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	01/30/2025

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** 48567 Based on medical record review, interview and review of the facility policy, the facility failed to ensure Resident #22's resident representative was informed of a medication change and a fall. This affected one resident (#22) of three residents reviewed for changes in condition. The facility census was 65. Findings include: Review of the medical record for Resident #22 revealed he was admitted to the facility on [DATE] with diagnoses including fracture of the nasal bone with routine healing, fracture of the distal phalanx of the right little finger with routine healing, emphysema, encounter after fall, repeated falls, severe protein-calorie malnutrition, muscle weakness, laceration of unspecified cheek and temporomandibular area, ischemic cardiomyopathy, presence of a cardiac pacemaker, and type two diabetes mellitus. Review of the resident profile and contact information revealed the daughter of Resident #22 was listed as his emergency contact and responsible party. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 12/29/24 revealed Resident #22 had intact cognition, no behaviors, received insulin injections and hypoglycemic medication. Further review of the MDS revealed Resident #22 had sustained falls within one month of admission, within two to six months of admission, and since being admitted to the facility. Review of the physician orders dated 12/26/25 revealed Resident #22 had an order to increase Insulin Glargine-yfgn 100 units per milliliter (ml) to 13 unit subcutaneously daily. Review of the electronic and paper progress notes from 12/16/24 through 01/31/25 revealed no documented evidence that Resident #22's responsible party was notified of his medication dosage change. Review of the facility incident log revealed Resident #22 sustained an unwitnessed fall on 01/13/25. Review of the progress notes and the fall investigation revealed no documented evidence that Resident #22's responsible party was notified of his fall. Interview on 01/31/25 at 5:19 P.M. with the Director of Nursing (DON) confirmed the medical record contained no evidence of family/responsible party notification of Resident #22's insulin dose change on 12/26/24 or his fall on 01/13/25. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Change in Resident's Condition or Status, dated February 2021, revealed the facility was to promptly notify the resident representative of any changes in the resident's medical condition, mental condition, or status, including incidents or injuries and changes involving the need to alter clinical interventions. This deficiency represents non-compliance investigated under Complaint Number OH00161190.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on record reviews, interviews and facility policy review, the facility failed to implement baseline care plans within 48 hours after admission for Resident #22, Resident #38 and Resident #62. This affected three residents (#22, #38, and #62) of three residents reviewed for baseline care plans. The facility census was 65. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including fracture of nasal bones, displaced fracture of distal phalanx of the right little finger, diabetes, and emphysema. Initial review of the of the electronic medical record (EMR) and the hard chart on 01/28/25 revealed there was no baseline care plan in place. Review of the binders containing paper documentation from 12/22/24 through 12/31/24 provided by the Director of Nursing (DON) revealed there was no baseline care plan in place. A subsequent review of the EMR (days after survey entrance) revealed a written baseline care plan dated 12/19/24 was uploaded into the EMR the evening of 01/28/25 for Resident #22. Further review of the baseline care plan revealed it was incomplete, as it contained the functional and medical history assessment criteria but listed no goals or care plan interventions. Interview on 01/30/25 at 5:19 P.M. with the DON confirmed Resident #22 had no interventions or goals listed on his baseline care plan. 2. Review of the medical record for Resident #38 revealed an admitted [DATE] and readmission on 01/17/25. Diagnoses included diabetes, hypertensive heart and chronic kidney disease with heart failure, and chronic diastolic congestive heart failure. Review of the EMR, the hard chart and binders provided by DON revealed there were no baseline care plan in place for Resident #38. 3. Review of the medical record for Resident #62 revealed an admitted [DATE] with diagnoses including congestive heart failure, atrial fibrillation, and dementia. Review of the EMR, the hard chart and binders provided by DON revealed there was no baseline care plan in place for Resident #62. Interview on 01/29/25 at 3:45 P.M. with Social Service Designee (SSD) #334 verified Resident #22 only had a nutritional goal in the system and no other care plan (including baseline) was in place. Interviews on 01/30/25 at 10:00 A.M. with DON and Administrator revealed they gave surveyors all the resident chart information they had verifying there were no baseline care plans for Residents #22, Resident #38, and Resident #62. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Care Plans-Baseline, revised 03/2022, revealed baseline care plans should be developed for each resident within forty-eight hours of admission. This deficiency was an incidental finding identified during the complaint investigation.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on medical record review, interview, and review of facility policy the facility failed to ensure a comprehensive care plan was developed and implemented for Resident #22. This affected one resident (#22) of three residents reviewed for care plans. The facility census was 65. Findings include: Review of the medical record for Resident #22 revealed he was admitted to the facility on [DATE] with diagnoses including fracture of the nasal bone with routine healing, fracture of the distal phalanx of the right little finger with routine healing, emphysema, encounter after fall, repeated falls, severe protein-calorie malnutrition, muscle weakness, laceration of unspecified cheek and temporomandibular area, ischemic cardiomyopathy, and presence of a cardiac pacemaker, and type two diabetes mellitus. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 12/29/24 revealed Resident #22 had intact cognition. Further review of the MDS revealed Resident #22 had sustained falls within one month of admission, within two to six months of admission, and since being admitted to the facility. Review of Resident #22's comprehensive care plan dated 12/23/24 revealed a nutritional care plan focus only. Interview on 01/30/25 at 5:19 P.M. with the Director of Nursing (DON) confirmed Resident #22's comprehensive care plan only contained one nutritional focus and did not reflect the complete and accurate care planning needs for Resident #22. Review of the undated policy titled Care Plans, Comprehensive Person-Centered revealed a comprehensive care plan was to be developed within seven days of completion of the required comprehensive MDS which included the services, goals and objectives needed for the resident to attain or maintain their physical, mental, and psychosocial well-being. This deficiency was an incidental finding identified during the complaint investigation.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on medical record review, interview and review of the facility policy, the facility failed to ensure Resident #22's fall was thoroughly investigated and failed to ensure fall interventions were in place to prevent a subsequent fall. This affected one resident (#22) of three residents reviewed for falls. The facility census was 65. Findings include: Review of the medical record for Resident #22 revealed he was admitted to the facility on [DATE] with diagnoses including fracture of the nasal bone with routine healing, fracture of the distal phalanx of the right little finger with routine healing, emphysema, encounter after fall, repeated falls, severe protein-calorie malnutrition, muscle weakness, laceration of unspecified cheek and temporomandibular area, ischemic cardiomyopathy, and presence of a cardiac pacemaker, and type two diabetes mellitus. Review of the baseline care plan completed on 12/19/24 revealed Resident #22 was a fall risk and was admitted for a previous fall. Further review of the baseline care plan revealed there were no goals or interventions related to falls or fall prevention. Review of the progress notes revealed a note dated 12/22/24 at 12:00 A.M. that Resident #22 was found on his bed holding a napkin to a previous facial laceration that was re-bleeding. The note further revealed Resident #22 reported to the nurse that he had fallen when he was in his bathroom and hit his head on the rail in the bathroom. Review of the comprehensive care plan dated 12/23/24 revealed there was no care plan focus related to falls and no intervention in place to prevent falls. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 12/29/24 revealed Resident #22 had intact cognition, no behaviors, and no rejection of care. Further review of the MDS revealed Resident #22 had sustained falls within one month of admission, within two to six months of admission, and since being admitted to the facility. Review of the facility incident logs from 11/01/24 through 01/27/25 revealed Resident #22 sustained only one fall while in the facility, an unwitnessed fall on 01/13/25. There was no incident logged for a fall that Resident #22 sustained on 12/22/24. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/30/25 at 2:15 P.M. with the Director of Nursing (DON) confirmed only two incidents were logged on paper during their scheduled electronic medical record (EMR) downtime between 12/22/24 and 12/31/24, and Resident #22 was not one of them. A follow-up interview on 01/30/25 at 5:19 P.M. confirmed the facility was to conduct an investigation into falls to try to find the root cause of the fall and a way to prevent future falls. She also confirmed there was no fall investigation, just an initial Fall Review assessment completed by the floor nurse at the time of the incident, and no evidence an interdisciplinary team (IDT) meeting was held to review Resident #22's fall, interventions, or the need to alter or add new interventions. During this interview, the DON confirmed Resident #22 had no interventions for falls in his baseline care plan (dated 12/19/24) or his comprehensive care plan (dated 12/23/24). Review of the policy titled Fall Risk Assessment, dated March 2018, revealed that an interdisciplinary care team, including the physician and nursing staff, was to identify and document fall risk factors and develop and implement a resident-centered fall prevention plan based on the assessment information to mitigate the risk of falls. This deficiency represents non-compliance investigated under Master Complint Number OH00161407 and Complaint Number OH00161190.

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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 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** 48567 Based on record review, observation, interview, manufacturer's instructions for use of Insulin Glargine - yfgn and review of the facility policy, the facility failed to ensure a medication error rate of less than five percent. This affected three residents (#4, #38, and #54) of five residents observed for medication administration and yielded a 13.79 percent medication error rate. The facility census was 65. Findings include: 1. Review of the medical record for Resident #38 revealed an admitted [DATE] and a re-entry date of 01/18/25. Admitting diagnoses included type two diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure, chronic diastolic congestive heart failure (CHF), stage three chronic kidney disease, morbid obesity, gastroesophageal reflux disease (GERD), hyperglycemia, obstructive sleep apnea, chronic pain, hypothyroidism, and long-term use of insulin. