STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366403	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bath Creek Estates	186 West Bath Road Cuyahoga Falls, OH 44223

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** 43061 Based on observation, record review, facility policy review and interview, the facility failed to provide timely and necessary treatment for Resident #22 following laboratory testing that included a critically high sodium level to prevent a hospitalization . This affected one resident (#22) of three residents reviewed for laboratory testing. The facility census was 88. Findings included: Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnosis including attention to gastrostomy (tube), severe protein-calorie malnutrition, acute kidney failure, end stage renal disease, dementia, bipolar disorder with current episode manic severe with psychotic features, and patient's noncompliance with other medical treatment and regimen. Review of the care plan dated 08/01/23 revealed Resident #22 had increased risk for nutritional status related to diagnosis of end state renal disease, dysphagia with risks associated with overall disease process, underweight, low body mass index (BMI) with history of suboptimal intake and history weight fluctuation. Interventions included monitor lab values and monitor for signs and symptoms of dehydration. Review of the progress note dated 09/11/24 at 4:58 P.M. documented as a late entry on 09/12/24 at 10:00 P. M., authored by RN #166 revealed an aide notified this nurse resident brief was dry throughout the day and this nurse asked the oncoming nurse to monitor (the resident) for output. Review of the progress note dated 09/12/24 at 10:00 P.M. revealed Registered Nurse (RN) #166 documented the resident did have a wet brief prior to bed. The nurse assessed the resident in the morning and his brief was wet times one. Review of Resident #22's progress note dated 09/17/24 revealed the revealed the resident refused all meals on this date, the nurse and care staff offered multiple times and tried to feed the resident during all meals, and he still refused. The note revealed the resident did drink four chocolate boosts and two mighty shakes on this day. (continued on next page)

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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(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	Review of a monthly ordered laboratory report dated 09/18/24 at 5:08 P.M. revealed Resident #22 had a critically high sodium (NA+) level of 164 (normal range 138 to 145). High sodium levels, known as hypernatremia, can include thirst, urinating less, vomiting, diarrhea, confusion, muscle twitching, seizures, lethargy, irritability and stupor or coma. The lab results had a handwritten note (dated 09/18/24) with no new orders (NNO), monitor and consult nephrology and was initialed by Licensed Practical Nurse (LPN) #213. Review of the progress note dated 09/18/24 at 8:12 P.M., authored by Assistant Director of Nursing (ADON) #170 revealed CBC with Differential and CMP reported to on call Nurse Practitioner (NP) #232 and (resident's) sister. No new orders (NNO) were received at this time. The progress note included to monitor and notify nephrology. Review of a progress note dated 09/19/24 at 9:10 A.M. authored by ADON #170 revealed labs from 09/18/24 faxed to Physician #231's (nephrology) office at this time. Review of the progress note dated 09/19/24 at 12:17 P.M. authored by ADON #170 revealed, attempted to reach Physician #231's (nephrology) office to discuss labs from 09/18/24. Office at lunch at this time. Record review revealed no evidence of additional attempts by facility staff to contact Physician #231 prior to this note or following this note. Review of the progress note dated 09/19/24 at 1:35 P.M. authored by ADON #170 revealed the Director of Nursing (DON) reviewed labs and lab ranges with Resident #22's sister. Review of the progress note dated 09/19/24 at 1:38 P.M. authored by ADON #170 revealed Resident #22's sister was notified of labs faxed to Physician #231's office with no response. Resident #22's sister contacted Physician #231's office and had an appointment scheduled for 09/23/24 at 2:00 P.M. Resident #22's sister stated she would arrange transportation to appointment. Review of the progress note dated 09/19/24 at 3:29 P.M. authored by ADON #170 revealed Resident #22's sister requested the resident be transferred to hospital due to the resident's labs and consistent poor oral intake. Resident #22's sister was concerned about waiting until appointment on 09/23/24 with Physician #231 to evaluate. The NP was notified and gave the okay to transfer the resident to the hospital emergency department per the sister's request. Review of the progress note dated 09/19/24 at 11:38 P.M. revealed Resident #22's sister transported the resident to hospital, and they left the facility at 10:00 P.M. Resident #22's sister called facility and stated the resident may be admitted due to his sodium level. Review of Resident #22's progress notes from the time of the lab was reported on 09/18/24 through the time the resident was hospitalized on [DATE] revealed no additional comprehensive assessment or monitoring of the resident related to the critically high sodium level was documented in the resident's medical record. Review of the progress note dated 09/20/24 at 3:50 A.M. revealed Resident #22 was admitted to intensive care unit (ICU) due to hypernatremia. Resident #22 returned to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had impaired cognition. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 7:31 A.M. Resident #22 was observed sleeping in his room with the head of bed (HOB) elevated, tube feeding was infusing, and no signs of incontinence were noted. During an interview on 12/31/24 at 10:22 A.M. with Resident #22's sister, the sister revealed after being notified of the resident's critical lab result (sodium level) in September 2024, she notified the resident's nephrologist. On 12/31/24 at 10:58 A.M. an interview with ADON #170 revealed Resident #22 had lab work on 09/18/24 which was abnormal with a critically high sodium level of 164. ADON #170 revealed the on-call NP, NP #232 was notified with no new orders received. ADON #170 revealed she faxed the labs to Physician #231 on 09/19/24 and attempted to call the office on 09/19/24 but was unable to leave a message. ADON #170 reported she contacted Resident #22's sister regarding the abnormal lab. On 01/02/25 at 12:21 P.M. an interview with NP #232 revealed she wasn't sure if she was the NP on call on 09/18/24 and didn't have any information about Resident #22 from this date. NP #232 called back and confirmed she was the NP who was on call on this date, but indicated she didn't remember much about the conversation that was had regarding Resident #22. On 01/02/25 at 2:36 P.M. a telephone interview with LPN #213 revealed she was the nurse taking care of Resident #22 on 09/18/24. LPN #213 verified she received the laboratory testing with the critically high sodium level and notified the on-call NP. On 01/07/25 at 5:17 P.M. interview with Physician #233 revealed for Resident #22's critical sodium lab result of 164 she would have given orders to send the resident to the hospital for evaluation and until emergency medical services (EMS) arrived she would have ordered (water) flushes via the resident's gastrostomy tube. On 01/09/25 at 1:02 P.M. an interview with Physician #231 (the nephrologist) revealed his office did not receive any calls from the facility regarding Resident #22's critical sodium level of 164 in September 2024. Physician #231 reported labs were typically faxed but for critical labs his office wanted to be notified by phone so they could look at the labs otherwise they wouldn't timely know there was a concern. Physician #231 revealed (on 09/19/24) Resident #22's sister called the office regarding the critical lab. Physician #231 reported it was not the responsibility of Resident #22's sister to notify the office of the abnormal lab, and his expectation was that the facility should have provided the notification. Physician #231 revealed for a critically high sodium level of 164, intervention would have been necessary, and orders should have been given. Physician #231 revealed he saw Resident #22 in the intensive care unit during the resident's hospitalization and the resident was profoundly dehydrated. Physician #231 revealed at the time the laboratory testing results were obtained; the resident should have had orders for increased fluids and to hold/discontinue diuretic medication the resident was on. During the interview, Physician #231 reiterated for critical labs facility should have called and not just faxed labs. Review of facility policy titled, Resident Change in Condition Policy, revised 06/27/24 revealed the licensed nurse would recognize and intervene in the event of a change in resident condition A Significant Change of condition was a decline or improvement in the resident's status that would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention(s) and/or one that impacted more than one area of the resident's health status, and/or one that required interdisciplinary review and or revision to the care plan. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00160448.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review, interview and facility policy, the facility failed to properly assess Resident #89's pain upon admission to ensure an effective pain management plan was in place. This affected one resident (#89) out of three residents reviewed for pain management. Facility census was 88. Findings included: Review of the closed medical record for Resident #89 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included but were not limited to sepsis, intraspinal abscess and granuloma, lumbar epidural abscess, post laminectomy syndrome, fusion of spine lumbar region, urinary tract infection (UTI), wedge compression fracture of third lumbar vertebra, bacteremia, type 2 diabetes mellitus (DM) with peripheral angiopathy, and bipolar disorder. Review of the hospital medication records revealed Resident #89 last received Oxycodone 5 milligrams (mg) on 09/04/25 at 1:15 P.M. Review of the physician orders for September 2024 revealed an order for Oxycodone 5 mg one to two tablets every six hours as needed (PRN) for pain. Review of Resident #89's medical record revealed no progress notes dated 09/04/24 regarding pain upon admission. Review of the admission assessment dated [DATE] at 6:00 P.M. revealed for the past five days Resident #89 had a #9 pain (scale 0 the least to 10 the worse pain) on admission, which was moderate, throbbing and aching almost daily. There was no documentation in the MDS data for pain assessment completed on admission, 09/04/24 for the evening shift. Review of the scheduled 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #89 had intact cognition. Review of the medication administration records (MARS) and treatment administration records (TARS) for 09/04/24, revealed there was no documentation of a pain assessment completed on 09/04/24 the evening of admission. The first documentation for pain assessment completed was on 09/05/24 for day shift. Interview was attempted two times on 01/06/25 at 7:35 A.M. and at 3:00 P.M. with Licensed Practical Nurse (LPN) #213, nurse who admitted Resident #89 and no return call was received. Interview on 01/08/25 at 9:09 A.M. with Registered Nurse (RN) #177 revealed pain assessments were to be completed every shift and PRN and documented on the MARS/TARS. RN #177 reported Resident #89 had Oxycodone 5 mg available in the omnicel (secure locked case with medications available to pull as needed) and could have been pulled for administration. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/08/25 at 9:15 A.M. via phone with RN # 136 revealed pain assessments were to be completed every shift and PRN and documented on the MARS/TARS. RN #136 reported Resident #89 had the Oxycodone 5 mg available in the omnicel (secure locked case with medications available to pull as needed) and it could have been pulled for administration. Interview on 01/08/25 at 7:20 A.M. with Director of Nursing (DON) confirmed Resident #89 was admitted to facility on 09/04/24 at 5:45 P.M. and had a script for Oxycodone 5 mg on admission. DON confirmed the discharge medication list from hospital showed Oxycodone was last given at 1:15 P.M. DON confirmed a pain assessment was to be completed on admission, per shift and PRN and no pain assessment was completed for Resident #89 on admission. DON confirmed Resident #89 first received Oxycodone 5 mg on 09/05/24 at 12:43 A.M. Interview on 01/08/24 at 10:11 A.M. with Assistant Director of Nursing (ADON) #170 confirmed there was no pain assessment completed on 09/04/24 for Resident #89. ADON #170 reported pain assessments were to be completed on admission, every shift and PRN. Review of facility policy, Pain Management Protocol, revised 10/24/22, revealed it is the policy of this community to ensure any resident that is admitted to the facility is assessed for pain and/or the potential for pain in order for the resident to reach and maintain his/her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. This deficiency represents non-compliance investigated under Complaint Number OH00161187.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review and interviews the facility failed to ensure Resident #89 was administered medication per physician orders. This affected one resident (89) out of three residents for medication administration. Findings included: Review of the medical record for Resident #89 revealed an admitted [DATE] at 5:45 P.M. and a discharge date of [DATE]. Diagnosis included but were not limited to sepsis, intraspinal abscess and granuloma, lumbar epidural abscess, post laminectomy syndrome, fusion of spine lumbar region, urinary tract infection (UTI), wedge compression fracture of third lumbar vertebra, bacteremia, type 2 diabetes mellitus (DM) with peripheral angiopathy, and bipolar disorder. Review of the physician orders for September 2024 revealed an order for Cefazolin (antibiotic) in dextrose 5% solution to administer 2 grams per 100 milliliter (gram/ml) intravenous (IV) three times a day (TID) for seven (7 days). Review of the hospital medication records revealed Resident #89 last received Cefazolin 2 gram/100 ml at 1:31 P.M. Review of the scheduled 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #89 had intact cognition. Review of the medication administration records and treatment administration records (MARS and TARS) for 09/04/24, revealed Resident #89 did not receive the 8:00 P.M. dose of Cefazolin as ordered. Review of the MAR revealed Resident #89 received the first dose of Cefazolin on 09/05/24 at 8:00 A.M. Phone interview was attempted on 01/06/25 at 7:35 A.M. and at 3:00 P.M. with Licensed Practical Nurse (LPN) #213, nurse who admitted Resident #89. The interview was unsuccessful and no return call was received. Interview on 01/08/25 at 9:09 A.M. with Registered Nurse (RN) #177 revealed Cefazolin 2gram/100 ml was available in the omnicel (secure locked case with medications available to pull as needed) and should have been pulled and administered to Resident #89 the night of admission. Interview on 01/08/25 at 9:15 A.M. via phone with RN # 136 revealed Cefazolin 2gram/100 ml was available in the omnicel (secure locked case with medications available to pull as needed) and should have been pulled and administered to Resident #89 the night of admission. Interview on 01/08/25 at 7:20 A.M. with Director of Nursing (DON) verified Resident #89 was admitted to facility on 09/04/24 at 5:45 P.M. and had a script for Cefazolin on admission. DON verified Cefazolin 2 grams was last given at 1:31 P.M. and confirmed Resident #89 was not administered the medication on 09/04/24 at ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/08/24 at 8:48 A.M. with DON confirmed Cefazolin 2 gram antibiotic was available in the Omnicel to pull as needed. DON reported facility shouldn't take admissions at change of shift, which is 6:00 P.M. Interview on 01/08/25 at 12:40 P.M. with Pharmacist #234 confirmed Cefazolin was available in Omnicel to pull Review of facility policy, Medication Administration Times, revised 05/01/10, revealed facility should commence medication administration within sixty (60) minutes before the designated times of administration and should be completed by 60 minutes after the designated times of administration. This deficiency represents non-compliance investigated under Complaint Number OH00161187.