

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Oaks of Brecksville		STREET ADDRESS, CITY, STATE, ZIP CODE  8757 Brecksville Road Brecksville, OH 44141	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38522</p> <p>Based on record review, interview and facility policy review, the facility failed to ensure advance directive orders were consistent across electronic and paper medical records. This affected two residents (#13 and #225) out of 29 resident records reviewed. Facility census was 74.</p> <p>Findings include:</p> <p>1. Review of Resident #13's medical record revealed an admitted [DATE] and diagnoses including cardiomyopathy, cerebra infarction due to thrombosis of right posterior cerebral artery, left bundle-branch block, dementia with psychotic disturbance and type two diabetes.</p> <p>Review of Resident #13's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 was cognitively intact, required set-up for eating and oral hygiene and required partial/moderate assistance for showering/bathing.</p> <p>Review of Resident #13's electronic medical record (EMR) revealed in a green-highlight across the top of the screen that Resident #113 had an advance directive of full code. Review of a physician's orders as of 01/21/25 revealed no order could be located for an advance directive.</p> <p>Review of a care plan dated 03/19/24 and revised 12/10/24 revealed Resident #113 had chosen an advance directive of Do Not Resuscitate Comfort Care Arrest (DNRCCA).</p> <p>Review of Resident #113's paper medical record revealed multiple sheets indicating she was to receive full measures and had an advance directive of full code.</p> <p>Interview on 01/21/25 at 4:10 P.M. with the Director of Nursing (DON) verified Resident #13 had an advance directive of full code in her paper chart, did not have an order for any advance directive in her electronic medical record and had a care plan for an advance directive of DNRCCA. The DON indicated an order was to be in place specifying the resident's chosen advance directive and confirmed the paper chart, care plan and EMR did not match as required.</p> <p>2. Review of Resident #225's medical record revealed an admitted [DATE] and diagnoses including constipation, Parkinson's disease, chronic kidney disease, hypertension, anxiety, unspecified severe protein-calorie malnutrition and low back pain.</p> <p>(continued on next page)</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #225's 5-day MDS 3.0 assessment dated [DATE] revealed Resident #225 had moderate cognitive impairment, was dependent on staff for bathing and toileting and required substantial assistance for upper body dressing and putting on/taking off shoes.</p> <p>Review of Resident #225's EMR revealed in a red-highlight across the top of the screen that Resident #225 had an advance directive of DNRCCA/Do Not Intubate (DNI). Review of a physician's order dated 01/09/25 revealed Resident #225 had an advance directive of DNRCCA/DNI.</p> <p>Review of a care plan dated 01/09/25 revealed Resident #225 had chosen an advance directive of DNRCCA/DNI.</p> <p>Review of Resident #225's paper medical record revealed no evidence of an advance directive could be located.</p> <p>Review of a hospital discharge summary revealed Resident #225 was a DNRCCA/DNI at the hospital but no formal advance directive was noted in the hospital documentation.</p> <p>Interview on 01/21/25 at 4:10 P.M. with the DON verified no written DNR form could be found in Resident #225's chart. The DON indicated the facility process surrounding advance directives included nurses putting the advance directive form in the paper chart, putting an order in in the EMR and then she would get a paper copy of the advance directive form to get signed by the physician.</p> <p>Review of the policy, Advanced Directives Protocol, no date, did not address how advanced directives were to be documented.</p> <p>Review of the facility policy, Advance Care Planning Meeting Protocol, revised 10/01/23 revealed in the event there are legal documents to be obtained, the patient, family and facility staff will coordinate as a team to obtain such documents and place in the clinical record. Results of the advanced care planning will be communicated to the resident's care providers and documented in the medical record.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37095</p> <p>Based on observation, record review, and interview, the facility failed to ensure insulin multi-dose syringe pens were labeled appropriately with resident identifiers and open dates, and failed to ensure medications were properly stored and secured. These findings affected five (Resident #13, #26, #46, #49, and #50) of eight residents reviewed for medication storage and administration. The total census was 74.</p> <p>Findings include:</p> <p>1. Observation of Registered Nurse (RN) #533 on 01/21/25 at 8:49 A.M. during a medication administration procedure for Resident #13 revealed the resident had a multi-dose injection pen of Soliqua (a combination medication of insulin Glargine and Lixisenatide) in the [NAME] Northwest medication cart with no open date indicated on the pen or container.</p> <p>Observation of the [NAME] Northwest medication cart following the above observation revealed Resident #50's insulin Lispro and insulin Glargine (Lantus) pens had no open date, Resident #49's insulin Glargine pen had no open date, and two pens of insulin Glargine and Lispro had no name and were labeled B.H. One of these pens had no open date, the other had an open date of 12/02/24.</p> <p>Interview with RN #533 on 01/21/25 confirmed the above findings at the time of observation. She said the insulin pens for B.H. belonged to Resident #46 as they matched her initials.</p> <p>Record review of the facility pharmacy storage recommendations for injectable diabetes medications revealed insulin Lispro, Lantus, and Soliqua were to be only stored for 28 days after opening or when kept at room temperature.