STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366231	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roselawn Gardens Nursing & Rehabilitation	11999 Klinger Avenue NE Alliance, OH 44601

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review, interview and facility policy review, the facility failed to ensure non-pharmacological interventions and parameters were in place to effectively manage pain for Resident #19. This affected one resident (#19) of five residents reviewed for unnecessary medications. The facility census was 40. Findings include: Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, hepatitis, schizophrenia, chronic pain syndrome, and cirrhosis. Review of the care plan dated 01/15/25 revealed Resident #19 was at risk for pain due to chronic pain syndrome. Interventions included administering medications as ordered, assisting with repositioning when in a chair or bed, observing for medication side effects and assessing for pain frequency, intensity, duration, and onset. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 was cognitively intact. He was independent for eating, oral and personal hygiene, and required supervision for showering and toileting. Review of Resident #19's current physicians' orders dated 01/14/25 revealed an order for Acetaminophen 325 milligrams (mg) (analgesic) give two tablets every six hours as needed (prn) for chronic pain and an order for Oxycodone HCL oral concentrate (a narcotic pain medication) 100 mg/5 milliliters (ml) give 0.75 ml by mouth every six hours prn for chronic pain. Review of the Medication Administration Record (MAR) for January 2025 revealed Resident #19 was given Oxycodone one time on 01/15/25 for a pain level of six, one time on 01/16/25 for a pain level of four, one time on 01/16/25 for a pain level of nine, one time on 01/16/25 for a pain level of seven, one time on 01/17/25 for a pain level of three, one time on 01/17/25 for a pain level of six, one time on 01/18/25 for a pain level of seven, one time on 01/20/25 for a pain level of six, one time on 01/21/25 for a pain level of seven, one time on 01/22/25 for a pain level of eight, one time on 01/23/25 for a pain level of seven, one time on 01/25/25 for a pain level of two, one time on 01/25/25 for a pain level of nine, one time on 01/26/25 for a pain level of three, one time on 01/26/25 for a pain level of nine, one time on 01/27/25 for a pain level of eight, one time on 01/29/25 for a pain level of nine, and one time on 01/30/25 for a pain level of eight. He was never offered the Acetaminophen. (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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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for February 2025 revealed Resident #19 received one dose of Acetaminophen 02/05/25 for a pain level of four. Resident #19 received Oxycodone one dose on 02/04/25 for a pain level of four, one dose on 02/05/25 for pain level of six, one dose on 02/07/25 for a pain level of four, two doses on 02/08/25 for pain level of nine, one dose on 02/08/25 for pain level of three, one dose on 02/09/25 for a pain level two, one dose on 02/10/25 for pain level of four, and one dose on 02/10/25 for pain level five. Review of the progress notes for January and February 2025 revealed no evidence Resident #19 was provided non-pharmacological interventions prior to the administration of Oxycodone. Interview on 02/13/25 at 7:59 A.M. with Licensed Practical Nurse (LPN) #235 revealed non-pharmacological interventions would be attempted and documented in the progress notes for pain management, and she would offer a non-narcotic pain medication prior to a narcotic medication, if the resident was experiencing pain. She did not know if there were any parameters to assist in determining which medication to administer. Review of the facility policy titled Pain Assessment and Management, dated March 2015, revealed pain management would include non-pharmacological interventions and lower doses of medication would be administered and titrating upward as necessary.

