concerns staff did not provide timely assistance with turning and repositioning, off-loading and timely incontinence care believed to be a contributing factor to the development. The facility census was 160. Findings include Review of Resident #165's closed medical record revealed an admitted [DATE] with diagnoses including cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, and cognitive communication deficit. Resident #165 was discharged from the facility on 09/16/24. Review of Resident #165's Nursing Admission Evaluation, Braden Scale for Predicting Pressure Sore Risk dated 08/03/24 revealed Resident #165 was at high risk for developing a pressure ulcer/injury. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #165's care plan dated 08/03/24 and revised on 09/24/24 included Resident #165 had impaired skin integrity or was at risk for altered skin integrity. Revision on 09/24/24 (Resident #165 was discharged from the facility on 09/16/24) revealed Resident #165 had a bilateral buttock, coccyx pressure injury and on 09/12/24 developed a pressure injury to her left buttock. The goal developed was for Resident #165 to have improved or maintain current skin status through the next review date. Interventions included to complete weekly skin checks; intervention initiated on 08/03/24 was encourage Resident #165 to turn and reposition or assist as needed as resident allowed; intervention initiated on 08/05/24 was encourage Resident #165 to turn and reposition every two hours and as needed as tolerated; provide peri care as needed to avoid skin breakdown due to incontinence. Review of Resident #165's medical record including physician orders, progress notes and Treatment Administration Record (TAR) from 08/03/24 through 08/17/24 did not reveal evidence Resident #165 was turned and repositioned every two hours and as needed or encouraged to turn and reposition. Review of Resident #165's Admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #165 had severe cognitive impairment. Resident #165 was dependent for toileting, personal hygiene, bathing, dressing, rolling left and right from lying on her back, sit to lying, and lying to sitting. Resident #165 was frequently incontinent of urine and bowel. Resident #165 was at risk for developing pressure ulcers/injuries, and Resident #165 did not have a pressure ulcer/injury at this time. Review of Resident #165's progress notes dated 08/11/24 at 10:00 P.M. and written by Registered Nurse (RN) #809 revealed she was called into Resident #165's room by an unidentified State tested Nursing Assistant (STNA) and RN #809 identified several skin tears on Resident #165's right and left buttock. The area was cleansed with normal saline and covered with a foam dressing. Telehealth was contacted and asked to follow up with wound care. Review of Resident #165's progress notes dated 08/11/24 at 10:07 P.M. and written by a Telehealth Provider revealed the Telehealth Provider was notified Resident #165 had a Stage II (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) pressure ulcer. Resident #165 did not ambulate, and off load to prevent worsening. The progress note did not include treatment orders being implemented and to have the wound care nurse evaluate the area. Review of Resident #165's physician orders on 08/11/24 did not reveal treatment orders for Resident #165's pressure ulcer at this time. Review of Resident #165's Skin Grid Pressure dated 08/11/24 at 11:38 P.M. included Resident #165 had a new pressure area, in-house acquired, risk factors were impaired and the resident had decreased mobility. Resident #165's right buttock had a Stage II pressure injury and measurements were length 1.0 cm, width 1. 0 cm and depth 0. The edges were distinct, outlined clearly visible, attached and even with the wound base. The wound bed had granulation tissue present, the wound bed was pink, reddened and had no drainage. There were no measurements for Resident #165's left buttock or evaluation of the wound appearance at this time. Review of Resident #165's progress notes dated 08/12/24 revealed her sister (guardian) was aware of skin areas and new orders and Resident #165 was evaluated by Wound Nurse Practitioner (WNP) #815. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #165's skin and wound progress notes dated 08/12/24 at 4:42 P.M. written by WNP #815 included Resident #165 was seen for a new Stage III pressure injury of the sacrum (investigation noted this to be the same area previously identified by facility staff on 08/11/24) and measurements included length 3.0 cm, width 5.0 cm and depth 0.1 cm. The wound edges were attached, exposed tissue was subcutaneous, wound base 90 percent granulation, 10 percent epithelial and a moderate amount of serosanguineous drainage was noted. A sharp debridement was not performed due to patient, family refusal. Treatment recommendations were cleanse with normal saline, apply silver alginate to base of the wound, secure with bordered foam dressing, and change twice a day (BID) and as needed (PRN). Recommend ongoing pressure reduction and turning/repositioning per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. Use appropriate moisture barrier creams per approved list, to provide thorough skin care for each incontinent episode. Resident #165 was recommended for a nutritional consult for presence of a wound, and reevaluation of current supplementation. Discussed with Unit Manager and would follow up in one week and as needed. Review of Resident #165's physician orders dated 08/12/24 revealed an order to cleanse areas to bilateral buttocks, coccyx with normal saline, pat dry, apply silver alginate and border foam, change twice daily and as needed until resolved. Review of Resident #165's progress notes and evaluations dated 08/12/24 through 08/27/24 did not reveal an evaluation of Resident #165's Stage III sacral pressure injury including appearance and measurements during this time period. Review of Resident #165's medical record including evaluations and progress notes from 08/12/24 through 09/09/24 did not reveal a nutritional consult for the presence of a Stage III pressure ulcer or reevaluation of Resident #165's current supplementation. Review of Resident #165's physician orders dated 08/16/24 at 3:30 P.M. (was ordered on 08/12/24) revealed turn and reposition every two hours and as needed as tolerated, every shift. Review of Resident #165's Treatment Administration Record (TAR) dated 08/16/24 at night did not reveal documentation Resident #165 was turned and repositioned every two hours as ordered. Review of Resident #165's medical record including progress notes did not indicate a reason why turning and repositioning was not completed. Review of Resident #165 TAR dated 08/16/24, 08/17/24, 09/01/24, 09/02/24, 09/08/24 at night and 09/09/24 in the morning revealed Resident #165's treatment orders to cleanse her buttocks, coccyx with normal saline, pat dry, apply silver alginate and border foam were not completed as ordered. Review of Resident #165's medical record including progress notes, physician orders did not indicate a reason why the treatment was not completed on these dates. Review of Resident #165's progress notes dated 08/20/24 at 6:13 P.M. revealed Resident #165 was unavailable and wound care would follow up in one week. There was no reason given why Resident #165 was unavailable for her wound evaluation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #165's skin and wound noted dated 08/27/24 at 1:41 P.M. written by WNP #815 included Resident #165 had a Stage III sacral pressure injury and measurements were length 4.5 cm, width, 8.0 cm and depth 0.1 cm. Wound status was improving despite measurements (the wound base on 08/12/24 and 08/27/24 was 10 percent epithelial and 90 percent granulation). The wound base was 10 percent epithelial and 90 percent granulation, exposed tissue subcutaneous, wound edges attached, and a moderate amount of serosanguineous drainage was noted. Treatment recommendations were cleanse with normal saline, apply silver alginate to the base of the wound, secure with bordered foam and change twice a day and as needed. Resident #165 was recommended for a nutritional consult for the presence of a wound and reevaluation of current supplementation. This was discussed with the Unit Manager. Review of Resident #165's dietary progress notes dated 08/28/24 and 08/30/24 did not reveal evidence Resident #165 had a nutritional consult for her sacral Stage III pressure ulcer or reevaluation of current supplementation. Review of Resident #165's aide charting of skin observation in the electronic record from 08/27/24 through 09/16/24 did not reveal evidence skin areas were noted. Review of Resident #165's skin and wound note dated 09/03/24 at 4:23 P.M. written by WNP #815 included Resident #165 had a surgical sacral wound debridement of her Stage III pressure ulcer, it was improving without complications, and pre-debridement measurements were length 4.5 cm, width 7.0 cm and depth 0.1 cm and 100 percent of the wound was debrided and indications for the debridement were removal of biofilm (bacteria form aggregates, or communities of slow-growing cells) causing delayed wound closure, stimulate acute healing response. A surgical excisional debridement of devitalized subcutaneous (tissue that was no longer living or was weak and could be detrimental to healing) was performed. Tissue removal including but not limited to biofilm was performed to keep the wound in an active state of healing. Post debridement measurements were length 4.5 cm, width 7.0 cm and depth 0.2 cm. Treatment was