STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366266	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enniscourt Nursing Care	13315 Detroit Ave Lakewood, OH 44107

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, interview and review of the facility policy, the facility failed to correctly transcribe and record oxygen orders upon admission to ensure oxygen was administered properly. This affected one resident (#43) of three residents reviewed for oxygen. Facility census was 40. Findings include: Review of Resident #43's closed medical record revealed an admitted [DATE] and diagnoses including right arm humorous fracture, acute on chronic congestive heart failure, hypertensive heart disease with heart failure, hyperlipidemia, chronic obstructive pulmonary disease, type two diabetes and chronic kidney disease stage four. Resident #43 expired in the facility on [DATE]. Review of Resident #43's 5-day minimum data set (MDS) 3.0 assessment dated [DATE] revealed he was cognitively intact and was dependent on staff for toileting and transfers. The assessment indicated Resident #43 expired in the facility. Review of Resident #43's hospital paperwork dated [DATE] revealed additional discharge instructions of oxygen to be administered at 2 liters/minute. Review of Resident #43's physicians' orders revealed an order dated [DATE] for apply oxygen in order to keep oxygen saturation at or above 92% as needed. The order was timed [DATE] at 1:34 P.M. and was put in by Previous Director of Nursing (PDON) #109. Review of the order audit details revealed PDON #109 created and confirmed the order on [DATE] at 2:19 P.M. No other oxygen orders were noted for Resident #43 during this admission. Review of Resident #43's Medication Administration Record (MAR) for [DATE] revealed his oxygen was not signed off as being administered on [DATE] or [DATE]. Interview on [DATE] at 8:48 A.M. with Family Member (FM) #111 revealed an autopsy was done after Resident #43 passed away and recalled they were told Resident #43 did not have oxygen supplied to him for five hours. Interview on [DATE] at 9:45 A.M. with FM #112 revealed Resident #43's death certificate reported his cause of death to be congestive heart failure for three years and cardiorespiratory failure for three hours. (continued on next page)

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 10:44 A.M. with Licensed Practical Nurse (LPN) #110 revealed she was responsible for Resident #43's admission documentation on [DATE]. LPN #110 explained the Director of Nursing (DON) handled a new resident's admission orders including verifying the orders with the physician but floor nurses like herself did the head-to-toe assessments, initial vital signs, fall assessment and wandering assessment. Interview on [DATE] at 11:03 A.M. with the DON revealed she was the facility's DON as of [DATE]. The DON explained orders from the after visit summary from the hospital were reviewed with the physician and then she would put the orders in to the electronic medical record. The DON stated if she did not put in the orders, other administrative nurses would do so for a new admission. The DON indicated ancillary orders, such as oxygen, were handled in the same way. The DON was asked about Resident #43's oxygen orders from the hospital on [DATE] and at the facility on [DATE] during the interview and confirmed the facility's orders for PRN oxygen did not match the continuous rate of oxygen as indicated on Resident #43's hospital paperwork. Interview on [DATE] at 11:21 A.M. with PDON #109 revealed she was the DON at the time Resident #43 resided in the facility during [DATE]. PDON #109 explained she verified Resident #43's hospital orders with the physician and the orders were transcribed into the computer and then activated when the resident was in the building. PDON #109 stated she always put oxygen into the electronic medical record as a PRN order as the facility had a standing order for oxygen and would do this unless otherwise indicated in the referral information or other documentation from the hospital. PDON #109 explained unless the nurse had told her about the continuous oxygen after the resident arrived, the order would have been changed over to a continuous rate first thing the next morning after admission. PDON #109 was unaware Resident #43 had an order for continuous oxygen from the hospital at the time of the interview. Review of the facility policy, Admissions - from Other Healthcare Facilities, revised [DATE] revealed residents from other healthcare facilities may be admitted upon receipt of appropriate documentation. The following information will be provided to the facility prior to or upon the resident's admission . physician orders for immediate care. Review of the facility policy, Medication and Treatment Orders, revised [DATE] revealed orders for medications must include: name and strength of the drug; number of doses, start and stop date, and/or specific duration of therapy; dosage and frequency of administration; route of administration; clinical condition or symptoms for which the medication is prescribed and interim follow-up requirements. This deficiency represents noncompliance investigated under Complaint Number OH00161291.