STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366339	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Lake Vista	303 North Mecca Street Cortland, OH 44410

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on interview, record review, review of facility policy, review of the Ohio Board of Nursing Registered Nurse scope of practice, and review of facility investigation the facility failed to ensure staff provided care and services according to professional standards of practice/within their scope of practice. This affected one (#146) of five residents (#8, #15, #46, #142, #145) reviewed for medication errors. The facility census was 39. Findings include: Review of the medical record for Resident #146 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #146 was receiving hospice services and expired in the facility. Diagnoses included chronic obstructive pulmonary disease, bipolar disorder, and dysphagia (difficulty swallowing). Resident #146 had no known allergies. Review of the care plan dated [DATE] revealed Resident #146 was at risk for cardiovascular complications related to her disease process. Interventions included to administer medications as ordered and to monitor vital signs. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #146 had severe cognitive impairment and required extensive assistance with all activities of daily living. Review of nursing progress notes dated [DATE] timed at 4:56 A.M. authored by Registered Nurse (RN) #500 revealed the following. On [DATE] at 7:45 P.M. Resident #146 took pills with whole thin liquids. Resident #146 was conversant. On [DATE] at 8:45 P.M. the aide informed the nurse Resident #146 could not breathe, and her lips were blue. On [DATE] at 8:46 P.M. the aide obtain equipment to obtain vital signs and the nurse stayed with Resident #146. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 8:50 P.M. vital signs were Blood pressure ,d+[DATE], Oxygen level 92% on six liters of oxygen, respirations 33, pulse 112. RN #500 attempted to contact Resident #146's family because Resident #146 had an advance directive of Do Not Resuscitate Comfort Care (DNRCC). On [DATE] at 8:55 P.M., RN #500 called Resident #146's son with no answer. On [DATE] at 9:00 P.M., RN #500 called emergency services (911). Resident #146 was struggling more to breath and had hemoptysis (spitting up blood or blood stained mucous). RN #500 made a clinical decision to administer 1 milligram of Morphine. RN #146 obtained the Morphine that was prescribed for another resident, Resident #145. On [DATE] at 9:05 P.M., RN #500 called the daughter who asked RN #500 to hold off sending Resident #146 to the hospital until speaking with her brother the power of attorney (POA). The daughter successfully called her brother on three way conference call. The son was notified of Resident #146's condition and that Morphine was given because RN #500 had no other options to keep Resident #146 comfortable. The ambulance squad spoke to the son, and he decided Resident #146 should be sent to the hospital. Resident #146 was sent to the emergency room via squad and admitted to the hospital intensive care unit with a diagnosis of hypoxia related to pneumonia. Review of Self-Reported Incident (SRI) dated [DATE] revealed Resident #145's Morphine was administered to another resident (Resident #146). Review of the controlled medication flowsheet confirmed that on [DATE], one milligram of Morphine was taken from Resident #145 and administered to another resident. Review of the witness statement dated [DATE] timed 9:00 P.M. from RN #500 confirmed RN #500 gave Resident #146 Morphine that belonged to Resident #145 without checking Resident #146's orders or calling the physician. RN #146 indicated she was called to Resident #146's room and found Resident #146 with blue lips struggling to breath. RN #500 assessed Resident #146's vital signs and placed her on six liters of oxygen via nasal cannula. Resident #146's vital signs were stable, but she was struggling to breath. They assessed her code status and learned she was a DNRCC. RN #500 assumed this meant the resident was receiving hospice services so she was unsure if she should call the medics. RN #500 attempted to reach Resident #146's son with no answer. RN #500 then decided to call 911 and made the independent clinical decision to administer Morphine 1 mg by mouth to Resident #146 to help with her breathing because she was a DNRCC, and she assumed the resident had an order for medication. Resident #146 began coughing up blood, so she administered the dose sublingually. The family did reach back out at the time the emergency squad arrived, and RN #500 informed the family of the situation and that she administered Morphine without an order. The family decided to send Resident #146 to the hospital. Later, that evening she received a call from the hospital informing her Resident #146 was pleasantly confused and being admitted to the hospital for hypoxia. Review of the hospital discharge summary dated [DATE] revealed Resident #146 was discharged with a diagnosis of hypoxia related to pneumonia and an order for a palliative care consult was placed. Review of the nursing progress note dated [DATE] revealed Resident #146's family decided to place Resident #146 under hospice care and an order for Morphine was obtained at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 3:30 P.M. with the Director of Nursing (DON) confirmed Resident #146 was administered Morphine without a physician's order. The DON said the incident was investigated and reported to the State Agency and RN #500, who was an agency nurse, was reported the Board of Nursing and placed on the do not return list. All staff were educated regarding misappropriation, following physician orders and not administering medications without a physician order. In addition follow up auditing was