</p> <p>43063</p> <p>2. Review of the medical record for Resident #26 revealed an admissions date of 10/26/22 with diagnoses including diabetes and hypertension.</p> <p>Review of the physician's orders for January 2025 revealed Resident #26 had an order for Levetiracetam 100 milligrams (mg) per milliliter (mL), administer five mL twice a day for seizures dated 01/27/24. There was no indication the resident could keep medication at bedside or self-administer medication.</p> <p>Observation on 01/21/25 at 9:04 A.M. revealed Resident #26 had a medication cup with five mL of clear liquid in it sitting on a stand by her wheelchair. She stated it was medication and the nurse had forgotten to give it to her when he was in the room.</p> <p>Interview on 01/21/25 at 9:06 A.M. with Licensed Practical Nurse (LPN) #529 verified he had left Resident #26's Levetiracetam in a cup on her stand and forgotten to give it to her. He stated she was not able to administer her own medication.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled, General Dose Preparation and Medication Administration, dated 01/01/13, revealed facility staff should not leave medications unattended.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37095</p> <p>Based on observation, interview, and record review, the facility failed to ensure glucometer devices were sanitized appropriately between resident use and isolation precautions were maintained appropriately. This affected three residents (Resident #13, #48, and #58) out of seven residents observed for infection control and had the potential to affect all 74 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Observation of Registered Nurse (RN) #533 on 01/21/25 at 8:49 A.M. during a medication administration procedure for Resident #13 revealed RN #533 used and Assure Prism Multi glucometer to test Resident #13's blood glucose. Following the procedure she wiped the glucometer with alcohol swabs and continued her medication pass.</p> <p>Interview with RN #533 on 01/21/25 at 9:15 A.M. confirmed the above findings. She said she normally disinfected glucometers with bleach or sanitizer wipes but they were currently on-order.</p> <p>Record review of the Assure Prism Multi manufacturer instruction manual revealed the device was to be disinfected after each use by one of a specific list of disinfectants approved for use with the device. This list did not include alcohol swabs. The manual further revealed that blood glucose meters were at high risk of becoming contaminated with bloodborne pathogens such as Hepatitis C and that disinfection of meters between residents could prevent transmission through indirect contact.</p> <p>51067</p> <p>2. Review of the medical record for Resident #57 revealed an admitted [DATE] with an admitting diagnosis of intervertebral disc disorders with myelopathy, thoracic region, flaccid neuropathic bladder, heart failure, atrial fibrillation, hypertension, and cystitis with hematuria.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #57 was cognitively intact. The resident was dependent on assistance from staff for a majority of the activities of daily living.</p> <p>Review of the nursing progress notes dated 01/10/25 and timed 15:59 revealed Resident #57 was having complaints of pain when urinating. The resident's tip of his penis as red and open. The resident was repositioned with an order for urinalysis culture and sensitivity, complete blood count with differential, and basic metabolic panel.</p> <p>Review of Resident #57 current physician orders identified an order dated 01/18/25 for Isolation/ Transmission- Based Precautions Contact Precautions (TBP)/ Isolation related to extended- spectrum beta-lactamase (ESBL) in urine., and an order dated 01/21/25 for Cefepime (antibiotic) 1 gram to be administered via intravenous twice daily for seven days for ESBL in urine.</p> <p>Review of the plan of care dated 01/19/25 revealed Resident #57 had was on intravenous (IV) medications related to ESBL. Interventions included transmission-based precautions as ordered, including enhanced Barrier precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 01/21/25 at 11:40 AM of Licensed Practical Nurse (LPN) #529 entered into resident room with no gown on to assess Resident #57 IV and the pump which was alarming.</p> <p>Interview on 01/21/25 at 11:42 AM with LPN #529 revealed that he disconnected the IV infusion from Resident #57 as it was complete. LPN #529 stated he was leaving the room to obtain a cap to cover the entrance of the IV which was in the left peripheral forearm of the resident. LPN #529 confirmed the TBP signage outside of the door and admitted that he wasn't wearing the proper personal protective equipment (PPE) per the signage.</p> <p>Review of the facility signage provided for residents who were on TBP revealed those entering resident rooms were to put on a gown and gloves before entry into the room and discard prior to room exit.</p> <p>Review of the facility document titled Transmission- Based Precautions and Isolation, last revision dated 04/15/24, revealed contact precautions were intended to prevent transmission of infectious agents which were spread by direct or indirect contact with the resident or resident environment. The document further stated organisms could be spread by contact with the person or contaminated surfaces.</p> <p>51073</p> <p>3. Resident #48 was admitted on [DATE] with diagnoses that included unspecified heart failure, contact with and (suspected) exposure to other viral communicable diseases, anemia, hydronephrosis with renal and ureteral calculous obstruction, unspecified atrial fibrillation, obstructive and reflux uropathy, and major depressive disorder.