cleanse with normal saline, apply silver alginate to the base of the wound, secure with bordered foam and change twice a day and as needed. Resident #165 was recommended for a nutritional consult for the presence of a wound and reevaluation of current supplementation. Review of Resident #165's weight change progress notes dated 09/09/24 at 5:15 P.M. included meals and supplements meet re-estimated needs of 2032 to 2370 kcal (kilocalories) and 88 to 95 gm (gram) of protein for Stage III sacrum pressure ulcer (this was 28 days after the nutritional consult was ordered). Review of Resident #165's skin and wound note dated 09/12/24 at 2:40 A.M. written by WNP #816 revealed the date of service was 09/12/24 at 6:40 A.M. included Resident #165's Stage III sacrum pressure ulcer measurements included length 4.5 cm, width 7.0 cm, depth 0.1 cm and the area was improving without complications, wound base was 100 percent granulation soft, unhealthy, the wound edges were unattached, the peri wound was macerated, and exudate indicated stool contamination. New treatment was cleanse with normal saline, apply bacitracin ointment, apply Triad over bacitracin wound and over bilateral buttock and ischium to the base of the wound, cover with ABD (abdominal pad) twice a day and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further review of Resident #165's skin and wound note dated 09/12/24 at 2:40 A.M. revealed the date of service was 09/12/24 at 6:40 A.M. and included Resident #165 had a new full thickness (extend deeper than the skin's epidermis and dermis layers and can reach the subcutaneous tissue, muscle, bone or tendons) wound to the left buttock and stated the primary etiology was incontinence associated dermatitis (a combination of chemical and physical irritation to the skin from prolonged exposure to urine and/or feces). Resident #165 had diaper dermatitis. Measurements included length 6.0 cm, width 5.0 cm and depth 0 cm., peri wound was macerated, the wound base indicated scar tissue with scattered opened areas of epithelial tissue, exudate indicated contaminates with stool. Treatment was cleanse with wound cleanser, apply bacitracin ointment, apply Triad over the bacitracin ointment to the base of the wound and cover with ABD pad twice a day and as needed. Review of Resident #165's medical record from 08/27/24 through 09/12/24 including progress notes, physician orders, TAR did not reveal evidence Resident #165 had a new wound area to her left buttock. Review of Resident #165's physician orders dated 09/12/24 through 09/16/24 did not reveal new treatment orders for Resident #165's sacral Stage III pressure ulcer to cleanse with normal saline, apply bacitracin ointment, apply Triad over bacitracin wound and over bilateral buttock and ischium to the base of the wound, cover with ABD twice a day and as needed. Further review did not reveal treatment orders for left buttock to cleanse with wound cleanser, apply bacitracin ointment, apply Triad over the bacitracin ointment to the base of the wound and cover with ABD pad twice a day and as needed. Review of Resident #165's TAR dated 09/12/24 through 09/16/24 did not reveal evidence treatments for Resident #165's sacral Stage III pressure ulcer and full thickness wound of her left buttock were completed as ordered. Interview on 09/25/24 at 11:01 A.M. with Guardian #818 revealed Resident #165 was admitted to the facility and did not have any open areas on her skin. Guardian #818 stated sometime between 08/03/24 and 08/10/24 Resident #165 developed bedsores on her bottom, and she knew this because on 08/10/24 Resident #165 was soaking wet and was lying on soaking wet, brown stained sheets and she saw wounds on Resident #165's sacral area when the aides changed her. Guardian #818 stated she was really upset, was crying and talked to the Director of Nursing (DON) about the aides not changing Resident #165 timely. Guardian #818 stated Resident #165 was mildly retarded and she sat in a wheelchair all day long in the same position without taking the pressure off her bottom and did not get changed by staff (related to incontinence). Guardian #818 indicated Resident #165 told her that her butt hurt from bedsores. Guardian #818 stated Resident #165 was neglected at the facility. Interview on 09/25/24 at 5:03 P.M. with WNP #815 and the DON confirmed Resident #165's sacral Stage III pressure ulcer was not evaluated on 08/20/24. WNP #815 stated Resident #165 was not available, she did not know why she was not available and did not have to document why Resident #165 was not available for wound rounds even though Resident #165 was in the facility at the time of wound rounds. WNP #815 stated Resident #165 could have been at therapy or eating or with her family and it happened sometimes. WNP #815 stated she was not aware Resident #165's nutritional consult was not completed until 09/09/24 (although it was documented a nutritional consult needed completed on 08/12/24, 08/27/24 and 09/03/24 in the skin and wound notes). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/26/24 at 7:45 A.M. with Registered Nurse (RN) #809 revealed an STNA initially told her about Resident #165's buttocks and when she looked at the areas it looked like she had skin tears. RN #809 stated there was what looked like a skin tear on both the right and left buttock, she called the Telehealth provider, and the provider thought the areas looked like pressure injuries. RN #809 indicated she measured the right and left buttock areas, documented them in Resident #165's nurses notes; the wounds were pink and there was no drainage (record review revealed only the right buttock had measurements and appearance documented). Interview on 09/26/24 at 3:01 P.M. with Licensed Practical Nurse/Unit Manager/Infection Preventionist (LPN/UM/IP) #800 confirmed Resident #165 did not have her sacral Stage III pressure ulcer evaluated on 08/20/24. LPN/UM/IP #800 stated the Unit Manager should have evaluated the wound if WNP #815 did not evaluate it and should have completed a pressure skin grid and documented measurements and appearance of the wound. LPN/UM/IP #800 stated each Unit Manager was responsible for the residents with wounds who resided on their nursing units, and not all Unit Managers did the same thing. LPN/UM/IP #800 stated the nurse's cleansed the new area with normal saline, put a foam dressing on, completed a skin grid and notified the Unit Managers, WNP #815 or a facility Nurse Practitioner, and if it was after hours the Telehealth provider was contacted for treatment orders. Interview on 09/27/24 at 2:06 P.M. with the DON and Registered Dietician (RD) #817 revealed RD #817 stated he worked on site at the facility Monday through Friday and all his documentation for the residents could be found in their electronic records. RD #817 stated he was familiar with Resident #165 and met with her a few times after she was admitted on [DATE]. RD #817 stated when he was notified a resident had a pressure ulcer, he would complete a nutritional evaluation with in about a week of the notification. RD #817 confirmed Resident #165's Stage III pressure ulcer was identified on 08/12/24 and the first time he documented a nutritional evaluation for the Stage III pressure ulcer was on 09/09/24. RD #817 stated he could not remember when he first found out Resident #165 had a Stage III sacral pressure ulcer, but stated it was probably in the daily morning meeting. Interview on 09/29/24 at 9:08 A.M. with the DON revealed she was not aware of Guardian #818's concerns regarding Resident #165's care including incontinence care and pressure ulcer concerns. The DON confirmed Resident #165's treatment orders written on 09/12/24 were not placed by WNP #816. The DON stated on 09/12/24 WNP #816 was filling in for WNP #815 and should have put the orders in if they were new orders. The DON indicated the Unit Manager should have reviewed the skin and wound notes, and she was not sure what happened with Resident #165's orders. The DON confirmed treatments were not completed as ordered from 09/12/24 through 09/16/24 as noted above for Resident #165's sacral Stage III pressure ulcer and full thickness wound to the left buttock. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility undated policy titled Skin Care and Wound Management Overview included facility staff strived to prevent resident skin impairment and to promote the healing of existing wounds. The interdisciplinary team worked with the resident and/or family/responsible party to identify and implement interventions to prevent and treat potential skin integrity issues. The interdisciplinary team evaluated and documented identified skin impairments and pre-existing signs to determine the type of impairment, underlying condition(s) contributing to it and description of impairment to determine appropriate treatment. Each resident was evaluated upon admission and weekly thereafter for changes in skin condition. Resident skin condition was also re-evaluated with change in clinical condition, prior to transfer to the hospital and upon return from the hospital. Skin care and wound management program included implementation of prevention strategies to decrease the potential for developing pressure ulcers. Develop a care plan with individualized interventions to address risk factors, communicate risk factors and interventions to the care giving team. For treatment select and complete the appropriate form, pressure ulcer documentation, complete for all pressure ulcers, review and select the appropriate treatment for the identified skin impairment, obtain a physician's order. This deficiency represents non-compliance investigated under Complaint Number OH00157677.