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 01/23/25 revealed the Brief Interview for Mental Status (BIMS) was not completed and her cognition was not assessed; however, the BIMS completed on 11/28/24 during a previous admission to the facility revealed Resident #38 had severely impaired cognition. Further review of the admission MDS revealed Resident #38's primary medical condition was type two diabetes mellitus with chronic kidney disease, and she received insulin daily, as well as medications from other high-risk categories which included antidepressants, diuretic, antiplatelet, and hypoglycemic medications. Review of the January 2025 physician orders revealed an order dated 01/18/25 for Insulin Glargine-yfgn 100 units per milliliter (ml) solution pen-injector, 27 units subcutaneously two times a day for glucose. Further review of the orders dated 01/18/25 revealed an order for Omeprazole oral capsule delayed release (DR) 40 milligrams (mg) by mouth one time a day for GERD. Review of the medication administration record (MAR) revealed the Omeprazole was scheduled to be administered at 7:00 A.M. Observation of medication preparation and administration on 01/28/25 from 9:30 A.M. to 9:46 A.M. revealed Registered Nurse (RN) #310 did not prime the insulin needle by dialing and wasting two units prior to setting the dose in the insulin pen to the ordered 27 units when preparing Resident #38's medications. Further observation revealed the ordered Omeprazole was not placed in the medicine cup for administration. Interview on 01/28/25 at 9:40 A.M. with RN #310 confirmed the Omeprazole was not in stock, and she would have to order more from the pharmacy after she completed the medication pass. Another interview with RN #310 on 01/28/25 at 11:45 A.M. revealed she learned the facility had Omeprazole in stock and planned to administer the medication to Resident #38 shortly and would notify the surveyor when ready to give this medication. RN #310 did not notify the surveyor that the Omeprazole was administered. A follow-up interview with RN #310 at 3:44 P.M. confirmed she did administer Resident #38's Omeprazole, but not until around 2:00 P.M. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/28/25 at 3:22 P.M. with Resident #38 confirmed she received the Omeprazole (scheduled for 7:00 A.M.) that afternoon when she stated, The nurse just came a little bit ago to give me that stomach pill. Further interview with Resident #38 revealed she typically received her morning insulin after breakfast and that her blood sugar was sometimes high in the morning because the nurses do not check it until after she eats. Interview on 01/28/25 at 5:00 P.M. with RN #310 confirmed she did not prime Resident #38's insulin needle with two units prior to setting the ordered dose of 27 units on the insulin glargine - yfgn pen and administering the medication. RN #310 further confirmed she was unaware of the manufacturer's instructions to prime the needle with two units prior to administration. Review of the manufacturer's instructions for use of Insulin Glargine - yfgn prefilled pen revealed Step three required the needle to be primed to make sure the needle was working properly, and the resident received the correct dose of the insulin. Further review of the instructions revealed the user was to dial two units on the dose selector and then press the injection button all the way in, causing the insulin to come out of the tip of the pen prior to turning the dial on the dose selector to the ordered number of units. The instructions further cautioned the pen should not be used unless insulin was seen coming from the needle prior to preparing and administering the proper dose. Review of the facility policy titled Administering Medications, dated April 2019, revealed medications were to be administered in accordance with prescriber orders, including any required timeframes, and medications were to be administered within one hour of their prescribed time, unless otherwise specified, such as before and after meal orders. 2. Review of the medical record for Resident #4 revealed he was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, polyneuropathy, toxic encephalopathy, muscle weakness, major depressive disorder, localized edema, dysphagia, chronic pain, unspecified convulsions, age-related cognitive decline, and glaucoma. Review of the quarterly MDS 3.0 assessment completed on 10/12/24 revealed Resident #4 had impaired vision and intact cognition. Further review of the MDS revealed Resident #4 had impaired range of motion (ROM) of the upper and lower extremities on one side of his body and required substantial to maximal assistance with personal care and transfers. Review of the January 2025 physician orders revealed an order dated 09/08/24 for brimonidine tartrate ophthalmic solution 0.2 % (a medication used to lower intraocular pressure), one drop in both eyes two times a day. Further review revealed an order dated 09/09/24 for dorzolamide HCl-timolol solution 22.3-6.8 mg per ml, one drop in both eyes two times a day for glaucoma. Review of the medication administration record (MAR) revealed the dorzolamide/timolol eye drops were scheduled for 7:00 A.M. and 7:00 P.M. and the brimonidine tartrate drops were scheduled to be administered at 9:00 A.M. and 9:00 P.M. Observation on 01/28/25 from 9:10 A.M. to 9:15 A.M. revealed Resident #4 sitting in his wheelchair in the dining hall during morning medication administration. During the observation, RN #310 administered one drop of the dorzolamide/timolol solution into each eye of Resident #4 and informed him she would return in approximately five minutes to administer the other ordered eye drops (the brimonidine tartrate). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/28/25 at 9:50 A.M. revealed RN #310 returned to the dining hall to administer Resident #4 his brimonidine tartrate ophthalmic solution 0.2 %, but Resident #4 was unable to lean his head back and she was unable to successfully administer the prescribed drops. At this time, RN #310 informed Resident #4 she would try again later after the Certified Nurse Aides (CNAs) laid him down in bed. Review of the MAR on 01/28/25 at 2:29 P.M. still revealed no documentation the brimonidine tartrate ophthalmic solution 0.2 %, timed for 9:00 A.M., was administered. Interview on 01/28/2 at 3:44 P.M. revealed RN #310 had just exited the room of Resident #4 and confirmed she just administered his scheduled morning dose of brimonidine tartrate drops. Review of the Medication Administration Audit Report (MAAR) for brimonidine tartrate ophthalmic Solution 0. 2 % administration on 01/28/25 revealed the eye drops were scheduled to be given at 9:00 A.M. and 9:00 P. M. and the 9:00 A.M. dose was not documented as given until 3:47 P.M. (the evening dose was then administered at 8:22 P.M. on 01/28/25). Review of the facility policy titled Administering Medications, dated April 2019, revealed medications were to be administered in accordance with prescriber orders, including any required timeframes, and medications were to be administered within one hour of their prescribed time, unless otherwise specified. 