

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Lakes of Monclova Health Campus The		STREET ADDRESS, CITY, STATE, ZIP CODE 6935 Monclova Road Maumee, OH 43537	

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 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>37451</p> <p>Based on record review of staff schedules, review of posted staffing, and staff interview, the facility failed to use the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 56 residents residing in the facility. The census was 56.</p> <p>Findings include:</p> <p>Review of facility staffing schedules and posted staffing information from 05/02/24 to 06/02/24 revealed there was no Registered Nurse (RN) coverage in the facility on 05/18/24 or 05/19/24.</p> <p>Interview on 06/06/24 at 2:04 P.M., with the Director of Nursing (DON) verified there was no RN on duty in the facility on 05/18/24 and 05/19/24. The DON reported they had RN's on call but not in the facility.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH000154300.</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 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on medical record review, interview of nephrology clinic staff, review of fax confirmation, and staff interviews, the facility failed to timely notify the nephrologist of abnormal laboratory test as ordered by the primary care physician. This affected one (#25) of two residents reviewed for hospitalization . The facility census was 56.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #25 revealed an admitted [DATE], with diagnoses of type 2 diabetes mellitus, hypertensive heart disease, chronic kidney disease stage 3, and hypokalemia (low potassium).</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #25 had severely impaired cognition and required supervision or touching assistance for eating, and substantial/maximal assistance for all other activities of daily life.</p> <p>Review of a progress note dated 05/10/24, by Certified Nurse Practitioner (CNP) #600, revealed Resident #25 was evaluated after a fall without injury or pain and after recently elevated blood sugars, and CNP #600 requested laboratory (labs) tests thyroid stimulating hormone (TSH), hemoglobin A1c (HbA1c), complete blood count (CBC) and a comprehensive metabolic panel (CMP).</p> <p>Review of a physician order dated 05/12/24 revealed a Comprehensive Metabolic Panel (CMP) laboratory test was ordered for Resident #25.</p> <p>Review of a progress note dated 05/16/24 by CNP #600 revealed the laboratory tests were still pending.</p> <p>Review of a progress note dated 05/21/24, by CNP #600, revealed the laboratory tests ordered 05/10/24 had not been drawn. Further review revealed CNP #600 reminded the facility to draw labs ordered 05/10/24: HbA1c, TSH, CMP, CBC.</p> <p>Review of a physician order dated 05/21/24 revealed a CMP laboratory test was ordered for Resident #25.</p> <p>Review of the CMP laboratory test drawn 05/28/24, with results available on 05/30/24, revealed Resident #25's BUN was critically high at 78 milligrams per deciliter (mg/dL) (normal range of 6-21 mg/dL), her creatinine (an indicator of kidney function) was high at 2.4 mg/dL (normal range 0.5-0.9 mg/dL) and her potassium was high at 5.6 millimoles per liter (mmol/L) (normal range of 3.5-5.1 mmol/L).</p> <p>Review of a physician order dated 05/30/24 revealed Resident #25's order for bumetanide was on hold. The order was discontinued on 06/02/24.</p> <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 05/31/24 at 7:13 A.M., by CNP #600, revealed Resident #25's laboratory tests were reviewed, and CNP #600 requested the facility send the laboratory tests with medication list and vital signs to Resident #25's nephrology clinic.</p> <p>Review of a handwritten physician order dated 05/31/24 revealed Resident #25's laboratory tests, vital signs, and medication list should be sent to the nephrology clinic.</p> <p>Review of a fax confirmation dated 05/31/24 revealed the facility sent a 31-page document to a nephrology clinic.</p> <p>Interview on 06/05/24 at 11:03 A.M., with CNP #600 revealed she was aware of Resident #25's elevated laboratory values dated 05/28/24 and requested the laboratory results be sent to her nephrology clinic. CNP #600 stated she hand writes her orders on paper and hands them to staff and discusses her orders with the nurse. CNP #600 wanted the nephrology clinic notified the day she wrote the order, 05/31/24. A further interview with CNP #600 revealed she believed the nephrology clinic was notified and was addressing Resident #25's abnormal laboratory test results.</p> <p>Review of progress note dated 06/05/24, (a late entry dated 05/31/24), revealed the facility faxed Resident #25's laboratory results, medication list and face sheet to the nephrology clinic.</p> <p>Telephone interview on 06/05/24 at 11:35 A.M., with Medical Assistant (MA) #615 at Resident #25's nephrology clinic revealed no laboratory tests were received from the facility on 05/31/24. Further interview with MA #615 confirmed Resident #25 was a patient at their clinic.