STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366419	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Twinsburg	8551 Darrow Road Twinsburg, OH 44087

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, medical record review, policy review and interview, the facility failed to ensure medications were administered without error. This affected two residents (#32 and #79) of four residents observed during 29 medication opportunities with seven medication errors. The medication administration error rate was 24.13 %. The facility census was 80. Findings include: 1. Resident #32 was admitted [DATE] with diagnoses including Alzheimer's disease, dementia, anxiety, high blood pressure, pulmonary embolism, constipation, and hyperlipidemia. A review of Resident #32's physician orders dated 03/02/24 indicated to administer ethylene glycol 17 grams once a day for constipation. (The bottle cap is a measuring cap marked to contain 17 grams of powder when filled to the indicated line inside the cap). An observation of LPN #82 on 05/14/24 at 8:30 A.M. revealed an inaccurate dose of ethylene glycol was administered to Resident #32. LPN #82 obtained a medication cup and measured 17 milliliters (ml) of ethylene glycol powder by pouring the powdered medication into the medication cup. LPN #82 poured the ethylene glycol powder in a cup of water, stirring the mixture until the powder was dissolved. LPN #82 entered Resident #32's room and administered the ethylene glycol/water medication including five additional medications (docusate sodium, D-Mannose, vitamin D3, fluoxetine, donepezil) to Resident #32. LPN #82 handed Resident #32 the ethylene glycol medication/water mixture and exited the room without observing to ensure Resident #32 drank the full cup of ethylene glycol/water mixture. An interview with LPN #82 on 05/14/24 at 8:55 A.M. verified she had failed to measure the ethylene glycol powder accurately (using the provided cap) and did not observe Resident #32 to ensure she consumed the full cup of ethylene glycol/water mixture. 2. Resident #79 was admitted on [DATE] with diagnoses including diabetes mellitus, multiple sclerosis, heart failure with high blood pressure, glaucoma, paranoid personality disorder, psychosis, cerebral vascular disease with a history of transient ischemic attack (TIA) and stroke. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #79's physician order dated 05/05/24 indicated to administer Humalog insulin three units subcutaneously before meals, Novolog solution 100 units/ml per sliding scale. The siding scale indicated if the blood sugar was 151 to 200 mg/deciliter (dL), administer two units of Novolog insulin before meals. Further review revealed the resident was to also receive the following medications: Brimonidine Tartrate Ophthalmic eye drops 0.2 percent, Timolol Maleate 0.5 percent ophthalmic drops, Aspirin 81 milligrams (mg) orally, Jardiance 25 mg orally, losartan 25 mg orally, methocarbam 500 mg orally, Torsemide 20 mg orally, Trospium Chloride 20 mg orally, Lidocaine patch 4 percent topically, carvedilol 12.5 mg orally, potassium 20 milliequivalent (mEq) orally, colace 100 milligrams (mg) orally, senna 8.6 mg orally, and vitamin B12 1000 mg orally. An observation of medication administration on 05/14/24 at 9:10 A.M. revealed RN #83 prepared the following medications for Resident #79: RN #83 obtained the Humalog insulin pen and measured six units to administer to Resident #79. RN #83 stated she was administering three units of Humalog as the scheduled dose and three units of Humalog as the sliding scale dose (RN #83 stated Resident #79's blood sugar was 191 mg/dL) for a total of six units of Humalog insulin; Brimonidine Tartrate Ophthalmic eye drops 0.2 percent (for glaucoma), Timolol Maleate 0.5 percent ophthalmic drops (for glaucoma), Aspirin 81 milligrams (mg) orally, Jardiance (for diabetes) 25 mg orally, losartan (for high blood pressure) 25 mg orally, methocarbam (muscle relaxant) 500 mg orally, Torsemide (diuretic) 20 mg orally, trospium chloride (to treat overactive bladder) 20 mg orally, Lidocaine patch four percent topically, RN #83 proceeded to dispense carvedilol (used to treat high blood pressure and heart failure) 12.5 mg in a medication cup and failed to transfer the carvedilol to the medication cup with the six other oral medications. RN #83 left the medication cup with the carvedilol tablet sitting on the medication cart and proceeded to enter Resident #79's room to administer her other medications. RN #83 administered Resident #79 Humalog six units subcutaneously, the six prepared oral medications and two different types of eye drops. RN #83 failed to administer the medications potassium 20 milliequivalent (mEq) orally, colace 100 milligrams (mg) orally, senna 8.6 mg orally, and vitamin B12 1000 mg orally. RN #83 returned to the medication cart after administering Resident #79's medications and found the carvedilol still sitting in the medication cup on the top of the medication cart. RN #83 proceeded to discard the carvedilol medication in the trash receptacle. An interview with RN #83 on 05/14/24 at 9:25 A.M. verified she discarded the carvedilol medication she had left on the medication cart in the trash receptacle and was unsure which one of Resident #79's medications she had left in the cup. RN #83 was unable to locate the medication in the trash receptacle until the Director of Nursing (DON) emptied the trash receptacle later in the day and was able to verify the discarded medication was a carvedilol 12.5 mg tablet. At 1:20 P.M. RN #83 verified she had failed to administer the accurate dose and ordered insulin (Humalog versus Novolog) and failed to administer five oral medications (carvedilol, colace, potassium, senna and vitamin B12), but had documented on Resident #79's Medication Administration Record that she had administered the five oral medications. The facility policy and procedure titled Medication Administration -General Guidelines dated November 2021 indicated staff were to use the Five Rights for the three step process when preparing medications for administration. The five rights included: 1. The right resident. 