3. Review of the medical record for Resident #54 revealed he was admitted on [DATE] with diagnoses including type two diabetes mellitus with diabetic chronic kidney disease, unspecified severe dementia with agitation, epilepsy, moderate protein-calorie malnutrition, anxiety disorder, mental disorder not otherwise specified, anemia, hyperlipidemia, alcohol dependence (in remission), and long-term (current) use of insulin. Review of the January 2025 physician orders revealed Resident #54 had an order dated 10/17/24 for insulin lispro 100 units per milliliter (units/ml) per sliding scale subcutaneously two times a day as follows: notify physician or nurse practitioner of blood sugar less than 70 or greater than 400; three units for blood sugar 181 to 250; six units for blood sugar 21 to 300; 12 units for blood sugar 301 to 400; and 15 units for blood sugar greater than 401. Review of the MAR revealed the insulin lispro was scheduled to be administered at 7:00 A.M. and 1:00 P.M. Further review of the physician orders revealed an order dated 11/26/24 for insulin glargine subcutaneous solution 100 units/ml, 14 units subcutaneously once daily for diabetes mellitus. Review of the MAR revealed the insulin glargine was scheduled for 7:00 A.M. Observation on 01/28/25 at 10:11 A.M. revealed RN #310 performed a fingerstick blood sugar (FSBS) test on Resident #54, which confirmed the FSBS result at that time was 297. During the FSBS test, Resident #54 was noted to be agitated and had bilateral hand tremors. RN #310 then exited Resident #54's room and began preparing medications for another resident. When asked what time the surveyor should return to watch insulin administration for Resident #54, RN #310 stated she would do it later when he called down. This surveyor instructed RN #310 to notify the surveyor when she was ready to prepare the insulin injection for Resident #54 and informed RN #310 that the surveyor would remain in her sight at the nurse's station. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/28/25 at 11:45 A.M. with RN #310 confirmed she had not notified the surveyor when she was ready to administer Resident #54's scheduled 7:00 A.M. insulin but revealed she had given Resident #54 his insulin around eleven (11:00 A.M.) with the assistance of another floor nurse. Review of the facility policy titled Administering Medications, dated April 2019, revealed medications were to be administered in accordance with prescriber orders, including any required timeframes, and medications were to be administered within one hour of their prescribed time, unless otherwise specified. This deficiency represents non-compliance investigated under Complaint Number OH00161190.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, review of the manufacturer's instructions for use of Insulin Glargine - yfgn and review of facility policy, the facility failed to ensure medications were administered according to physician's orders for Residents #22, #38, and #54. This affected three residents (#22, #38 and #54) of three residents reviewed for insulin administration and had the potential to affect ten additional residents (#2, #3, #5, #12, #16, #25, #26, #34, #44 and #45) identified by the facility with physician's orders for insulin. The facility census was 65. Findings include: 1. Review of the medical record for Resident #38 revealed an admitted [DATE] and a re-entry date of 01/18/25. Admitting diagnoses included type two diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure, chronic diastolic congestive heart failure (CHF), stage three chronic kidney disease, morbid obesity, gastroesophageal reflux disease (GERD), hyperglycemia, obstructive sleep apnea, chronic pain, hypothyroidism, and long-term use of insulin. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 01/23/25 revealed the Brief Interview for Mental Status (BIMS) was not completed and Resident #38's cognition was not assessed; however, the BIMS completed on 11/28/24 during a previous admission to the facility revealed Resident #38 had severely impaired cognition. Further review of the admission MDS revealed Resident #38's primary medical condition was type two diabetes mellitus with chronic kidney disease, and she received insulin daily, as well as medications from other high-risk categories which included antidepressants, diuretic, antiplatelet, and hypoglycemic medications. Review of the physician orders revealed an order dated 01/18/25 for Insulin Glargine-yfgn 100 units per milliliter (ml) solution pen-injector, 27 unit subcutaneously two times a day for glucose. Further review of the orders revealed orders dated 01/18/24 for insulin lispro 100 units per milliliter (units/ml), 10 units subcutaneously with meals for diabetes and per sliding scale to be administered before meals and at bedtime subcutaneously as follows: notify physician if blood sugar was greater than 400; give zero units for blood sugar 0 to 150; one unit for blood sugar 151 to 200; two units for blood sugar 201 to 250; three units for blood sugar 251 to 300. Observation of medication preparation and administration on 01/28/25 from 9:30 A.M. to 9:46 A.M. revealed Registered Nurse (RN) #310 did not prime the insulin needle by dialing and wasting two units prior to setting the dose in the insulin pen to the ordered 27 units when preparing Resident #38's medications. Further observation revealed the ordered Omeprazole was not placed in the medicine cup for administration. During the observation, Resident #38 was informed by RN #310 how much insulin lispro coverage she would receive per the sliding scale and Resident #38 replied, well, that's because I already ate. Interview on 01/28/25 at 5:00 P.M. with RN #310 confirmed she did not prime Resident #58's insulin needle with two units prior to setting the ordered dose of 27 units on the insulin glargine - yfgn pen and administering the medication. RN #310 further confirmed she was unaware of the manufacturer's instructions to prime the needle with two units prior to administration. (continued on next page)

