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	07/16/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to ensure Resident #28's physician, power-of-attorney (POA) and hospice service were notified in a reasonable timely manner for a change of condition, and failed to ensure Resident #28's POA was notified of new physician's orders as well as radiology results. This affected one (Resident #28) of three residents reviewed for a change in condition and notification. The facility census was 78. Findings include: Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure and dementia. She was admitted to hospice on 05/22/24. Resident #28's son was listed as her POA. Review of the nursing progress note dated 06/18/24 at 6:55 P.M. revealed Resident #28 had a new order for an X-ray to her right hip. There was no documentation of the POA being updated on the new order or the results of the X-ray. Review of the nursing progress note dated 06/22/24 at 5:04 P.M. by Licensed Practical Nurse (LPN) #207 revealed at 4:40 P.M. Resident #28 was on the floor by the side of her bed. She was responsive and alert and oriented to herself which was her baseline. LPN #207 observed a small cut on the resident's left arm that was bleeding. The note stated Resident #28 thought she hit her head but denied pain. Vital signs were obtained and were stable. LPN #207 stated due to the resident not remembering if she hit her head, emergency medical services were called so she could go to the emergency room and get scans of her brain. Review of the nursing progress note dated 06/22/24 at 5:12 P.M., Nurse Practitioner (NP) #206 stated Resident #28 had an unwitnessed fall and was sent to the hospital prior to the staff calling her. NP #206 noted nursing was unsure of what hospital the resident was sent to. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the fall investigation dated 06/22/24 at 5:35 P.M. by LPN #207 revealed Resident #28 fell over the side of her bed. LPN #207 assessed her and noted she had a scratch on her left forearm that was bleeding. Resident #28 was responsive, oriented to person (which was her baseline) and vital signs were stable. Resident #28 stated she was not sure if she hit her head. LPN #207 stated she chose to send the resident to the emergency room as she was unsure if the resident had hit her head. The investigation stated family and the on-call nurse practitioner were notified after Resident #28 was sent to the emergency room due to the need for an emergent transfer. Review of the facility form titled, 72 Hour Neuro-Checks Assessment Flow Sheet, dated from 06/22/24 through 06/25/24 revealed Resident #28 had neuro-checks performed on 06/22/24 at 4:45 P.M. She was noted to be alert, have equal hand grasps, could move all her extremities, responded to pressure and pain and had equal pupils that were reactive to light and brisk. Her vital signs were stable. Interview on 07/09/24 at 11:09 A.M. with Resident #28's son (POA) revealed he was not notified prior to the facility sending his mother to the hospital on 06/22/24. He stated when he was updated the nurse stated she had performed an initial exam and did not find anything visibly wrong with his mother. He stated the nurse sent her to the emergency room to be examined because she did not know if Resident #28 had hit her head. He stated he would not have sent her out to the hospital and he believed the trip to the emergency room was worse on his mother than the fall itself. Resident #28's son also stated he was not updated on the X-ray order on 06/18/24 nor when the results were received. Interview on 07/09/24 at 12:29 P.M. with NP #206 verified she was the on-call nurse practitioner on 06/22/24. She stated the nurse on duty, LPN #207, called her after she had sent Resident #28 to the hospital. She stated she wouldn't have sent Resident #28 to the hospital had she been notified prior. She stated Resident #28 should not have been sent to the hospital as it was not an emergent situation. She stated Resident #28's vitals were stable, neurological checks were within normal limits and she only had a skin tear to her left forearm. She stated LPN #207 should have contacted hospice prior to sending her out to the hospital as well. Interview on 07/09/24 at 1:40 P.M. with the Director of Nursing (DON) verified Resident #28 was a hospice resident. He stated he did not know why LPN #207 sent her to the emergency room prior to calling hospice or her POA. He verified her vital signs were stable. DON also verified there was no documentation as to the POA being notified of the X-ray order on 06/18/24 or the results. Interview on 07/09/24 at 4:41 P.M. with LPN #207 verified she was the nurse on duty on 06/22/24 when Resident #28 fell . She stated it was the first and last day she had worked at the facility as she was an agency nurse. She stated she did not know Resident #28 and due to the resident having dementia and being unable to tell her if she hit her head, she decided it was an emergent situation. She verified Resident #28 had stable vital signs, was able to state her name and had no pain. She verified Resident #28 stated she did not know if she hit her head. LPN #207 stated after she sent Resident #28 to the hospital, she then called NP #206 and the resident's son. Review of the facility policy titled, Change in a Resident's Condition, dated 11/30/23, revealed the facility nurse was to notify the resident's attending physician or on-call physician when there was a change in the resident's condition. The nurse was also to notify the resident's family or representative on changes in the resident's medical/mental condition. This deficiency represents non-compliance investigated under Complaint Number OH00155258.