completed to ensure no medication was administered without a valid physician order. Review of the employee file for RN #500 confirmed she was employed by a staffing agency contracted by the facility. RN #500 had a current nursing license at the time of the incident and background screening had been completed. Documentation validated RN #500 received training on abuse and neglect and medication administration. Review of the Ohio Department of Health Scopes of Practice: Registered Nurses (RN) and Licensed Practical Nurses (LPN) dated [DATE] revealed the following. Registered Nurses Section 4723.01(B), ORC, defines the scope of RN practice as: Providing to individuals and groups nursing care requiring specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, social, and nursing sciences. Such nursing care includes: (1) Identifying patterns of human responses to actual or potential health problems amenable to a nursing regimen; (2) Executing a nursing regimen through the selection, performance, management, and evaluation of nursing actions; (3) Assessing health status for the purpose of providing nursing care; (4) Providing health counseling and health teaching; (5) Administering medications, treatments, and executing regimens authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice; (6) Teaching, administering, supervising, delegating, and evaluating nursing practice. RNs have independent licensed authority to engage in all aspects of practice specified in Section 4723.01(B), ORC, except that, when providing nursing care pursuant to Section 4723.01(B)(5), ORC, the RN must have an order from an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice for administration of medication or treatments or for the regimen that is to be executed. Rule [DATE](D), OAC. Review of the facility's undated Safe Medication Administration Practices, Long-Term Care policy revealed you must check the resident's medical record to make sure that all required documents, medication information, sensitivities, history and physical examination findings, diagnoses, and laboratory results are present and current. The deficient practice was corrected on [DATE] when the facility implemented the following corrective actions: On [DATE] all medication carts were audited for any missing narcotic medications. On [DATE] the DON reported the incident to the contracted staffing agency and RN #500 was placed on the do not return list. On [DATE] the DON reported RN #500 to the Ohio Board of Nursing. On [DATE] all staff were educated on the abuse and misappropriation policies and procedures. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] Resident #145's Morphine was replaced. On [DATE] and [DATE] all staff were educated on medication administration and that there was on call physician coverage 24-hours a day and they were not to administer medications without an order. Audits were completed twice weekly regarding change of condition and calling the physician as appropriate for direction/orders and to ensure there was no misappropriation of resident medication for the weeks of [DATE] and [DATE], then monthly for three months on [DATE], [DATE], and [DATE]. No additional concerns were noted. Review of the quality assurance and performance improvement (QAPI) during the annual survey revealed the committee was involved in the development of the corrective action plan and ongoing compliance.

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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** 44810 Based on interview, record review, and review of facility policies the facility failed to ensure appropriate and consistent communication regarding dialysis treatment provided and the resident's response, complications, reactions, or recommendations. This affected Resident #15 who was identified as the only resident receiving dialysis in the facility. The facility census was 39. Findings include: Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included end stage renal disease, acute and chronic respiratory failure with hypoxia, and congestive heart failure. Review of the physician's order dated 02/16/21 revealed Resident #15 was to receive dialysis every Monday, Wednesday, and Friday from 10:00 A.M. to 1:15 P.M. at an outside dialysis center. Review of the care plan dated 06/28/22 revealed Resident #15 had end stage renal disease and received dialysis every Monday, Wednesday, and Friday at an outside dialysis center. Interventions included to have no trauma to the access site, Resident #15 would maintain her dry weight, and the facility was to communicate with dialysis facility as needed regarding resident dialysis care issues. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had intact cognition and required assistance with all activities of daily living. Review of the nursing progress note dated 08/28/24 at 2:30 P.M. revealed Resident #15's son called the facility to notify them that Resident #15 had issues at dialysis and was returning to the facility. He reported the dialysis center scheduled a treatment for the next day and the family would provide the transportation. The nurse notified the physician. Interview on 09/04/24 at 10:00 A.M. with the Director of Nursing (DON) revealed the facility communicated with the dialysis center on an as needed basis. They did not communicate with every treatment and maybe only monthly if a problem arose. The DON confirmed on 08/28/24 the family notified the facility of Resident #15's trouble at dialysis and the added treatment not the dialysis center. Review of the facility's policies and procedures related to dialysis revealed the policies did not address a communication process with the dialysis providers to include how the communication would occur, who was responsible for communication, and where the communication and responses would be documented in the medical record.