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	366419	A. Building B. Wing	01/30/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication administration record (MAR) revealed no documentation of the administration of insulin lispro 10 units/ml subcutaneously with meals on 01/18/25, no documented blood sugar results or insulin administered or held on 01/18/25 for breakfast, lunch or dinner, at bedtime on 01/21/25 and 01/22/25, and overlapping orders for insulin glargine - yfgn pen injector 100 units/ml subcutaneously twice per day. Of the overlapping orders, two were ordered to start on 01/18/25 at 9:00 A.M., for which there was no documentation. One of the orders was discontinued on 01/19/25, the other remined active as of the date of the survey, with doses scheduled for 9:00 A.M. and 8:00 P.M. The other was dated 01/20/25 through 01/24/25 with a supplemental order to hold from 8:05 P.M. on 01/21/25 through 7:29 P.M. on 01/22/25. Further review of the MAR revealed documentation that Resident #38 received the morning dose of 27 units of insulin glargine on 01/22/25. Review of the Medication Administration Audit Report (MAAR) for times of administration and the MAR for blood sugar readings with insulin administration from 01/18/25 through the morning of 01/30/25 revealed the following: For insulin glargine-yfgn 100 units/ml solution pen-injector, 27 unit subcutaneously two times a day for glucose (scheduled for 9:00 A.M. and 9:00 P.M.): 01/18/25 - 9:00 A.M., when there were two overlapping orders for this medication, dose and time, doses were noted as given at 10:11 A.M. and 12:11 P.M 01/19/25, the 9:00 A.M. dose was given at 12:28 P.M. 01/20/25, the 9:00 A.M. dose was given at 10:59 A.M. 01/22/25, the 9:00 A.M. dose given at 10:43 A.M. 01/25/25, the 9:00 A.M. dose given at 11:07 A.M. 01/28/25, the 9:00 A.M. dose was given at 9:50 A.M. (the pen was not primed prior to administration as observed above). For insulin lispro injection solution 100 units/ml, 10 unit subcutaneously with meals for diabetes: 01/19/25, the breakfast dose was given at 12:28 P.M. (blood sugar 285) 01/20/25, the breakfast dose was given at 10:58 A.M. (blood sugar 167) 01/20/25, the dinner dose was administered at 6:33 P.M. (blood sugar 17) 01/22/25, the dinner was dose was given at 7:31 P.M. (blood sugar 170) 01/25/25, the breakfast dose was given at 11:07 A.M. (blood sugar 159) 01/26/25, the lunch dose was given at 2:33 P.M. (blood sugar 132) 01/26/25, the dinner dose given at 7:23 P.M. (blood sugar 208) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/28/25, the breakfast dose was given at 9:50 A.M (blood sugar 183) 01/29/25, the breakfast dose was given at 9:44 A.M. For insulin lispro subcutaneous Solution Pen-injector 100 units/ml per sliding scale before meals and at bedtime subcutaneously as follows - give zero units for blood sugar 0 to 150; one unit for blood sugar 151 to 200; two units for blood sugar 201 to 250; three units for blood sugar 251 to 300: 01/21/25, the dose due before breakfast was given at 9:21 A.M. (blood sugar 168) 01/21/25, the dose due before dinner was given at 6:32 P.M. (blood sugar 213) 01/22/25, the dose due before dinner was administered at 7:31 P.M. (blood sugar 15) 01/21/25 and 01/22/25, there was no documented evidence of blood sugar or insulin lispro administration per sliding scale at bedtime. 01/25/25, the dose due before breakfast was administered at 11:06 A.M. (blood sugar 159) 01/28/25, the dose due before breakfast was given at 9:50 A.M. (blood sugar 183. (The resident told nurse, Well, I already ate.). 01/29/25, the dose due before breakfast was given at 9:44 A.M. Interview on 01/30/25 at 5:19 P.M. with the Director of Nursing (DON) confirmed insulin that was ordered before meals or with meals should be administered as ordered and long-acting insulins should be given around the same time each day. Review of the manufacturer's instructions for use of Insulin Glargine - yfgn prefilled pen revealed Step three required the needle to be primed to make sure the needle was working properly, and the resident received the correct dose of the insulin. Further review of the instructions revealed the user was to dial two units on the dose selector and then press the injection button all the way in, causing the insulin to come out of the tip of the pen prior to turning the dial on the dose selector to the ordered number of units. The instructions further cautioned the pen should not be used unless insulin was seen coming from the needle prior to preparing and administering the proper dose. Further review of the manufacturer's instructions revealed insulin glargine should be given the same time each day. Review of the facility policy titled Administering Medications, dated April 2019, revealed medications were to be administered in accordance with prescriber orders, including any required timeframes, and medications were to be administered within one hour of their prescribed time, unless otherwise specified, such as before and after meal orders. 2. Review of the medical record for Resident #54 revealed he was admitted on [DATE] with diagnoses including type two diabetes mellitus with diabetic chronic kidney disease, unspecified severe dementia with agitation, epilepsy, moderate protein-calorie malnutrition, anxiety disorder, mental disorder not otherwise specified, anemia, hyperlipidemia, alcohol dependence (in remission), and long-term (current) use of insulin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders revealed Resident #54 had an order dated 10/17/24 for insulin lispro 100 units per milliliter (units/ml) per sliding scale subcutaneously two times a day as follows: notify physician or nurse practitioner of blood sugar less than 70 or greater than 400; three units for blood sugar 181 to 250; six units for blood sugar 21 to 300; 12 units for blood sugar 301 to 400; and 15 units for blood sugar greater than 401. Review of the medication administration record (MAR) revealed the insulin lispro was scheduled to be administered at 7:00 A.M. and 1:00 P.M. Further review of the physician orders revealed an order dated 11/26/24 for insulin glargine subcutaneous solution 100 units/ml, 14 units subcutaneously once daily for diabetes mellitus. Review of the MAR revealed the insulin glargine was scheduled for 7:00 A.M. Observation on 01/28/25 at 10:11 A.M. revealed RN #310 performed a fingerstick blood sugar (FSBS) test on Resident #54, which confirmed the FSBS result at that time was 297. During the FSBS test, Resident #54 was noted to be agitated and had bilateral hand tremors. RN #310 then exited Resident #54's room and began preparing medications for another resident. When asked what time the surveyor should return to watch insulin administration for Resident #54, RN #310 stated she would do it later when he called down. This surveyor instructed RN #310 to notify the surveyor when she was