

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Saybrook Landing		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 Center Road Ashtabula, OH 44004	

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)
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on medical record review, review of pharmacy recommendations and staff interview, the facility failed to ensure a physician approved pharmacy recommendation was implemented. This affected one (#34) of five residents reviewed for unnecessary medications. The facility census was 95.</p> <p>Findings include:</p> <p>Review of the medical record for resident #34 revealed an admitted [DATE]. Diagnoses included bipolar disorder, cirrhosis of the liver, protein calorie malnutrition, anorexia, repeated falls and kidney disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 was moderately cognitively impaired. Resident #34 required supervision or touching assistance with eating and oral hygiene, partial to moderate assistance with toileting and substantial or maximum assistance with showering and personal hygiene.</p> <p>Review of the care plan dated 06/12/24 revealed Resident #34 was at risk for adverse effects of psychoactive medication use. Interventions included assessing for behaviors, assessing for adverse effects, giving medications as ordered and reporting negative outcomes to the physician.</p> <p>Review of current physician's orders revealed Resident #34 had an order for Latuda 60 milligrams (mg) by mouth (PO) once per day (QD).</p> <p>Review of a pharmacy recommendation/note to attending physician/prescriber, dated 03/19/24, revealed Latuda was being given upon rise and the medication had better efficacy when provided with at least 350 calories. A request was made to verify the medication was given at breakfast or with at least 350 calories. The physician agreed with the recommendation and signed the document.</p> <p>Interview on 07/24/24 at 1:03 P.M. with the Director of Nursing (DON) confirmed the ordered for Latuda was not updated to indicate Resident #34 should receive the medication with breakfast or with at least 350 calories.</p> <p>Review of the facility policy titled Physician Orders - Telephone and Verbal dated 08/16/10 revealed physician's orders would be received and confirmed in writing by the prescriber. When a new order changed an old order, the older order would be discontinued and the new order written completely.</p>

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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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>45441</p> <p>Based on review of the Payroll-Based Journal (PBJ) report, review of the daily assignment sheets, review of the staffing tool, review of staff timecards, review of the facility Centers for Medicare and Medicaid Services (CMS) submission report and staff interview, the facility failed to submit complete and accurate staffing information to CMS. Additionally, the facility failed to maintain records of staffing hours for audit. This had the potential to affect all 95 residents in the facility. The facility census was 95.</p> <p>Findings Include:</p> <p>Review of the PBJ report for Fiscal Year (FY) Quarter Two 2024 (01/01/24 through 03/31/24) revealed the facility triggered an area of concern for excessively low weekend staffing.</p> <p>Review of the staffing tool from 03/29/24 through 03/31/24 revealed the facility did not meet the minimum daily staffing requirement of 2.50 hours on 03/31/24.</p> <p>Interview on 07/24/24 at 11:21 A.M. with State tested Nursing Assistant/Scheduler (STNA/Scheduler) #467, and concurrent review of the Daily Assignment Sheets (DAS), revealed STNA/Scheduler #467 stated the DAS accurately reflected the staff who were scheduled and worked on 03/31/24. STNA/Scheduler #467 confirmed on 03/31/24 the minimum daily staffing requirement of 2.50 was not met and stated she would have to follow-up with the Director of Nursing (DON) about staffing for that date.</p> <p>Interview on 07/24/24 at 1:16 P.M. with the DON and STNA/Scheduler #467 revealed the facility had a concern on 03/31/24 and additional staff were brought in on that day to assist. In addition to the staffing identified on the DAS, STNA/Scheduler #467 stated Activities Director (AD) #401 worked 5.6 hours, Assistant Director of Nursing (ADON) #468 worked ten hours and the facility Nurse Practitioner (NP) provided four hours of direct resident care.</p> <p>Review of the Time and Attendance Detail Report confirmed AD #401 worked on 03/31/24 from 7:02 A.M. through 12:37 P.M. Further review revealed no evidence ADON #468 or the NP worked on 03/31/24.</p> <p>Follow-up interview on 07/25/24 at 2:32 P.M. with the DON verified the facility did not accurately report staffing levels on 03/31/24 and had no evidence of ADON #468 or the NP's working hours on 03/31/24.</p> <p>Review of the facility document titled CMS Submission Report PBJ Final File Validation Report dated 06/24/24 confirmed the facility submitted PBJ staffing information for FY Quarter Two. However, the facility was unable to produce any other documentation regarding the PBJ for FY Quarter 2.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>39969</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on review of Quality Assessment and Assurance (QAA) sign in sheets and staff interview, the facility failed to ensure the required members attended QAA committee meetings at least quarterly. This had the potential to affect all residents. The census was 95.</p> <p>Findings include:</p> <p>Review of the facility QAA committee agenda/minutes sign in sheets for the second quarter 2023 (April, May, June), third quarter 2023 (July, August, September), fourth quarter 2023 (October, November, December) and first quarter 2024 (January, February, March) revealed the Director of Nursing (DON), who was also the Infection Control Preventionist (ICP), was not in attendance for the third quarter 2023 and first quarter 2024 QAA committee meetings.</p> <p>Interview on 07/25/24 at 1:48 P.M. with the Administrator confirmed the facility's QAA committee met every three months (quarterly). The Administrator verified the DON/ICP was not in attendance for the third quarter 2023 and first quarter 2024 QAA committee meetings. The Administrator stated Assistant Director of Nursing (ADON) #468 functioned as the DON and attended the QAA meetings during the DON's leave. However, the Administrator confirmed ADON #468 was not a trained ICP. The Administrator indicated a corporate ICP covered those duties during the DON's absence, but did not attend the QAA meetings. The Administrator stated she would follow-up to determine who covered as the ICP at QAA meetings during the DON's leave.</p> <p>Follow-up interview on 07/25/24 at 2:30 P.M. with the Administrator verified there was no evidence of an ICP in attendance during the third quarter 2023 and first quarter 2024 QAA committee meetings.</p>		