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	06/10/2024

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on closed record review and interview, the facility failed to prevent a significant medication error for Resident #50 resulting in an acute change in condition requiring hospitalization . Actual Harm occurred on 05/17/24 when Resident #50, who had diagnoses of heart failure and chronic bilateral lower extremity lymphedema, was transferred to the hospital due to significant shortness of breath after not receiving the physician ordered diuretic medication, Torsemide following his admission to the facility on [DATE]. Findings include: Review of Resident #50's Hospital After Visit Summary form dated 05/15/24 revealed the resident was admitted (to the hospital) for a past medical history of medication non-compliance, heart failure, chronic bilateral lower extremity lymphedema and sarcoidosis. Aggressive diuresis was performed. Medications included Torsemide (diuretic) 20 mg (milligrams) two tablets by mouth twice daily with his last dose administered on 05/15/24 at 10:22 A.M. Review of Resident #50's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE]. The resident was transferred/discharged to the hospital on 05/17/24 and did not return to the facility. Resident #50 had diagnoses including pulmonary hypertension, lymphedema and obesity. Review of Resident #50's physician orders revealed an order dated 05/15/24 for Torsemide (oral tablet) 20 mg; give two tablets by mouth twice daily for swelling. The resident also had an order (dated 05/16/24) for Albuterol inhalation 108 mcg (micrograms) two puffs orally every four hours as needed for shortness of breath while awake. Review of Resident #50's Pharmacy packing slip dated 05/15/24 revealed the resident's Torsemide medication was not signed for until 05/17/24 by Registered Nurse (RN) #812. Review of Resident #50's Nurse Practitioner (NP) progress note, authored by NP #811 dated 05/16/24 at 11:03 A.M. revealed the resident had cellulitis of the lower extremity and venous ulcer. The resident was discharged (from the hospital) on oral Torsemide 40 mg twice daily and had chronic pain. (continued on next page)

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #50's medication administration records (MAR) and treatment administration records (TAR) from 05/15/24 to 05/17/24 revealed the resident was not administered Torsemide during his stay. In addition, there was no evidence the resident was administered the Albuterol inhaler during his stay. Review of Resident #50's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #50's undated Quality Improvement Tool for Review of Acute Care Transfers form dated 05/17/24 revealed the resident had a change in condition with complaints of increased epigastric pain. The nurse medicated the resident for pain but (the resident) insisted on going to the hospital. The physician was notified. Review of Resident #50's emergency medical service (EMS) squad report dated 05/17/24 revealed at 5:03 A. M. the squad was called to dispatch to the facility, and they arrived at 5:10 A.M. The report revealed Resident #50 had a hard time breathing. Upon squad arrival, the resident was in his room sitting up and could not breathe. The resident stated that the place was trying to kill him. The resident stated the concern had been going on for over an hour. The staff stated the resident had a breathing treatment and it did absolutely nothing for him. The report included the resident's room was 80 degrees, and he was over 600 pounds. The resident was placed on a CPAP machine and transferred to the hospital. Interview on 06/07/24 at 4:37 P.M. with RN #812 revealed Resident #50 was stable when she cared for him on 05/16/24. She stated she did not have medications to give the resident as they were ordered from pharmacy. She stated she removed what she could from the Pyxis starter system but was not able to administer his Torsemide because it was not available. Telephone interview on 06/07/24 at 6:40 P.M. with NP #811 revealed she was aware the resident's medications were on order from the pharmacy, including his Torsemide. Interview on 06/07/24 at 6:45 P.M. with RN #813 revealed she sent Resident #50 to the hospital on 05/17/24 around 1:00 A.M. to 1:30 A.M. for increased complaints of pain. She stated she had completed Resident #50's leg dressing around 12:00 A.M. and mediated the resident for pain with Oxycodone narcotic pain medication at that time. She stated the resident denied complaints of chest pain or shortness of breath. Telephone interview on 06/10/24 at 8:06 A.M. with Resident #50's insurance representative revealed they received a call from the resident's family member who reported the resident went two days without his prescription medication, being told the facility had not received the medication yet. On 05/18/24 the resident was having difficulty breathing, lost consciousness, and was sent to the emergency department. The resident was treated for having fluid on his lungs and was hospitalized . The insurance representative reached out to Resident #50 who further reported not receiving his prescription medication including Torsemide (following his admission to the nursing facility). Resident #50 indicated he would remain at the hospital until a bed became available at a different skilled rehabilitation facility. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Telephone interview on 06/10/24 at 9:33 A.M. with Fire Department #815 revealed they were called to the facility for a male resident with complaints of the resident having a hard time breathing. Staff stated a breathing treatment was implemented. The resident's room was approximately 80 degrees. A CPAP was placed on the resident and the resident's oxygen level was at 100%. The resident was transported to the hospital. Review of the Medication Administration policy dated 11/2021 revealed medications should be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. This deficiency represents non-compliance investigated under Master Complaint Number OH00154196 and Complaint Number OH00154137.