STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mentor Woods Skilled Nursing and Rehabilitation	8881 Schaefer St Mentor, OH 44060

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, review of hospital records, facility policy review and interview the facility failed to ensure Resident #91 was free from a significant medication error when the facility administered Resident #91's diuretic (medication to increase the production of urine) when it should have been on hold. Actual Harm occurred on 03/29/24 when the facility failed to hold Resident #91's diuretic medication resulting in a significant change in the resident's condition resulting in an unplanned hospitalization . On 03/29/24 Primary Care Physician (PCP) #615 ordered to hold Resident #91's Torsemide (diuretic medication) due to abnormal lab work including an increase in the resident's creatinine level (a test that measured how well the kidneys filter waste from the blood) to 3.3 mg/ deciliter (dl) indicating worsening of her kidney function, repeat the lab work on 04/01/24 and to notify Nephrologist #614 of the results. On 04/01/24 Resident #91's creatinine increased to 5.4 mg/dl; however, the facility restarted the Torsemide medication on this date without a physician order. The facility was unable to contact Nephrologist #614 regarding the increase in creatinine level until 04/03/24 without PCP #615 knowledge. The facility continued to administer Resident #91's Torsemide until 04/03/23 at 4:25 P.M. when the resident was sent to the hospital. Hospital Internal Medicine Physician #900 noted per his history and physical Resident #91 looked remarkedly dry and he suspected uremia (like threatening condition caused by kidney failure and waste build up in the blood). The note also revealed her labs were consistent with over diuresis (excessive production of urine usually caused by diuretics) and if no improvement the resident would require dialysis. This affected one resident (#91) of three residents reviewed for medication administration. The facility census was 87. Findings included: Review of closed medical record for Resident #91 revealed an admitted [DATE]. The resident was transferred to the hospital on 04/03/24 and she did not return to the facility. Resident #91 had diagnoses including partial amputation of her right foot, diabetes, chronic kidney disease, lymphedema, osteomyelitis, and hypertension. (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 0760 Level of Harm - Actual harm Residents Affected - Few	Review of March 2024 physician orders revealed Resident #91 had an order dated 03/20/24 for the diuretic medication, Torsemide 20 milligram (mg) one tablet by mouth two times a day for edema. She also had an order to have weekly lab work, a Completed Blood Count (CBC), Basic Metabolic Panel (BMP) and Renal Function Panel (RFP) with the order indicating to fax the results to Nephrologist #614. Resident #91 was on a 1500 milliliter (ml) fluid restriction per day. Review of an After Visit Summary dated 03/09/24 revealed hospital discharge instructions included start diuretics when approved by nephrology. The summary revealed the resident had chronic kidney disease with chronic edema to her bilateral legs. Her Lasix (diuretic) was discontinued in the hospital due to worsening of renal function. There was nothing in the medical record the nephrologist was aware Resident #91 started the diuretic on 03/20/24. Review of lab work dated 03/15/24 for Resident #91 revealed a BMP that indicated the resident's potassium was 3.6 milliequivalent (mEq)/ liter (l), sodium 146 mEq/l, chloride 100 mEq/l , and creatinine 1.1 mg/dl which were all within normal limits. Review of a care plan dated 03/15/24 revealed Resident #91 was at nutritional risk related to diabetes, chronic kidney disease, hypertension, and lymphedema. The resident was on a fluid restriction. Interventions included administering medications as ordered, encourage compliance with fluid restriction as tolerated, and monitor lab values as available. Review of lab work dated 03/20/24 for Resident #91 revealed a BMP that indicated the resident's potassium was 3.6 mEq/l, sodium was 144 mEq/l, and chloride 101 mEq/l which were all within normal limits. The resident's creatinine was slightly elevated at 1.9 mg/dl (Normal was .6 to 1.2). Review of admission Minimum Data Set (MDS) dated [DATE] revealed Resident #91 had impaired cognition. The assessment revealed the resident required set up help with eating. Review of lab work dated 03/22/24 for Resident #91 revealed a BMP that indicated a sodium level was high at 147 mEq/l (normal was 136 to 145), potassium was low at 3.3 mEq/l (normal was 3.5 to 5.3), and her creatinine increased to 2 mg/dl. The resident's chloride level continued to be 100 mEq/l within normal limits. Review of lab work dated 03/29/24 for Resident #91 revealed a BMP that indicated the resident's sodium had increased to 149 mEq/l, potassium had now decreased to 2.5 mEq/l, chloride decreased to 95 mEq/l, and her creatine now as at 3.3 mg/dl. The lab results showed signs of dehydration and renal failure. Review of a physician progress note dated 03/29/24 at 4:06 P.M. completed by Primary Care Physician (PCP) #615 revealed Resident #91's creatinine had jumped to three and her lab work was getting faxed to nephrology. He revealed under his assessment and plan a diagnosis of acute kidney injury, to hold diuretics, and check lab work on 04/01/24. Review of a nursing note dated 03/29/24 at 5:50 P.M. completed by Licensed Practical Nurse (LPN) #616 revealed PCP #615 was in to see Resident #91 and placed Torsemide on hold until Monday, 04/01/24 after BMP and encourage oral fluids. (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 0760 Level of Harm - Actual harm Residents Affected - Few	Review of April 2024 Medication Administration Record (MAR) revealed Resident #91 received the Torsemide 20 mg tablet by mouth after it was supposed to remain on hold on 04/01/24 4:00 P.M. to 6:00 P. M. dose, 04/02/24 both the early morning dose and the 4:00 P.M. to 6:00 P.M. dose, and on 04/03/24 the early morning dose until she was sent to the hospital. Review of lab work dated 04/01/24 for Resident #91 revealed a BMP that indicated the resident's sodium continued to be elevated at 146 mEq/l, potassium was still low at 3.4 mEq/l and her creatinine was now at 5. 