</p> <p>Telephone interview on 06/05/24 at 2:48 P.M. with Office Manager #620 at the nephrology clinic identified by the facility as the recipient of Resident #25's laboratory tests on 05/31/24, revealed the nephrology clinic does not provide care for Resident #25 and further could not confirm receipt of the laboratory tests faxed on 05/31/24.</p> <p>Interview on 06/05/24 at 3:08 P.M., with the Director of Nursing (DON) revealed she faxed the laboratory test results to the nephrology clinic on 05/31/24. The DON stated she did not follow up with the nephrology clinic to verify the laboratory test results were received.</p> <p>Interview on 06/06/24 at 8:25 A.M., with the DON revealed she identified Resident #25's nephrology clinic by referring to Resident #25's current orders. The DON stated there was an order to fax all laboratory tests to the nephrology clinic, but no fax number was in the order. The DON stated she had to look up the fax number on the internet. Concurrent review of the record with the DON confirmed she sent Resident #25's laboratory test results to the wrong nephrology clinic.</p> <p>Interview on 06/06/24 at 1:38 P.M., with Medical Assistant #635 at Resident #25's nephrology clinic revealed the nephrologist would have treated Resident #25's elevated potassium of 5.6 mmol/L in light of the elevated creatinine of 2.4 mg/dL, if they had received the laboratory test results.</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, review of medication administration records, review of staffing assignments, and review of Certified Registered Medication Aide (CRMA) licenses, the facility failed to ensure licensed staff were administering medications. This affected 21 residents (#8, #9, #12, #13, #15, #18, #19, #22, #23, #24, #27, #28, #31, #32, #24, #36, #37, #40, #42, #45, and #108) of 24 residents reviewed for medication administration. The facility census was 56.</p> <p>Findings include</p> <p>Review of the CRMA licenses for State tested Nursing Assistant (STNA) #433 and STNA #407 revealed their CRMA licenses for administering medications had expired on [DATE].</p> <p>Review of the staff assignment sheets revealed STNA #433 administered medications with an expired license on [DATE], [DATE], [DATE], and [DATE]. STNA #407 administered medications with an expired license on [DATE], [DATE], [DATE], and [DATE].</p> <p>Review of the medication administration records for 21 residents (#8, #9, #12, #13, #15, #18, #19, #22, #23, #24, #27, #28, #31, #32, #24, #36, #37, #40, #42, #45, and #108) revealed STNA #433 and/or STNA #407 had administered the residents' medications while working with expired medication certification licenses.</p> <p>Interview on [DATE] at 8:44 A.M., the Administrator revealed the facility had identified the two medication technicians working with expired licenses.</p> <p>Interview on [DATE] at 11:40 A. M., with Regional Clinical Support Registered Nurse (RCSRN) #610 revealed the facility reviewed all events for all the residents, removed the two medications technicians from the schedule for administering medications, and verbally educated the two staff members to renew their licenses. RCSRN #610 revealed ongoing assessments of residents were completed by the nurses and a daily check of the administration compliance report for all residents showed no medication errors.</p> <p>As a result of the incident, the facility took the following actions to correct the deficient practice by [DATE]:</p> <p>On [DATE], STNA #433 and STNA #407 were removed from the schedule as administering medications and remain of the CRMA schedule.</p> <p>On [DATE], the Director of Nursing assessed the 21 residents (#8, #9, #12, #13, #15, #18, #19, #22, #23, #24, #27, #28, #31, #32, #24, #36, #37, #40, #42, #45, and #108) and there were zero change in condition events.</p> <p>On [DATE], all CRMA licenses were verified to be active on [DATE], by the staffing scheduler.</p> <p>(continued on next page)</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Beginning on [DATE], the staffing scheduler/designee would verify via the Ohio Board of Nursing all CRMAs licenses were active monthly. The Director of Nursing will be monitoring this to ensure it is completed monthly.</p> <p>On [DATE], review of the CRMA licenses for the four medication aides in the facility revealed the licenses for STNA #433 and STNA #407 remained expired. Review of the licenses for CRMA #436 and CRMA #480 were active through [DATE].</p> <p>On [DATE] at 1:09 P.M., interview with STNA #433 revealed she had been educated by the facility to renew her medication administration certification license. STNA #433 verified she had administered medications with an expired license.</p> <p>On [DATE] at 12:08 P.M., interview with STNA #407 verified she had administered resident medications with an expired license. STNA #407 verified the facility had educated her to renew her medication administration certification license.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH000154300.</p>		