2. The right drug. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The right dose. 4. The right route. 5. The right time. A triple check of the five rights would be performed when the medication was selected, when the dose was removed from the packaging, and just after the dose was prepared and the medication was put away. The staff member would select the medication and inspect the label on the packaging and compare against the medication administration record (MAR) by reviewing the five rights. Next, the medication dose was removed from the packaging and verified against the label and MAR by reviewing the five rights. Lastly, complete the preparation of the dose and re-verify the label against the MAR by reviewing the five rights. This deficiency represents non-compliance investigated under Complaint Number OH00153682 and Complaint Number OH00153544.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on record review and interview the facility failed to ensure staff documented Resident #32's shower/bath accurately. This affected one out of three residents reviewed for activity of daily living needs. The facility census was 80. Findings include: Resident #32 was admitted [DATE] with diagnoses including Alzheimer's disease, dementia, anxiety, high blood pressure, pulmonary embolism, constipation, and hyperlipidemia. A review of Resident #32's plan of care dated 11/09/23 indicated Resident #32 preferred to receive a shower or bed bath in the evening or sometime during the morning. A review of the facility shower schedule indicated Resident #32 should receive a shower on Tuesdays and Saturdays during the night shift hours. A review of Resident #32's Minimum Data Set (MDS) assessment dated [DATE] indicated a shower/bath was not attempted due to medical condition or safety concerns. The MDS assessment indicated she had impairment of both upper/lower body extremities and needed substantial/maximal staff's assistance with upper body dressing, personal hygiene and bed mobility, was dependent on staff for lower body dressing and toileting. Resident 32's MDS assessment dated [DATE] indicated she had severe cognitive impairment. On 05/14/24 between 3:30 P.M. and 4:30 P.M. an observation with Registered Nurse Unit Manager (RNUM) #84 and Director of Nursing (DON) revealed a search was conducted for the shower sheet documentation of Resident #32's showers for the month of May 2024. RNUM #84 searched the nursing station and her office and stated she would have to check the administrative office file to see if Resident #32's shower sheet documentation was located in the file. RNUM #84 traveled down to the administrative office and asked DON to assist in finding the shower sheet documentation for Resident #32. DON entered an administrative office and checked the shower sheet file for May 2024 and was unable to locate the shower sheet documentation in the file. An interview at the time of the observation with DON verified there was no documentation found for Resident #32's showers for the month of May 2024. Immediately after completing the interview with the DON, the DON left the area and then returned with five shower sheets for Resident #32. Two of the shower sheets were dated 05/01/24 and the documentation indicated a bed bath was completed and Resident #32 had refused her shower. Resident #32's shower sheet dated 05/04/24 indicated Resident #32 refused a shower and received a bed bath. Resident #32's shower sheet dated 05/08/24 indicated Resident #32 received a shower and on 05/11/24 the shower sheet indicated Resident #32 refused a shower and received a bed bath. The signature of the nurse who co-signed Resident #32's shower sheets for each date listed above was not legible and the state tested nursing assistant (stna) signatures had only the first name of the stna who had signed the shower sheets. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with RNUM #84 on 05/15/24 at 9:00 A.M. revealed she was unable to remember which stna had found Resident #32's shower sheets and had given the shower sheets to her. RNUM #84 stated she gave the shower sheets to the DON after the stna (unnamed) had found them somewhere on the second floor nursing unit. An interview with STNA #85 on 05/16/24 at 6:25 A.M. verified she did not complete the shower sheet on 05/11/24. STNA #85 stated she wasn't aware she was supposed to complete the shower sheets when a resident received a shower/bed bath. STNA #85 verified Resident #32's shower sheet was falsified and verified Resident #32 did not refuse a shower on 05/11/24 during the night shift hours. STNA #85 stated she did provide a bed bath for Resident #32 during the night shift hours from 11:00 P.M. to 7:00 A.M. on 05/11/24 but did not know who had completed the shower sheet and agreed she was unable to decipher the nurse's signature on Resident #32's shower sheet dated 05/11/24. An interview with Administrator and DON on 05/16/24 at 9:51 A.M. agreed it was impossible to read the nurse's name on the five shower sheets with documentation of Resident #32's shower/bath that the facility had provided on 05/14/24. DON verified the above findings at the time of the interview.

