| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366419 | A. Building<br>B. Wing | 06/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Twinsburg Post Acute | 8551 Darrow Road<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>Based on record review and interview, the facility failed to ensure a Nurse Practitioner (NP) or physician was contacted when Resident #8's family requested several times to speak with one of them. No explanation was provided for the family. This affected one (Resident #8) of three residents reviewed for ability to speak with the NP and physician. The census was 70.<br><br>Findings Include:<br><br>Review of the medical record for Resident #8 revealed an admission date of 06/10/25. Diagnoses included sepsis, acute respiratory failure, diabetes, dementia, cerebral infarction acute embolism and thrombosis of deep veins of unspecified upper extremity, and acute postprocedural pain. The resident was discharged to the hospital 06/15/25.<br><br>Review of the Medicare 5-Day Minimum Data Set (MDS) assessment, dated 06/14/25, revealed Resident #8 had severely impaired cognition.<br><br>Review of the nurse's note, authored by Agency Nurse #211 dated 06/15/25 at 12:54 P.M. revealed the daughter of Resident #8 stated her mom was crying and miserable and she would like to talk to the Nurse Practitioner (NP). The Resident's temperature was 100.1 degrees Fahrenheit (F), Tylenol (pain reliever and fever reducer) was given.<br><br>Review of the nurse's note, authored by Agency Nurse #211, dated 06/15/25 at 6:38 P.M. revealed the daughter of Resident #8 stated the resident was not herself and something was wrong. The nurse took the residents' vital signs: Temperature 98.6 degrees F, Pulse 78, and Blood Pressure (BP) 172/86. The daughter stated she wanted the nurse to call the NP and asked the NP to call her. She stated the resident was confused but had a urinary tract infection (UTI). The resident had sepsis three times, and the daughter was afraid of the resident had sepsis again. The nurse educated the daughter that confusion was a symptom of a UTI.<br><br>Review of the nurse's note, authored by Assistant Director of Nursing (ADON) #209, dated 06/15/25 at 10:43 P.M. revealed the daughter of Resident #8 came to the nurse's station and complained that the resident had an elevated temperature, and that she needed to be sent out to the hospital. Vital signs were checked. Temperature was 98.9 degrees F, Pulse 80, BP 170/86, oxygen saturation (SpO2) 96% on room air. A call was placed to the NP on call, and an order was obtained to send resident out to the emergency room (ER) for evaluation. Resident #8 was sent out to the hospital via 911.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the Change in Condition evaluation revealed the clinician was notified on 06/15/25 at 8:45 P.M. and order was obtained to send Resident #8 to the hospital. The daughter was present at the facility at the time of the transfer.<br><br>Review of the Ambulance Run report revealed emergency medical services (EMS) was called on 06/15/25 at 8:59 P.M. Resident #8 left the facility at 9:27 P.M. Comments: The nurse on scene states that the patient was stable and did not need transport, her vital signs were stable, and fever was reduced with Tylenol.<br><br>Interview on 06/30/35 at 4:25 PM. with the daughter of Resident #8 revealed she had asked several times to have the on-call NP or physician call her. The agency nurse responded aggressively, saying she wasn't the only person that wanted to speak to a NP or doctor, and I'd have to wait my turn. Later in the evening, the resident's daughter told the nurse she felt Resident #8 should be sent to the hospital. Agency Nurse #211 tried to deter the family numerous times, telling them that it wasn't medically necessary for her mother to go to the ER.<br><br>An interview on 07/01/25 at 12:34 P.M. with Registered Nurse (RN)/ADON #209 revealed as soon as the ADON walked to the hall she heard Resident #8's family talking. The ADON went and asked the nurse what was going on, then went to talk to the family. The family said they wanted the resident sent out; she had experienced a change in mental status and wasn't acting like herself. The ADON told Agency Nurse #211 to call 911 and get Resident #8 sent out right away. ADON #209 revealed the family stated they had previously asked the nurse to send Resident #8 to the hospital. The facility has a NP and physician on call, it was not a problem to get ahold of them on the weekends.<br><br>Interview on 07/01/25 at 12:01 P.M. the Director of Nursing (DON) and Regional Nurse Manager #201 verified the daughter of Resident #8 had requested to speak with an NP or physician, and there was no documented evidence that the NP or doctor were contacted.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00166802. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure adequate supervision was provided to prevent Resident #7 from leaving the facility property unsupervised. This affected one (Resident #7) of four residents reviewed for leave of absence (LOA). The facility census was 70.<br><br>Findings include:<br><br>Review of the medical record for Resident #7 revealed an admission date of 06/09/25. Diagnoses included paranoid personality disorder, bipolar disorder, and schizophrenia.<br><br>Review of the Medicare 5-Day Minimum Data Set (MDS) assessment, dated 06/16/25, revealed Resident #7 had moderately impaired cognition. The assessment did not identify the resident to have behaviors, including the behavior of wandering. The resident was independent with ambulation.<br><br>Review of the physician's orders for June 2025 identified orders for Wanderguard (a bracelet that helps prevents residents with cognitive impairment from leaving the facility unsupervised and potentially getting lost or injured); Provide a reminder to resident to call for staff assistance prior to going outside by self dated 06/19/25; May go on supervised LOA dated 06/19/25; and Resident may go on LOA to smoke dated 06/19/25.<br><br>Review of the nurse's notes from 06/19/25 revealed Resident #7 had a period of confusion and exit seeking. Upon assessment, it was found the resident just wanted to check on a family member. The Nurse Practitioner (NP) was called, and an order was given to apply a Wanderguard to ensure the resident's safety, and supervised LOA. The guardian was notified and was in agreement with the plan.<br><br>Review of the nurse's note on 06/20/25 at 3:40 P.M. Resident #7 went on LOA to smoke, facility later received call that the resident was observed walking in the street against the flow of traffic by local police. As police attempted to escort Resident #7, the resident became combative, and the officers took the resident to the emergency room (ER).<br><br>Review of the incident investigation dated 06/20/25 revealed Nurse Manager #206 reported on an assessment dated [DATE] that Resident #7 was exit seeking, but it was discovered that the resident just wanted to go on LOA to check on her family members. At that time, Resident #7 expressed the need to smoke to help decrease her anxiety. Nurse Manager #206 reported she spoke with the resident's guardian and the NP. The guardian stated the resident could go home on LOA for smoking and may go on LOA with family as long as a family member was present. Nurse Manager #206 obtained LOA order from the NP. Nurse Manager #206 reported that there were no further behaviors noted. On 06/20/25, Licensed Practical Nurse (LPN) #210 reported at approximately 1:00 P.M. she saw Resident #7 standing by the back parking lot area. At that time the resident did not appear to be smoking. LPN #210 asked another nurse around 1:45 P. M. if Resident #7 had come in to get more cigarettes. LPN #210 was told the resident had not come back. A search of the facility and the outside parameter was immediately conducted. The Director of Nursing (DON) was alerted that the resident had not been seen since the last time she was observed outside by the smoke area. On 06/20/25 at around 2:12 P.M. the DON received a call from the local police department that Resident #7 was found and was being taken to the hospital for combative behavior.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 06/30/25 at 11:55 P.M. With Nurse Manager/Registered Nurse (RN) #201 revealed Resident #7 was alert and able to make basic decisions. When the resident arrived at the facility, she said she didn't smoke anymore. Later the resident decided she wanted to smoke. The facility was non-smoking, so the resident had to go on LOA. Residents had to be off the property when they smoked. Resident #7 would sign out, and staff would let her out the door to smoke at the edge of the facility property.<br><br>Interview on 06/30/25 at 2:51 P.M. with Social Service Designee (SSD) #204 revealed Resident #7 had a Brief Interview for Mental Status (BIMS) between 11 and 15 depending on the day tested, indicating moderate cognitive impairment (11) to cognitively intact (15). The resident had some good days and some not as good, mostly good days. She appeared able to go outside and smoke safely. The resident never mentioned any exit seeking intentions.<br><br>Interview on 06/30/25 at 3:15 P.M. with Nurse Manager #206 revealed Resident #7 had an order for LOA with supervision and had left the facility property unsupervised on 06/20/25.<br><br>Interview on 07/01/25 at 12:01 P.M. with Nurse Manager #201 and the DON verified Resident #7 had an order for LOA with supervision and left the facility property unsupervised on 06/20/25.<br><br>This deficiency represents non-compliance investigated under Master Complaint Number OH00166986. |