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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** 48567 Based on observation, interview, review of the medical record, review of the manufacturer's instructions and review of the facility policy, the facility failed to ensure Resident #38's medications were given per physician's orders. This affected one resident (#38) of six residents reviewed for medication administration. The facility census was 40. Findings include: Medical record review for Resident #38 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, nonpsychotic mental disorder, polyneuropathy, paranoid schizophrenia, unspecified malignancy of skin, essential hypertension, and atrial premature depolarization. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 11/25/24 revealed Resident #38 had mild cognitive impairment. Resident #38 received insulin injections seven days of the seven-day look-back period and had two insulin order changes during that time. Review of physician orders revealed the following two insulin orders dated 11/19/24: Insulin Lispro injection pen 100 units per milliliter (units/ml), inject four units subcutaneously before meals and at bedtime, and Insulin Lispro injection pen 100 units per milliliter (units/ml), inject per sliding scale: two units for blood sugar 150 to 200; four units for blood sugar 201 to 250; six units for blood sugar 251 to 300; eight units for blood sugar 301 to 350; 10 units for blood sugar 351 to 400; and 12 units for blood sugar 401 to 450 subcutaneously before meals and at bedtime. Observation on 02/11/25 at 4:30 P.M. of medication administration to Resident #38 by Licensed Practical Nurse (LPN) #206 revealed LPN #206 did not prime the insulin needle by dialing and wasting two units prior to setting the dose on the insulin pen to the ordered six units (four units plus an additional two units per sliding scale due to blood sugar reading of 194 at 4:26 P.M), attaching the needle, then administering the insulin to Resident #38. Interview on 02/11/25 at 4:30 P.M. with LPN #206 confirmed she did not prime Resident #38's insulin needle with two units prior to setting the ordered combined dose of six units on the Insulin Lispro pen, attaching the needle, and administering the injection. Review of the Insulin Lispro Instructions for Use revealed the pen needed primed to remove the air from the needle by turning the dose knob to two units and then depressing the dose knob in until it stopped at zero. The instructions further revealed the priming steps should be repeated if no insulin was noted exiting the tip of the needle and that failure to prime the needle could result in the recipient getting too much or too little insulin. Review of the facility policy titled Utilization of Prefilled insulin Pens Policy, dated 09/23/24, revealed that insulin pens were to be primed according to manufacturer's recommendations, two units, unless otherwise specified.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, record review, interview and review of facility policies, the facility failed to properly clean and disinfect the blood glucose monitor (BGM/glucometer) between resident use. This affected two residents (#6 and #18) of six residents observed during medication administration and had the potential to affect seven additional residents (#1, #2, #8, #10, #19, #21, and #23) in the 300 hall who had orders for blood sugar monitoring. The facility census was 40. Findings include: 1. Review of the medical record for Resident #6 revealed an original admitted [DATE] with a re-entry date of 06/25/21. Diagnoses included stage two chronic kidney disease, gastroesophageal reflux disease (GERD), iron deficiency anemia, major depressive disorder, hypertension, congestive heart failure, chronic gastritis, and type two diabetes mellitus. Review of the physician orders revealed Resident #6 had an order dated 06/25/24 for NovoLog FlexPen Solution Pen-injector (Insulin Aspart) 100 units per milliliter (units/ml) per sliding scale subcutaneously before meals and at bedtime as follows: two units for blood sugar 151 to 200; six units for blood sugar 201 to 250; 10 units for blood sugar 251 to 300; 12 units for blood sugar 301 to 350; 14 units for blood sugar 351 to 400; 16 units for blood sugar 401 to 450; and notify the physician for blood sugar less than 70 or greater than 451. Observation on 02/11/25 at 3:38 P.M. revealed Licensed Practical Nurse (LPN) #208 performed a fingerstick blood sugar (FSBS) test on Resident #10 then exited the resident's room and placed the glucometer on top of her med cart and began preparing medications for Resident #10 without cleaning the device. Observation on 02/11/25 at 3:48 P.M. revealed LPN #208 performed a FSBS test on Resident #6 using the same glucometer that was lying on top of the medication cart, which had not been properly cleaned or disinfected after it was used for Resident #10. Interview on 02/11/25 at 3:55 P.M. with LPN #208 confirmed she did not know the facility policy on how to clean and disinfect the glucometer between resident use. During the interview, LPN #208 stated she quickly wiped the glucometer with one disposable alcohol wipe before using it on Resident #6 when the surveyor was not looking. Interview on 02/11/25 at 4:47 P.M. with Regional Nurse #261revealed she acknowledged with a nod and yes to the glucometers needing to be cleaned with a germicidal wipe and allowed to dry for the specified amount of time (per the wipes instructions) before using again. Review of the Environmental and Equipment Cleaning