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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 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** 30809 Based on observation and interview the facility failed to ensure staff washed their hands appropriately to prevent possible cross contamination of germs during Resident #32's and Resident #79's medication administration, failed to ensure staff wore appropriate personal protective equipment (ppe) prior to administering insulin subcutaneously and eye drops to Resident #79, and failed to ensure Resident #79's eye drops were not contaminated prior to administering the eye drops to Resident #79. This affected two out of four residents observed for medication administration. The facility census was 80. Findings include: 1. Resident #32 was admitted [DATE] with diagnoses including Alzheimer's disease, dementia, anxiety, high blood pressure, pulmonary embolism, constipation, and hyperlipidemia. A review of Resident #32's physician orders dated 03/02/24 indicated to administer ethylene glycol 17 grams once a day for constipation. An observation of Licensed Practical Nurse (LPN) #82 revealed preparation to administer medications to Resident #32 on 05/14/24 at 8:21 A.M. The LPN did not wash/sanitize her hands to prevent possible cross contamination of germs. LPN #82 dispensed Resident #32's medications she obtained from the medication cart and found Resident #79's ethylene glycol medication was not in the medication cart. LPN #82 locked her cart and left the nursing unit to obtain the ethylene glycol medication from the storage area on a different floor ot the facility. LPN #82 used the elevator and traveled to the medication storage area and obtained the ethylene glycol medication and returned to the medication cart. LPN #82 proceeded to dispense the medication in a medication cup without washing/sanitizing her hands prior to dispensing the ethylene glycol medication. LPN #82 gathered Resident #32's medications and entered Resident #32's room and handed the medication to Resident #32. LPN then exited Resident #32's room and did not wash/sanitize her hands before starting to obtain medications from the medication cart to administer to another resident. LPN #82 was stopped and asked to wash her hands prior to obtaining and administering medications to another resident. An interview with LPN #82 on 05/14/24 at 8:55 A.M. verified the above findings and agreed she did not wash/sanitize her hands appropriately to prevent possible cross contamination of germs during Resident #32's medication administration task. 2. Resident #79 was admitted on [DATE] with diagnoses including diabetes mellitus, multiple sclerosis, heart failure with high blood pressure, glaucoma, spinal stenosis, paranoid personality disorder, psychosis, adult failure to thrive, cerebral vascular disease with a history of transient ischemic attack (TIA) and stroke, obstructive sleep apnea, and gastroesophageal reflux disease. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #79's physician order dated 05/05/24 indicated to administer Humalog insulin 3 units subcutaneously before meals, Novolog solution 100 units/ml subcutaneously per sliding scale before meals. The siding scale indicated if the blood sugar was 151 to 200 mg/deciliter (dL) administer 2 units of Novolog insulin before meals, and carvedilol 12.5 mg orally, potassium 20 milliequivalent (mEq) orally, colace 100 milligrams (mg) orally, and senna 8.6 mg orally, vitamin B12 1000 mg orally, aspirin 81 mg orally, Jardiance 25 mg orally, Trospium chloride 20 mg orally, losartan 25 mg orally, methocarban 500 mg orally, and torsemide 20 mg orally in the morning. An observation of Registered Nurse (RN) #83 on 05/14/24 at 9:10 A.M. revealed a failure to wash/sanitized her hands, wear appropriate ppe prior to administering insulin medication subcutaneously and eye drops to Resident #79 and contaminated the tip of Resident #79's eye drop containers during Resident #79's medication administration task. RN #83 obtained two types of eye drops (Timolol Maleate 0.5 percent eye drops and Brimonidine Tartrate 0.2 percent eye drops) from the medication cart. RN #83 then removed the cap from both of the eye drop containers and set the opened eye drop containers on the medication cart. RN #83 proceeded to obtain additional medications from the medication cart inadvertently touching the tips of the eye drop containers with her bare lower right arm. After obtaining all the medications to administer to Resident #79, RN #83 entered Resident #79's room and administered the oral medications to Resident #79. RN #83 proceeded to administer the two types of eye drops and insulin subcutaneously without washing/sanitizing her hands and donning a pair of gloves prior to administering the eye drops and insulin medication An interview with RN #83 on 05/14/24 at 9:25 A.M. verified the above findings and she did not follow infection control standards during Resident #79's medication administration to prevent possible cross contamination of germs. The facility policy and procedure titled Handwashing - Hand Hygiene dated 06/08/2022 indicated hand hygiene should be performed when coming on duty, before and after direct resident contact, before and after handling food trays and assisting resident with eating their meal, before and after handling medications, before and after donning/doffing gloves, after personal use of the toilet, after blowing or wiping nose, after handling soiled or used linens, supplies, equipment or utensils, and when getting off duty. The facility policy titled Medication Administration - General Guidelines dated November 2021 indicated The person administering medications adheres to good hand hygiene, which includes washing hand thoroughly before beginning medication administration, prior to handling medication (gloves are worn with direct contact), after coming in direct contact with a resident, before and after administration of ophthalmic, topical, vaginal, rectal, and parental preparations, and before and after administration of medications via enteral tubes. Examination gloves were worn when necessary.