4 mg/dl. Review of nursing note dated 04/02/24 at 2:31 A.M. and completed by LPN #617 revealed Resident #91's lab work was sent to PCP #615, and he was also sent a message. Review of a nursing note dated 04/02/24 at 8:16 A.M. and completed by Registered Nurse (RN) #618 revealed the resident's lab work was faxed to Nephrologist #614. Review of a nursing note dated 04/02/24 at 10:58 A.M. and completed by RN/ Assistant director of Nursing (ADON) #620 revealed she received a phone call from Nephrologist #614's office stating Resident #91's husband had called the office regarding Resident #91's lab work. The lab work was re-faxed to the office at 10:55 A.M. and no new orders were received as of this nursing entry. Review of a nursing note dated 04/03/24 at 11:30 A.M. completed by RN/ ADON #620 revealed she spoke with Resident #91's husband in the morning as he had questions regarding the resident's current medications and if Nephrologist #614 had called back with any order changes. She informed Resident #91's husband that the lab work was faxed to the Nephrologist #614's office and that she would follow up with the office. Review of a nursing note dated 04/03/24 at 4:25 P.M. completed by RN #601 revealed Resident #91 was sent to the hospital by a rescue squad. There was no other documentation regarding the resident assessment, the condition of the resident, who had ordered her to go to the hospital and the reason why she was sent. Review of the hospital History and Physical dated 04/03/24 and completed per Hospital Internal Medicine Physician #900 revealed Resident #91 looked remarkedly dry and that he suspected uremia (life threatening condition caused by kidney failure and waste build up in the blood). The note revealed her labs show alkalosis consistent with over diuresis (excessive production of urine usually caused by diuretics). Internal Medicine Physician #900 discussed in detail her status with Nephrologist #614 and if no improvement she would require dialysis. (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 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Clinical Note from the hospital dated 04/04/24 and completed by Nephrologist #614 revealed he had sent Resident #91 to the emergency room as he was sent lab work which he just became aware of for the first time yesterday afternoon, 04/03/24. The note revealed Resident #91's husband was concerned as his wife was displaying change in mental status including eyes rolling back in her head. The note revealed notably another provider had checked her lab work and stopped her Torsemide (the note does not reference how the facility had restarted the Torsemide on 04/01/24). The note revealed her creatine was 6.7 mg/dl, high sodium level at 149 and she was encephalopathic (disorder that affect the brain including confusion, memory loss and mental changes). The note revealed the resident appeared very dry and showed signs of significant dehydration. He recommended to continue to hold all diuretics. He diagnosed Resident #91 with acute kidney injury, and hypernatremia (low sodium) secondary to significant dehydration. He recommended if by the next morning, 04/05/24 her renal function had not improved, he would have her start dialysis. Interview on 05/06/24 at 4:42 P.M. with RN #601 revealed she was the nurse on duty on 04/03/24 caring for Resident #91. She revealed she could not remember why Resident #91 went to the hospital, who had ordered her to go to the hospital, and/ or her status at the time she was sent to the hospital. She revealed after reviewing the medical record, I cannot believe I did not write anything about it including documenting an assessment. Interview on 05/07/24 at 11:08 A.M. with PCP #615 revealed he thought Resident #91's husband had requested her to start on the Torsemide 20 mg twice a day on 03/19/24 but was unsure. He revealed he then ordered it as he knew she was getting weekly lab work that was being reviewed by Nephrologist #614. He revealed he was at the facility on 03/29/24 and was notified of Resident #91's lab work indicating her creatinine had increased to above three. He revealed he was told Nephrologist #614 was not in the office and since it was a Friday he handled the abnormal lab work. He revealed he placed her Torsemide on hold as residents displaying renal failure signs and dehydration should not continue a diuretic. He revealed he assumed then that the facility would have Nephrologist #614 address her lab work on 04/01/24 and continue to hold the Torsemide until then. He verified that he never gave the order to restart the Torsemide as this needed continued to be held especially since her creatinine on 04/01/24 increased to 5.4 as this medication would affect her kidney function. He revealed he was not informed she had received the Torsemide on 04/1/24 through 04/3/24 (date she was sent to the hospital). He stated, no she should not have. He revealed he was not aware the facility was not able to get a hold of Nephrologist #614 until 04/03/24 and that her lab work had not been addressed. Interview on 05/07/24 at 11:30 A.M. with Resident #91's husband revealed Resident #91 should