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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** 43063 Based on record review and interview, the facility failed to ensure Resident #28's pain medications were administered as ordered. This affected one (Resident #28) of five residents reviewed for medication administration. The facility census was 78. Findings include: Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure, dementia and osteoarthritis. Review of Resident #28's physician's orders for June 2024 and July 2024 revealed she had an order for Tramadol 50 milligrams (mg) three times a day for pain dated 06/14/24. Review of the Medication Administration Record (MAR) for June 2024 and July 2024 revealed Resident #28 received her Tramadol as ordered. Review of Resident #28's narcotic count sheet dated from 06/24/24 through 07/04/24 for Tramadol 50 mg revealed she received only one dose on 06/25/24, two doses on 06/30/24 and two doses on 07/01/24. Resident #28 was to receive three doses each day per the physician's order. Interview on 07/09/24 at 1:40 P.M. with the Director of Nursing (DON) revealed Resident #28 only had one card of Tramadol 50 mg medication and one narcotic count sheet for 06/25/24 through 07/04/24. He verified Resident #28's pain medication was not given as scheduled on 06/25/24, 06/30/24 and 07/01/24 and nursing staff had documented incorrectly on Resident #28's MAR stating that she had received all three doses on 06/25/24, 06/30/24 and 07/01/24. Review of the facility policy titled, Medication Administration-General Guidelines, dated November 2021, stated medications should be administered as prescribed. This deficiency represents non-compliance investigated under Complaint Number OH00155258 and Complaint Number OH00155569.

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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** 43063 Based on record review and interviews, the facility failed to ensure documentation in the medical record was complete and accurate. This affected two (Residents #28 and #55) of eight residents reviewed for documentation of medication and treatment administration. The facility census was 78. Findings include: 1. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure, dementia and osteoarthritis. Review of Resident #28's physician's orders for June 2024 and July 2024 revealed she had an order for Tramadol 50 milligrams (mg) three times a day for pain dated 06/14/24; treatment to her right fifth toe every night shift dated 07/04/24; treatment to her right heel with applying skin prep and covering with abdominal (ABD) pad every night shift dated 07/04/24; treatment to her bilateral buttocks/coccyx with cleansing with soap and water, patting dry and applying Zinc every shift and as needed dated 07/06/24; dycem under the cushion of her wheel chair for safety every shift dated 12/12/23; oxygen at two liters to maintain oxygen saturation above 92% dated 05/18/22; and turning every two hours for bony prominence support dated 05/13/24. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for June 2024 and July 2024 revealed Resident #28 received her Tramadol as ordered. However, the facility staff did not document Resident #28 received the treatments to her fifth toe and right heel on 07/05/24 and 07/07/24 on night shift; the treatment to her buttocks on evening and night shift on 07/07/24; dycem to her wheel chair on the evening shift of 07/01/24, 07/02/24 and 07/04/24 and on night shift on 07/03/24; that oxygen saturation was checked on the evening shift on 07/01/24, 07/02/24 and 07/04/24 and on night shift on 07/01/24 and 07/03/24; and turning every two hours was performed on 07/01/24 at 4:00 P.M., 6:00 P.M., 8:00 P.M. and 10:00 P.M., on 07/02/24 at 6:00 A.M., 4:00 P.M., 6:00 P.M., 8:00 P.M., and 10:00 P.M., on 07/03/24 at 10:00 A.M., 12:00 P.M. and 2:00 P.M., on 07/04/24 at 12:00 A.M., 2:00 A.M., 4:00 A.M., 6:00 A. M., 8:00 P.M. and 10:00 P.M. and on 07/05/24 at 4:00 P.M. and 6:00 P.M. Review of Resident #28's narcotic count sheet dated from 06/24/24 through 07/04/24 for Tramadol 50 mg revealed she received only one dose on 06/25/24, two doses on 06/30/24 and two doses on 07/01/24. Resident #28 was to receive three doses each day per the physician's order. Interview on 07/09/24 at 1:40 P.M. with the Director of Nursing (DON) revealed Resident #28 only had one card of Tramadol 50 mg medication and one narcotic count sheet for 06/25/24 through 07/04/24. He verified Resident #28's pain medication was not given as scheduled on 06/25/24, 06/30/24 and 07/01/24 and nursing staff had documented incorrectly on Resident #28's MAR stating that she had received all three doses on 06/25/24, 06/30/24 and 07/01/24. He also verified staff had not documented completed on Resident #28's MAR and TAR for the treatments listed above. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Medication Administration-General Guidelines, dated November 2021, stated medications should be administered as prescribed. The individual who administers the medication/treatment should document the administration on the resident's MAR directly after it is completed. 2. Review of the medical record for Resident #55 revealed an admitted [DATE] with diagnoses including difficulty walking, history of falling and altered mental status. Review of the physician's orders for July 2024 for Resident #55 revealed she had orders for oxygen at two liters as needed to maintain oxygen saturation of at least 92% dated 04/16/24; offload heels while in bed dated 04/16/24; pressure redistribution mattress to bed every shift dated 04/16/24; protective moisture barrier topically to perianal area every shift for protection dated 04/16/24; and turn and reposition as tolerated every shift and as needed dated 04/16/24. Review of the Treatment Administration Record (TAR) for July 2024 for Resident #55 revealed staff had not documented as completed the oxygen saturation assessment on 07/03/24, 07/04/24 and 07/07/24 on night shift as well as offloading her heels, ensuring mattress was to bed, moisture barrier cream was applied and turning and repositioning on 07/03/24, 07/04/24 and 07/07/24 on night shift. Interview on 07/09/24 at 1:40 P.M. with the Director of Nursing (DON) verified nursing staff had not documented completed on Resident #55's TAR for the treatments listed above. Review of the facility policy titled, Medication Administration-General Guidelines, dated November 2021, stated medications should be administered as prescribed. The individual who administers the medication (treatment) should document the administration on the resident's MAR directly after it is completed.