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident's #28 and Resident#127 were provided incontinence care timely. This affected two residents (Resident's #28 and #127) out of four residents reviewed for incontinence care. The facility census was 160. Findings include: 1. Review of Resident #28's medical record revealed an admitted [DATE] and diagnoses included Alzheimer's Disease, vascular dementia, and other speech and language deficits following unspecified cerebrovascular disease. Review of Resident #28's care plan dated 10/20/21 and revised on 08/07/24 included Resident #28 was incontinent of bowel and bladder related to impaired cognition, impaired mobility. Resident #28 would remain free of skin break down due to incontinence. Interventions included to check Resident #28 for incontinence and wash, rinse and dry perineum, and changed clothing as needed after incontinence episodes; Resident #28 used disposable briefs, change as needed. Review of Resident #28's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #28 had severe cognitive impairment. Resident #28 was dependent for personal and toileting hygiene, dressing, and the ability to roll left and right from lying on back, chair, bed-to-chair transfer, and to return to lying on back on the bed. Resident #28 was always incontinent of urine and bowel. Observation on 09/25/24 at 4:16 P.M. of State tested Nursing Assistant (STNA) #819 revealed she was providing incontinence care for Resident #28. Observation of Resident #28 revealed she was lying on her bed and her gown was soaked with urine, her bed was soaked with urine, there was a dried urine ring around the wet urine, the sheet also had some greenish brown material that looked like bowel movement, and she was wearing two incontinence briefs which were soaked with urine and bowel. STNA #819 stated she did not put two incontinence briefs on Resident #28, the night shift did it. STNA #819 indicated she checked Resident #28 when she arrived for work at 7:00 A.M., had not changed her incontinence brief since she arrived for work, and this was the first time Resident #28's incontinence brief was changed today. Resident #28's buttocks, sacral area and perineum were reddened. STNA #819 stated she was too busy until now to provide incontinence care. STNA #819 continued with the incontinence care and removed Resident #28's gown and top sheet and left her lying naked and uncovered. Resident #28 repeatedly said cover me, please cover me but STNA #819 did not acknowledge Resident #28's request and did not find a sheet or blanket to cover Resident #28. Licensed Practical Nurse (LPN) #820 entered Resident #28's room, Resident #28 said cover me, and LPN #820 did not acknowledge Resident #28 said anything, did not cover her, and left the room. When asked why Resident #28 was not provided a sheet or blanket to cover her as requested STNA #819 stated there were no sheets in the room she could use. 2. Review of Resident #127's medical record revealed an admitted [DATE] and diagnoses included polyosteoarthritis, dementia without behavioral, psychotic, mood disturbance, and anxiety, and cognitive communication deficit. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #127's Admission MDS 3.0 assessment dated [DATE] revealed Resident #127 had severe cognitive impairment. Resident #127 was dependent for toileting and personal hygiene, bathing, and was frequently incontinent of urine and bowel. Review of Resident #127's care plan dated 08/30/24 included Resident #127 was incontinent of urine. Resident #127 would remain free of skin breakdown due to incontinence. Interventions included to check resident for incontinence, wash, rinse, dry perineum and change clothing as needed after incontinence episodes. Observation on 09/25/24 at 4:16 P.M. of STNA #819 revealed she was finished providing incontinence care for Resident #127 but held up a bag with two incontinence briefs which were soaked with urine and a large bowel movement. STNA #819 stated she had to completely change Resident #127's gown and bed because they were soaked with urine and stool. STNA #819 confirmed Resident #127 was wearing two incontinence briefs which were put on her by the night shift aides. STNA #819 stated I am not going to lie, the night shift put two briefs on, indicated she arrived for work at 7:00 A.M. and she had not changed Resident #127's incontinence brief because she was too busy to provide Resident #127's incontinence care until now. Review of the facility policy titled Routine Resident Care undated included licensed staff would include the following services based upon their scope of practice, but not limited to maintaining nursing skills for appropriate areas of care management including but not limited to bowel and bladder management. Provide routine daily care by a certified nursing assistant with specialized training in rehabilitation, restorative care under the supervision of a licensed nurse including but not limited to implementing and maintaining a program for skin care, toileting, providing care for incontinence with dignity and maintaining skin integrity. This deficiency represents non-compliance investigated under Complaint Number OH00157677 and Complaint Number OH00157217.