have never been receiving a diuretic as this was what caused her renal failure to deteriorate. He revealed on 03/29/24 he had expressed concern that his wife was severely dehydrated as her lips/ mouth were severely dry and she was confused with mental status changes. He revealed he was told that they placed Torsemide on hold on 03/29/24 as her creatine level had increased. He revealed he found out that the level continued to rise as the facility kept giving her the Torsemide instead of holding it as it should have been. He revealed he continued to question the facility as she continued to not look well but they seemed to ignore her symptoms especially that she was severely dehydrated, and in renal failure. He revealed on 04/03/24 that since the facility was not doing anything he contacted Nephrologist #614's secretary who had called the facility to have her sent out by 911- emergency rescue services. He revealed at the hospital the resident's creatinine had increased further and that she required emergency dialysis to get her kidneys functioning again. He revealed she now was doing a lot better and no longer required dialysis. (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 0760 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/07/24 at 1:41 P.M. with the Director of Nursing verified she had nothing in the medical record to support Nephrologist #614 was aware Resident #91 had started on a diuretic. She also verified Resident #91 had received the following doses of Torsemide when it should have continued to be on hold: on 04/01/24 4:00 P.M. to 6:00 P.M. dose, 04/02/24 both the early morning dose and the 4:00 P.M. to 6:00 P.M. dose, and on 04/03/24. She revealed PCP #615 had contacted her after the interview with this surveyor and had stated the Torsemide should never had been restarted especially because of how high the resident's creatinine level was and that he was not aware that they were having difficulty contacting Nephrologist #614 and that they should have contacted him. Review of facility policy labeled, Administering Medications dated April 2019 revealed medications were to be administered in a safe and timely manner as prescribed. This deficiency represents non-compliance investigated under Complaint Number OH00152934 and Complaint Number OH00152981.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on medical record review, facility policy review and interview the facility failed to ensure Resident #91's medical record was complete and accurate. This affected one resident (#91) of nine residents reviewed for accuracy of medical records. The facility census was 87. Findings included: Review of the closed medical record for Resident #91 revealed an admitted [DATE]. The resident was transferred to the hospital on 04/03/24 and did not return to the facility. Resident #91 had diagnoses including partial amputation of her right foot, diabetes, chronic kidney disease, lymphedema, and osteomyelitis. Review of a nursing note dated 04/02/24 at 2:31 A.M. and completed by Licensed Practical Nurse (LPN) #617 revealed Resident #91's lab work was sent to PCP #615, and he was also sent a message. Review of a nursing note dated 04/02/24 at 8:16 A.M. and completed by Registered Nurse (RN) #618 revealed the lab work was faxed to Nephrologist #614. Review of a nursing note dated 04/02/24 at 10:58 A.M. and completed by RN/ Assistant director of Nursing (ADON) #620 revealed she received a phone call from Nephrologist #614 office stating Resident #91's husband had called the office regarding Resident #91's lab work. The lab work was refaxed to the office at 10:55 A.M. and no new orders were received as of this nursing entry. Review of a nursing note dated 04/03/24 at 11:30 A.M. completed by RN/ ADON #620 revealed she spoke with Resident #91's husband in the morning as he had questions regarding her current medications and if the Nephrologist #614 had called back with any order changes. She informed Resident #91's husband that the lab work was faxed to the Nephrologist #614's office and that she would follow up with the office. Review of a nursing note dated 04/03/24 at 4:25 P.M. completed by RN #601 revealed Resident #91 was sent to the hospital by a rescue squad. There was no other documentation regarding the resident assessment, the condition of the resident, who had ordered her to go to the hospital and the reason why she was sent. Interview on 05/06/24 at 4:42 P.M. with RN #601 revealed she was the nurse on duty on 04/03/24 caring for Resident #91. She revealed she could not remember why Resident #91 went to the hospital, who had ordered her to go to the hospital, and/ or her status at the time she was sent to the hospital. She revealed after review of the medical record, I can not believe I did not write anything about it. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/07/24 at 1:41 P.M. with the Director of Nursing verified Resident #91's medical record was not complete as RN #601 should have documented a resident assessment, condition of the resident, who had ordered her to go to the hospital and reason why she was sent to the hospital. She verified she had questioned RN #601 as well after the surveyor had brought it to her attention who could not remember why Resident #91 was sent to the hospital and/ or any details which were concerning especially since it was not documented. Review of facility policy labeled, Charting and Documentation dated July 2017 revealed all services provided to the resident, progress toward the care plan goals, or any changes in resident's medical, physical, functional, psychosocial condition shall be documented in the resident's medical record. This deficiency represents non-compliance investigated under Complaint Number OH00152934.