ready to prepare the insulin injection for Resident #54 and informed RN #310 that the surveyor would remain in her sight at the nurse's station. Interview on 01/28/25 at 11:45 A.M. with RN #310 confirmed she had not notified the surveyor when she was ready to administer Resident #54's scheduled 7:00 A.M. insulin and revealed she had given Resident #54 his insulin around eleven (11:00 A.M.) with the assistance of another nurse. Review of the MAAR for times of medication administration and the MAR for blood sugar readings with insulin administration from 01/01/25 through 9:25 A.M. on 01/30/25 revealed the following: For insulin glargine subcutaneous solution 100 units/ml, 14 unit subcutaneously daily (scheduled for 7:00 A.M.): 01/01/25 it was given at 11:17 A.M (blood sugar was 322) 01/06/25 it was given at 7:34 P.M. (blood sugar 331) 01/11/25 it was given at 11:54 A.M. (blood sugar was 81) 01/13/25 it was given at 10:58 A.M. (blood sugar 285) 01/14/25 it was given at 1:25 P.M. (blood sugar 170) 01/16/25 it was given at 11:13 A.M. (blood sugar 136) 01/17/25 it was given at 1:11 P.M. (blood sugar 160) 01/19/25 it was given at 11:49 A.M. (blood sugar 111) 01/22/25 it was given at 12:11 P.M. (blood sugar 208) 01/28/25 it was given at 11:01 A.M. (blood sugar 132) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/28/25 it was logged as given at 10:27 A.M. (logged blood sugar as 293, observed it was 297 at 10:11 A. M.) For insulin lispro100 units/ml per sliding scale subcutaneously twice a day (scheduled for 7:00 A.M. and 1:00 P.M.): 01/03/25, the 1:00 P.M. dose on was given at 4:28 P.M. (blood sugar 215) 01/06/25, the 7:00 A.M. dose was given at 7:33 P.M. (blood sugar 331) 01/13/25, the 7:00 A.M. dose was given at 10:59 A.M. (blood sugar 185) 01/14/25, the 7:00 A.M. dose was not given in the morning and held at 1:16 P.M. for blood sugar of 170. 01/14/25, the 1:00 P.M. dose was given at 7:23 P.M. (blood sugar 213) 01/17/25, the 1:00 P.M. dose was given at 6:40 P.M. (blood sugar 200) 01/18/25, the 1:00 P.M. dose was given at 5:44 P.M. (blood sugar 215) 01/20/25, the 7:00 A.M. dose was given at 6:07 P.M. while the 1:00 P.M. dose was documented as given at 11:07 A.M. 01/21/25, the 1:00 P.M. dose was given at 6:40 P.M. (blood sugar 285) 01/28/25, the 7:00 A.M. dose was given at 10:24 A.M. and the 1:00 P.M. dose was given at 12:27 P.M., which was two hours after the morning dose was given (blood sugar had risen to 399 at that time). 01/29/25, the 1:00 P.M dose was given at 5:01 P.M. (blood sugar 193) Interview on 01/30/25 at 5:19 P.M. with the DON confirmed insulin that was ordered before meals or with meals should be administered as ordered, and long-acting insulins should be given around the same time each day. Review of the manufacturer's instructions for use of Insulin Glargine - yfgn prefilled pen revealed insulin glargine should be given the same time each day. Review of the policy titled Administering Medications, dated April 2019, revealed medications were to be administered in accordance with prescriber orders, including any required timeframes, and medications were to be administered within one hour of their prescribed time, unless otherwise specified, such as before or after meals. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #22 revealed he was admitted to the facility on [DATE] with diagnoses including fracture of the nasal bone with routine healing, fracture of the distal phalanx of the right little finger with routine healing, emphysema, encounter after fall, repeated falls, severe protein-calorie malnutrition, muscle weakness, laceration of unspecified cheek and temporomandibular area, ischemic cardiomyopathy, and presence of a cardiac pacemaker, and type two diabetes mellitus. Review of the admission MDS 3.0 assessment completed on 12/29/24 revealed Resident #22 had intact cognition, no behaviors, and received insulin injections and hypoglycemic medication. Review of the physician orders dated 12/26/25 revealed Resident #22 had an order to increase insulin glargine-yfgn 100 units per ml to 13 units subcutaneously daily. Further review of the orders revealed that Resident #22's insulin glargine-yfgn 100 units per ml was increased to 15 units subcutaneously daily on 01/08/25. An order dated 12/19/24 revealed Resident #22 was to receive insulin lispro 100 units/ml per sliding scale subcutaneously with meals. The sliding scale was as follows: give one unit for blood sugar 111 to 150; three units for blood sugar 151 to 200; six units for blood sugar 201 to 250; nine units for blood sugar 251 to 300; 12 units for blood sugar 301 to 350; 15 units for blood sugar 351 to 400; and give 15 units and call the provider for blood sugar over 400. Review of the MAAR for times of medication administration and the MAR for blood sugar readings with insulin administration from 01/01/25 through 9:25 A.M. on 01/14/25 revealed the following: For the insulin lispro 110 units/ml per sliding scale order: 01/03/25, the 8:00 A.M. breakfast dose was given at 10:39 A.M. (blood sugar was 364) 01/03/25, the noon lunch dose was given at 2:38 P.M. (blood sugar was 288) 01/05/25, the 8:00 A.M. breakfast dose was given at 11:06 A.M. (blood sugar was 321) and the 01/05/25 noon scheduled lunch dose was documented as given at 12:31 P.M., less than one hour after the morning dose (blood sugar logged as 295). 01/09/25, the 8:00 A.M. breakfast dose was given at 10:23 A.M. (blood sugar 111) 01/09/25, the 5:00 P.M. scheduled dinner dose was given at 8:07 P.M. (blood sugar 111) 01/12/25 the scheduled 5:00 P.M. dinner dose was given at 7:27 P.M. (blood sugar was 222) 01/13/25 the scheduled 8:00 A.M. breakfast dose was given at 10:20 A.M. (blood sugar 292) 01/13/25, the 5:00 P.M. scheduled dinner dose was given at 7:30 P.M. (blood sugar 111) 01/14/25, the 5:00 P.M. dinner dose was given at 8:12 P.M. (blood sugar 160) For the insulin glargine-yfgn 100 units/ml,13 unit subcutaneously one time a day for diabetes mellitus (scheduled for 7:00 A.M.) order: 01/01/25, the dose was given at 12:15 P.M. (blood sugar 255) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/02/15, the dose was given at 12:53 P.M. (blood sugar 233) 01/03/25, the dose was given at 10:38 A.M. (blood sugar 364) 01/04/25, the dose was given at 10:51 A.M. (blood sugar was 295) 01/05/25, the dose was given at 11:07 A.M. (blood sugar 321) 01/06/25, the dose was given at 10:19 A.M. (blood sugar 270) 01/07/25, the dose was given at 