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure a medication error rate of less than 5 percent (%). A Total of two errors out of 26 opportunities were observed resulting in a 7.69% medication error rate. This affected two residents (Resident's #98 and #139) out of six residents reviewed for medication administration. The facility census was 160. Findings include: 1. Review of Resident #98's medical record revealed an admitted [DATE] and a re-entry date of 09/10/24. Resident #98's diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease, and dependence on renal dialysis. Review of Resident #98's physician orders dated 09/11/24 at 12:17 A.M. revealed orders for Spiriva Respimat 2.5 mcg/ACT Aerosol, solution, two puffs inhale orally in the morning for COPD (chronic obstructive pulmonary disease). Observation on 09/25/24 at 8:38 A.M. of Licensed Practical Nurse (LPN) #821 revealed she was standing at the medication cart preparing medications for Resident #98. LPN #821 prepared Guaifenisen 1200 ER (extended release) tablet and placed it in a small plastic cup, took Breo Ellipta inhaler 200 mcg/25 mcg (not the ordered Spiriva inhaler) out of the medication cart and laid it on top of the cart while she finished preparing the medications. LPN #821 was unable to find Resident #98's Potassium Chloride 10 millequivalents packet in the medication cart and locked the guaifenesin tablet and the Ellipta inhaler in the medication cart while she searched for the medication. LPN #821 could not find the Potassium Chloride packet and unlocked the cart and took the plastic cup with the guaifenesin tablet in it, but did not take the Ellipta inhaler out of the cart, and walked in Resident #98's room and administered the medication. LPN #821 walked back to the medication cart and signed off in the electronic record she administered Resident #98's guaifenesin and Breo Ellipta inhaler. LPN #821 was preparing to administer the next residents medication when she was asked about Resident #98's inhaler. LPN #821 confirmed she did not administer the Breo Ellipta inhaler, and signed off in Resident #98's electronic record she administered it. LPN #821 took the Breo Ellipta inhaler out of the medication cart and walked in Resident 98's room and had her take two puffs orally. This was identified as one medication error. 2. Review of Resident #139's medical record revealed an admitted [DATE] and diagnoses included anxiety disorder, chronic obstructive pulmonary disease, and polyneuropathy. Review of Resident #139's physician orders dated 09/19/24 revealed Anoro Ellipta (Umexlidinium-Vilanterol), inhalation aerosol powder breath activated 62.5-25 mcg/ACT, one inhalation, inhale orally one time a day for SOB (shortness of breath). (continued on next page)

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	09/30/2024

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/25/24 at 9:12 A.M. of LPN #804 revealed she was standing at the medication cart preparing to administer medications for Resident #139. LPN #804 took Resident #139's Anoro Ellipta inhaler out of the medication cart and walked into Resident #139's room. LPN #804 handed the Anoro Ellipta inhaler to Resident #139 without giving any instructions on how many inhalations were ordered, and Resident #139 proceeded to rapidly inhale four times. When asked how many inhalations were ordered, LPN #804 confirmed Resident #139 took four inhalation and stated Resident #139 was supposed to inhale two times (the order was for one inhalation), not four, and Resident #139 knew that. Resident #139 stated she did not know how many inhalations she was supposed to take. This was identified as one medication error. Review of the medication administration revealed two nurses were observed to have 26 opportunities for error while administering medications to six residents. Two errors were observed and the medication error rate was 7.69 percent. Review of the facility policy titled Medication Administration undated included to only administer medication as prescribed by the provider. Observe the five rights in giving each medication the right resident, the right time, the right medication, the right dose and the right route. This deficiency represents non-compliance investigated under Complaint Number OH00156479.