Policy, last revised August 2019, revealed glucometers were to be cleaned after each resident use with a bleach product disinfecting wipe and air dried before next use. The policy further revealed alcohol was not an acceptable product for disinfecting glucometers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #18 revealed he was admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus, traumatic shock, insomnia, schizoaffective disorder, conductive hearing loss left ear, anxiety disorder, and mild receptive-expressive language disorder. Review of the physician orders revealed Resident #18 had an order dated 08/28/24 for Insulin Lispro 100 units per milliliter (units/ml) to be administered before meals and at bedtime per a sliding scale as follows: two units for blood sugar 151 to 200; four units for blood sugar 201 to 250; six units for blood sugar 251 to 300; eight units for blood sugar 301 to 350; 10 units for blood sugar 351 to 400; and notify the physician or nurse practitioner for blood sugar greater than 400. Observation on 02/11/25 at 3:48 P.M. revealed LPN #208 performed a FSBS test on Resident #6. Further observation on 02/11/25 revealed LPN #208 exited Resident #6's room and placed the glucometer on top of the medication cart and placed a dry cloth that looked like a tissue on top of it. No cleaning or disinfecting of the glucometer was observed. Observation on 02/11/25 t 3:54 P.M. revealed LPN #208 picked the glucometer up off the top of the medication cart and used it to check Resident #18's blood sugar at the medication cart without first properly disinfecting the device. Interview on 02/11/25 at 3:55 P.M. with LPN #208 confirmed she did not know the facility policy on how to clean and disinfect the glucometer between resident use. During the interview, LPN #208 stated she used a cloth on the top of the glucometer, picking the item up and showing it to the surveyor. When asked what the cloth was, she verified she did not know but showed the surveyor several other similar looking items placed in the top drawer of the medication cart. At the time of this interview, LPN #208 confirmed the cloth and the other similar items in the drawer were dry. Interview on 02/11/25 at 4:47 P.M. with Regional Nurse #261revealed she acknowledged with a nod and yes to the glucometers needing to be cleaned with a germicidal wipe and allowed to dry for the specified amount of time (per the wipes instructions) before using again. Review of the Environmental and Equipment Cleaning Policy, last revised August 2019, revealed glucometers were to be cleaned after each resident use with a bleach product disinfecting wipe and air dried before next use. The policy further revealed alcohol was not an acceptable product for disinfecting glucometers.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on medical record review, interview, and review of the facility policy, the facility failed to ensure Resident #31 received the pneumococcal vaccine after signing consent, failed to ensure that Residents #34, #36, and #39 or their resident representative were given the opportunity to consent to or refuse the pneumococcal vaccine, and failed to ensure the medical record contained evidence Residents #31, #34, #36, #38, and #39 received education regarding the benefits and risks of immunization against the pneumococcal virus and each of these residents either received or did not receive the pneumococcal vaccine. This affected five residents (#31, #34, #36, #38, and #39) of 13 residents who were reviewed for immunizations. The facility census was 40. Findings include: 1. Review of the medical record for Resident #31 revealed an admitted [DATE]. Diagnoses included epilepsy, depression, dementia, chronic obstructive pulmonary disease (COPD), and alcohol abuse. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the pneumococcal vaccine was not offered, and Resident #31 was not up to date with the vaccine. Review of the immunization tab in the electronic medical record (EMR) revealed no vaccine history for Resident #31. Review of the hard chart alongside the Director of Nursing (DON) revealed a signed consent to receive the pneumococcal vaccine for Resident #31, but there was no documented evidence the vaccine had been administered. Interview on 02/13/25 at 10:20 A.M. with the DON confirmed Resident #31 signed consent to receive the pneumococcal vaccine but the EMR and the hard charts contained no documented evidence that the pneumococcal vaccine was administered to Resident #31. Review of the undated facility policy titled Pneumococcal Vaccine revealed all residents would be offered pneumococcal vaccines and were to be assessed for eligibility prior to or within five working days of admission to the facility. The policy further revealed the residents would be offered the vaccine series within 30 days of admission unless medically contraindicated or the resident had already been vaccinated. Refusals were to be documented in the resident's medical record, indicating the date of the refusal. 2. Review of the medical record for Resident #34 revealed an admitted [DATE]. Diagnoses included heart disease, kidney disease, asthma, and prediabetes. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed the pneumococcal vaccine was not offered, and Resident #34 was not up to date with the vaccine. Review of the vaccine consent binder, immunization tab in the EMR, and review of the hard chart revealed no documented evidence of pneumococcal vaccine eligibility assessment, education, consent, declination, or administration of the pneumococcal vaccine for Resident #34. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/13/25 at 10:28 A.M. with the DON confirmed Resident #34's EMR and hard chart contained no documented evidence of pneumococcal vaccine education, consent, declination, or administration. Review of the undated policy titled Pneumococcal Vaccine revealed all residents would be offered pneumococcal vaccines and were to be assessed for eligibility prior to or within five working days of admission to the facility. The policy further revealed the residents would be offered the vaccine series within 30 days of admission unless medically contraindicated or the resident had already been vaccinated. Refusals were to be documented in the resident's medical record, indicating the date of the refusal. 3. Review of the medical record for Resident #36 revealed an admitted [DATE] and re-entry dated of 12/03/24. Diagnoses included nondisplaced fracture of the neck of the left radius, chronic ulcerative proctitis, posthemorrhagic anemia, malignant neoplasm of the rectum, malignant neoplasm of the anus, hypertension, and COPD. Review of the quarterly MDS 3.0 assessment completed on 12/31/24 revealed Resident #36 was not up to date with the pneumococcal vaccine and the vaccine was not offered. Review of the facility's vaccine consent binder, immunization tab in the EMR, and Resident #36's hard chart revealed no documented evidence of pneumococcal vaccine eligibility assessment, education, consent, declination, or administration of the pneumococcal vaccine for Resident #36. Interview on 02/13/25 at 10:15 A.M. with the DON confirmed Resident #36's EMR and hard chart contained no documented evidence of pneumococcal vaccine education, consent, declination, or administration. Review of the undated policy titled Pneumococcal Vaccine revealed all residents would be offered pneumococcal vaccines and were to be assessed for eligibility prior to or within five working days of admission to the facility. The policy further revealed the residents would be offered the vaccine series within 30 days of admission unless medically contraindicated or the resident had already been vaccinated. Refusals were to be documented in the resident's medical record, indicating the date of the refusal. 4. Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, nonpsychotic mental disorder, polyneuropathy, paranoid schizophrenia, unspecified malignancy of skin, essential hypertension, and atrial premature depolarization. Review of the admission MDS 3.0 assessment completed on 11/25/24 revealed Resident #38 was not up to date with the pneumococcal vaccine, and the vaccine was not offered. Review of the facility's vaccine consent binder and the immunization tab in the EMR revealed no pneumococcal vaccine eligibility assessment, education, consent, declination, or administration of the vaccine. Review of the hard chart revealed admission paperwork titled INFLUENZA/PNEUMOCOCCAL ASSESSMENT/CONSENT which contained Resident #38's signature, dated 11/18/24, but no assessment information had been completed, and Resident #38 did not indicate whether he would consent or refuse the pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/13/25 at 10:23 A.M. with the DON confirmed Resident #38 signed a blank vaccine assessment and consent form and that it did not indicate his eligibility for the vaccine or wishes regarding vaccine administration. The DON further confirmed there was no indication Resident #38 received pneumococcal immunization. Review of the undated policy titled Pneumococcal Vaccine revealed all residents would be offered pneumococcal vaccines and were to be assessed for eligibility prior to or within five working days of admission to the facility. The policy further revealed the residents would be offered the vaccine series within 30 days of admission unless medically contraindicated or the resident had already been vaccinated. Refusals were to be documented in the resident's medical record, indicating the date of the refusal. 5. Review of the medical record for Resident #39 revealed an admitted [DATE]. Diagnoses included sepsis, respiratory failure, lung cancer, anxiety, and COPD. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed the pneumococcal vaccine was not offered, and Resident #39 was not up to date with the vaccine. Review of the facility's vaccine consent binder, immunization tab in the EMR, and Resident #39's hard chart revealed no documented evidence of pneumococcal vaccine eligibility assessment, education, consent, declination, or administration of the pneumococcal vaccine for Resident #39. Interview on 02/13/25 at 10:49 A.M. with the DON and Licensed Practical Nurse (LPN) #217 confirmed Resident #39's EMR and hard chart contained no documented evidence of pneumococcal vaccine education, consent, declination, or administration. Further interview with the DON confirmed there were no progress notes or admission paperwork to support Resident #39 had received pneumococcal vaccine education, assessment for vaccine eligibility, or consented to or refused vaccination. Review of the undated policy titled Pneumococcal Vaccine revealed all residents would be offered pneumococcal vaccines and were to be assessed for eligibility prior to or within five working days of admission to the facility. The policy further revealed the residents would be offered the vaccine series within 30 days of admission unless medically contraindicated or the resident had already been vaccinated. Refusals were to be documented in the resident's medical record, indicating the date of the refusal.