</p> <p>A review of progress notes from the past month showed that the resident began to feel ill on 01/10/25 at 03:35 A.M. with symptoms of her mouth feeling dry, a temperature of 99.1 degrees temporal. Orders were received for blood work and urine culture and sensitivity in the morning if indicated. Later on 01/10/25 at 11:52 A.M. the resident experienced nausea and vomiting. Labs and urinalysis results remained pending at that time, so the resident was administered Ceftriaxone (antibiotic) gram intramuscularly to be repeated daily for five days. Over the next six days antibiotics were adjusted while final results were pending.</p> <p>A progress note on 01/13/25 at 02:25 A.M. revealed the urine culture results demonstrated possible contamination. The nurse practitioner was notified and an order to change the foley catheter in the resident was received and another specimen to be obtained. The specimen was obtained 01/13/25 at 6:44 A.M. which demonstrated on 01/16/25 at 6:39 P.M. on the final urine culture results the positive Escherichia coli and Enterococcus faecalis growth which could be treated with the appropriate antibiotics to which the microbes were sensitive.</p> <p>Review of a urine culture report reported on 01/16/25 showed positive for Escherichia coli with a growth of greater than 100,000 CFU/milliliter and Enterococcus faecalis with a growth of 50-60,000 CFU/milliliter. This result required treatment with an antibiotic. The culture report also indicated the resident be placed in isolation or cohorted with other vancomycin-resistant enterococci carriers.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A progress not on 01/18/25 at 6:45 A.M. verified that the resident was in contact isolation precautions.</p> <p>Review of Resident #48's active physician orders revealed the resident to be placed in contact precautions/isolation due to the ESBL in the urine. The resident was also ordered an antibiotic, Zosyn 3.378 grams/50 milliliters intravenously three times a day, along with a second antibiotic of Cipro 250 milligrams orally twice a day.</p> <p>Review of the care plan included areas of indwelling catheter with the goal of appropriate management to prevent infection.</p> <p>On 01/21/25 at 12:01 P.M. the resident was observed to be in contact precautions for Enterococcus faecalis. The room had an isolation cart outside of the room containing isolation supplies. A sign stating that the resident was in contact isolation precautions was also hanging on the wall next to the door of the room.</p> <p>On 01/22/25 at 08:58 A.M. Nursing Student #625 was observed entering the resident's room without donning gloves or gown. While in the room, the student was observed to be delivering the resident's breakfast tray and assisting with opening items on the tray. Nursing Student #625 worked right next to the bed from both sides assisting the resident. When the student left the room, hand sanitizer was applied. The isolation cart was outside of the room containing supplies and the sign from the previous day was still hanging in the same place as the previous day.</p> <p>Upon exit from the room on 01/22/25 at 08:58 A.M. after delivering and assisting with set up of the breakfast tray to the resident, Nursing Student #625 was interviewed. He verified that he entered the resident's room without gowning or gloving. He also verified that a sign for contact isolation precautions was hanging next to the door and that an isolation cart was also present with items inside of the cart. He stated that he was instructed by his instructor to function as a certified nursing assistant (CNA) today. Normally he would be following the nursing and observing procedure. He then stated that he did not need to wear isolation items since he was not performing patient care. He verified that he had been instructed by the facility regarding personal protective equipment and the various types of isolation precautions.</p> <p>Review of the sign placed outside of a room where contact precautions was listed revealed everyone entering the room of a resident in contact precautions should clean their hands before entering and when leaving the resident's room. Care providers and staff were also required to put on gloves and gown before entering and before exiting the room. The sign also identified the use of dedicated or disposable equipment for the resident and that reusable equipment had been cleaned and disinfected before use on another person. Signage indicated that the appropriate type of precautions along with the need to have visitors stop at the Nurses Station before entering was to be placed outside of the room. Transmission-based precautions were to remain in effect during the period of time the risk of transmission of the infectious agent persists.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/22/25 at 09:10 A.M. Licensed Practical Nurse #522 was interviewed. She also verified that a contact isolation sign was hanging next to the door and that an isolation cart was also present with items inside of the cart. She stated that she wanted to stop the student from entering the room since he entered without the proper donning of personal protective equipment. She verified that anytime a caregiver, including CNAs, enters a room that has precautions in place, the identified personal protective equipment needs to be applied.</p> <p>On 01/22/25 at 5:58 P.M. an order to discontinue contact isolation and continue enhanced barrier precautions for the foley catheter was obtained which was after the above cited break in contact isolation precautions.</p> <p>Review of the Transmission-Based Precautions and Isolation policy dated 04/15/24 revealed the precautions are used when discharges from the body that cannot be contained because of an increased potential for environmental contamination and risk of transmission of the pathogen. Personal protective equipment that is recommended includes gloves whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident, and gowns whenever anticipating that clothing will have direct contact with the resident or potentially contaminated environmental surface or equipment in close proximity to the resident.</p>		