12:22 P.M. (blood sugar 224) For the insulin glargine-yfgn 100 units/ml,13 unit subcutaneously one time a day for DM (scheduled for 7:00 A.M.) order: 01/08/25, the dose was given at 10:36 A.M. (blood sugar 301) 01/09/25, the dose was given at 10:26 A.M. (blood sugar 120) 01/12/25, the dose was given at 11:18 A.M. (blood sugar 349) 01/13/25, the dose was given at 10:19 A.M. (blood sugar 120) 01/14/24, the dose was given at 10:16 A.M. (blood sugar was 120) Interview on 01/30/25 at 5:19 P.M. with the DON confirmed insulin that was ordered before meals or with meals should be administered as ordered. and long-acting insulins should be given around the same time each day. Review of the manufacturer's instructions for use of Insulin Glargine - yfgn prefilled pen revealed insulin glargine should be given the same time each day. Review of the facility policy titled Administering Medications, dated April 2019, revealed medications were to be administered in accordance with prescriber orders, including any required timeframes, and medications were to be administered within one hour of their prescribed time, unless otherwise specified, such as before or after meals. This deficiency represents non-compliance investigated under Complaint Number OH00161190.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48567 Based on review of electronic medical records (EMR), hard charts and binders (utilized during transition of EMR) and interviews with staff, the facility failed to maintain complete, accurate, and readily accessible records for Residents #6, #17, #22, #51 and #53. This affected five (#6, #17, #22, #51 and #53) of seven resident records reviewed for complete and accurate medical records. The facility census was 65. Findings include: 1. Review of the medical record for Resident #6 revealed an admitted [DATE] with a readmitted [DATE]. Diagnoses included dementia with agitation, chronic kidney disease, and history of falls. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was cognitively impaired. Review of the care plan initiated on 03/29/24 revealed a problem for resistive behaviors indicating Resident #6 became easily agitated. Review of a progress note dated 12/29/24 revealed Resident #6 was combative prior to a fall; however, it did not specify the resident choked CNA #303 during a transfer (per interview below). Review of Resident #6's Fall Risk assessment dated [DATE] revealed it was incomplete, missing the prior number of falls, vision status, cognitive and behavioral symptoms, health conditions, medications and score so the Fall Risk Assessment did not accurately reflect Resident #6's risk factors for falls. Review of the Treatment Administration Record (TAR) for December 2024 revealed no evidence of behavior tracking dated 12/29/24 when Resident #6 became combative and choked an aide. The TAR, on 12/30/24, had a checkmark which indicated administered but no description on whether or not Resident #6 had a behavior and what type of behavior was specified. No other dates indicated behaviors. There was no other documented evidence that was provided regarding behavior tracking. Further review of Resident #6's care plan revealed the new behavior of choking staff that occurred on 12/29/24 was not added to the care plan and there were no updated interventions. Further review of the EMR, hard chart and binder for certified nursing assistant (CNA) documentation from 12/22/24 to 12/31/24 revealed no meal intake records for Resident #6, and no CNA documentation related to incontinence care. Interview on 01/28/25 at 9:30 A.M. with Administrator revealed she was unaware Resident #6 choked CNA #303 on 12/29/24. The Administrator took a statement from CNA #303 on 01/28/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/28/25 at 9:45 A.M. with CNA #303 revealed Resident #6 had choked her while she was trying to transfer him. She was unsure of the date but indicated it was at the end of December 2024. She stated she reported Resident #6's behavior to the nurse. The nurse wrote a note stating, Resident #6 was combative and completed a fall assessment on 12/29/24 as he fell off the bed during this same episode. CNA #6 had never displayed choking behavior before. 2. Review of the medical record for Resident #17 revealed an admitted [DATE] with diagnoses including cerebrovascular disease, asthma, cirrhosis of liver, and history of falls. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #17 was cognitively intact. Review of the binder for CNA documentation from 12/22/24 to 12/31/24 revealed no BM record and no documentation related to incontinence care for Resident #17. 3. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including fracture of nasal bones, displaced fracture of distal phalanx of right little finger, diabetes, and emphysema. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #22 was cognitively intact. Review of the care plan dated 12/23/24 revealed Resident #22 had a nutritional care plan only. Review of the binder with CNA documentation from 12/22/24 to 12/31/24 revealed two of 21 entries for meal intakes. There was no bowel movement (BM) record. There was no other point of care (POC) aide documentation. Review of the facility incident/accident log dated December 2024 revealed no logged incident regarding Resident #22 sustaining a fall on 12/22/24; however, review of the progress note dated 12/22/24 at 12:00 A. M. revealed Resident #22 was found on his bed holding a napkin to a previous facial laceration that was re-bleeding and reported to the nurse he had fallen when he was in his bathroom and hit his head. Review of the progress notes in the EMR, the hard chart, and the binder throughout facility admission revealed no follow-up investigation or review of fall interventions related to the fall Resident #22 had on 12/22/24. 4. Review of the medical record for Resident #51 revealed an admitted [DATE] with the diagnoses including epilepsy, respiratory failure and schizoaffective disorder. Review of the binder for CNA documentation from 12/22/24 to 12/31/24 revealed two of 21 entries for meal intake. Review of the BM record revealed no entries on 12/22/24, 12/25/24, 12/26/24, 12/27/24, 12/28/24, 12/29/24, 12/30/24 and 12/31/24. 5. Review of the medical record for Resident #53 revealed she was admitted on [DATE] with diagnoses including Meckel's Diverticulum, mild protein calorie malnutrition, dysphasia, dysarthria, major depressive disorder, difficulty walking, and need for assistance with personal care. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS 3.0 assessment completed on 11/17/24 revealed Resident #53 had intact cognition, required substantial assistance with toileting hygiene, and was incontinent of bowel and bladder. Review of the CNA POC documentation of the bladder continence task in the last 30 days revealed only one entry in the medical record at 6:54 A.M. on 01/28/25. Review of the POC aide paper documentation binder revealed from 12/22/24 through 12/31/24 revealed the only aide documentation of POC tasks included BM and meal intake tracking, and no documentation of incontinence care. Interview on 01/29/25 at 3:59 P.M. with the DON regarding not receiving the documentation requested beginning on 01/27/25 for Residents #6, #17, #22, #51 and #53, and the DON revealed she created binders for each unit to use during the EMR transition from 12/22/24 to 12/31/24. Surveyors requested the binders, and the DON was gone for 45 minutes. Surveyors then requested the binders from the Administrator at 4:45 P.M. The DON brought them at 4:50 P.M. There were binders for the medication administration records (MARs) and TARs for each medication cart, progress notes for each unit, and four binders for the CNAs to document bowel and bladder information and meal intakes. There were 15 binders. These were not provided to the surveyors until 01/29/25 at 4:50 P.M. despite asking for all resident documentation throughout the survey beginning 01/27/25. Interview on 01/29/25 at 4:50 P.M. with the DON and Administrator revealed the DON felt she had to dumb it down for nursing regarding documentation during the EMR transition. She chose to create binders for written documentation rather than have the staff document in the residents' hard charts. She stated any completed handwritten documentation was to be given to the Assistant Directors of Nursing (ADONs) who would then manage. Review of the progress notes and CNA binders with DON and Administrator verified there was little to no documentation for Residents #6, #17, #22, #51 and #53. Review of the undated facility policy titled Documentation and Communication revealed information recorded should include all assessment data and reason for resident refusal of procedure and interventions taken. This deficiency was an incidental finding identified during the complaint investigation.

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	01/30/2025

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 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** 48567 Based on observation, interview, review of the facility policy and review of the Centers for Disease Control and Prevention (CDC) website's Considerations for Blood Glucose Monitoring and Insulin Administration summary of recommendations for blood glucose monitoring, the facility failed to properly clean and disinfect the blood glucose monitor (BGM) between resident use. This affected one resident (Resident #54) of five residents observed during medication administration and had the potential to affect three additional residents (#5, #12 and #38) who receive blood sugar monitoring in the 200 Mid Hall. The facility census was 65. Findings include: Review of the medical record for Resident #54 revealed he was admitted on [DATE] with diagnoses including type two diabetes mellitus with diabetic chronic kidney disease, unspecified severe dementia with agitation, epilepsy, moderate protein-calorie malnutrition, anxiety disorder, mental disorder not otherwise specified, anemia, hyperlipidemia, alcohol dependence (in remission), and long-term (current) use of insulin. Review of the physician orders revealed Resident #54 had an order dated 10/17/24 for insulin lispro 100 units per milliliter (units/ml) per sliding scale subcutaneously two times a day as follows: notify physician or nurse practitioner of blood sugar less than 70 or greater than 400; three units for blood sugar 181 to 250; six units for blood sugar 21 to 300; 12 units for blood sugar 301 to 400; and 15 units for blood sugar greater than 401. Observation on 01/28/25 at 9:30 A.M. revealed Registered Nurse (RN) #310 performed a fingerstick blood sugar (FSBS) test on Resident #38. Further observation on 01/28/25 revealed RN #310 exited the resident's room and placed the BGM in the top drawer of the medication cart at 9:32 A.M. without cleaning it. Observation on 01/28/25 at 10:11 A.M. revealed RN #310 performed a fingerstick blood sugar FSBS test on Resident #54, after pulling the same BGM used to check Resident #38's blood sugar out of the top drawer of the medication cart. RN #310 then exited Resident #54's room at 10:14 A.M. and placed the BGM in the top drawer of the medication cart without cleaning it. Interview on 01/28/25 at 10:18 A.M. with RN #310 confirmed the same BGM was used for both Resident #38 and Resident #54 and that it had been stored in the top drawer of her medication cart without being clean or properly disinfected in between uses. During the interview, RN #310 also confirmed she typically had two BGMs in her medication cart but checked all the drawers at that time and found she only had the one BGM. RN #310 further revealed she knew she was to use the disinfecting wipes on her cart and allow for a five-minute dry time prior to reusing the BGM, but she was rushing to pass medications timely and forgot. Review of the CDC website's Considerations for Blood Glucose Monitoring and Insulin Administration summary of recommendations for blood glucose monitoring revealed BGM's were to be cleaned and disinfected per the manufacturer's recommendations after every use to prevent the spread of bloodborne pathogens and infectious agents. (continued on next page)

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	01/30/2025

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

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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	Review of the undated policy titled Twinsburg Post Acute Glucometer Cleaning/Disinfecting revealed multi-resident use glucometers (BGMs) were to be cleaned after each use and disinfected with a wipe that was pre-saturated with an EPA (Environmental Protection Agency) registered disinfectant that was effective against Human Immunodeficiency Virus (HIV), Hepatitis C, and Hepatitis B viruses. This deficiency was an incidental finding identified during the complaint investigation.