STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366392	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burbank Parke Care Center	14976 Burbank Road Burbank, OH 44214

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on observation, interview and record review the facility failed to ensure pressure ulcer treatments were consistent with professional standards or practice. This affected one of three residents (Resident #24) for pressure ulcer dressing changes. The census was 72. Findings Included: Review of the open medical record for Resident #24 revealed an admitted [DATE]. Diagnosis included diabetes type 2 and Stage 4 pressure ulcer (Full-thickness skin and tissue loss). Review of the physician order for July 2024 revealed a treatment to cleanse sacrum with normal saline, apply collagen sheet to wound bed, skin prep peri wound and cover with border gauze dressing. Observation on 07/26/24 at 9:31 A.M. of Dressing change for Resident #24 with Licensed Practical Nurse (LPN) #303 and State tested Nurses Assistant (STNA) #366 revealed LPN #303 and STNA #366 both used hand sanitizer when they came into the room. LPN #303 setup her supplies she needed for the sacrum dressing change. She removed the old dressing and discarded the old dressing and gloves. LPN #303 replaced her gloves and did not wash her hands or use hand sanitizer. LPN #303 applied new gloves cleansed the wound with normal saline, removed her gloves and applied new glove, she did not wash her hands or use hand sanitizer. LPN #303 put the new dressing on. Finished cleaning up the trash and removed her gown and gloves and used hand sanitizer when she was walking out of the room. Interview on 07/26/24 at 9:45 A.M. with LPN #303 verified she did not wash her hands or use hand sanitizer between glove changes while completing Resident #24's dressing change. LPN #303 verified she should have washed her hands or used hand sanitizer every time she changed her gloves. Review of the facility policy Dressings, Dry/Clean, dated 09/2013 revealed to wash and dry hands and put on clean gloves between removing old dressing, cleaning wound and applying new dressing. This substantiates Complaint Number OH0015586.

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 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** 39333 Based on observation, record review and interview, the facility failed to ensure Resident #65's isolation precautions were implemented as required. This finding affected one (Resident #65) of three residents reviewed for infection control. Findings include: Review of Resident #65's medical record revealed the resident was admitted on [DATE] to the facility with diagnoses that included but not limited to Alzheimer's Disease, angina pectoris, major depressive disorder, and atherosclerotic heart disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #65 was severely cognitively impaired and required maximal assistance with activities of daily living (ADLs). Review of the physician's orders for July 2024 revealed that Resident #65 did not have a catheter. Review of the physician orders dated 07/22/24 revealed that Resident #65 was ordered one gram of ertapenem sodium for ESBL intramuscularly (IM) once a day for five days. Review of Resident #65's progress note dated 07/22/24 dated revealed Resident #65 was retested for COVID-19 virus. To remain in isolation for the full 10-day period and retest on the date of 7/27/24. All services rendered in room with no safety concerns at this time. Vitals within normal limits (WNL). The urine analysis and culture and sensitivity returned with positive for extended spectrum beta-lactamase (ESBL). The physician was notified and at this time he opted not to order antibiotic (ATB) therapy at this time due to Resident #65 being on antiviral for COVID. Review of Resident #65's progress note dated 07/23/24 at 5:26 P.M. revealed Resident #65 was retested for COVID-19 virus. To remain in isolation for the full 10-day period and retest on the date of 7/27/24. All services rendered in room with no safety concerns at this time. Vitals WNL. The urine analysis and culture and sensitivity returned with positive for extended spectrum beta-lactamase (ESBL). The physician has ordered IM ATB after reviewing to make sure there are no interactions with the antiviral that is in place. This nurse phoned in to call and spoke to Dr. [NAME] herself to verify that we are going to go ahead with ATB therapy at this, this nurse will notify power of attorney of new orders. Observation and interview on 07/26/24 at 12:42 P.M. with Licensed Practical Nurse (LPN) # 303 revealed that Resident #65 was not on isolation precautions or enhanced barrier precautions. LPN #303 verified that Resident #65 was not on isolation precautions and stated that she took Resident #65 off isolation precautions because the resident had a negative test for COVID, so Resident #65 did not have to remain on isolation precautions. Interview on 07/26/24 at 1:40 P.M. with Director of Nursing (DON) revealed that Resident #65 could have been off droplet precautions but should have been on contact precautions because she was newly diagnosed with ESBL. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Centers for Medicare and Medicaid QSO-24-08-NH memo dated 03/20/24 revealed enhanced barrier precautions (EBP) revealed that contact precautions should be implemented with infected or colonized with any MDRO and has secretions or excretions that are unable to be covered or contained. This substantiates Complaint Number OH0015586.