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	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinsburg Post Acute	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 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. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident, family, staff and certified nurse practitioner (CNP) interviews, record review, and review of the facility policy, the facility failed to timely notify the physician/CNP when physician orders were not completed and pharmacy irregularities on a antibiotic and notify a resident's representative of an incident and a room change involving the resident. This affected two (Residents #1 and #20) of three residents reviewed for notification of change. The facility census was 70. 1. Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI) and retention of urine. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 had no indwelling catheter or intermittent catheter noted on the MDS assessment. Review of the physician's orders revealed an order dated 03/31/25 to straight catheterize every six hours for urinary retention four times a day. The procedure was scheduled to be completed at 5:00 A.M., 11:00 A.M., 5:00 P.M. and 11:00 P.M.Review of the progress note for Resident #20 dated 07/21/25 at 2:32 A.M. revealed Licensed Practical Nurse (LPN) #275 documented completed straight catheterization two times with no visible output. The note included the resident was able to urinate on her own and does it every time she was straight catheterized. The note also included this had been a recurrent issue with Resident #20 and her straight catheterization ordered may need to be revised. However, there was no evidence the physician or certified nurse practitioner (CNP) were contacted to report this or discuss the ongoing care needs of the resident related to her urinary status/urinary retention and/or straight catheterization order. A progress note dated 07/27/25 at 10:42 A.M. completed by LPN #511 revealed Resident #20 was to be straight catheterized every six hours for urinary retention. The procedure was not completed; the supplies were pending order. There was no documentation of notification to the physician/CNP the nurse was unable to complete the procedure, and no documentation Resident #20 requested to speak to the CNP on this date (07/27/25)A progress note dated 07/28/25 at 8:44 P.M. completed by Unit Manager (UM) #293 revealed UM #293 was informed by staff the resident placed call to 911 demanding to be sent to the emergency room (ER) related to uncontrolled pain. The note included Resident #20 was assessed by floor nurse, and all vital signs were within normal limits and no other areas of concern noted. Resident #20 continued to demand to go to ER for further evaluation. Call placed to the CNP making the CNP aware and a verbal order was given to transfer Resident #20 to ER for further evaluation. Review of the hospital After Visit Summary dated 07/28/25 revealed the reason for visit was urinary problem. Diagnosis was urinary retention. The summary included: You had an indwelling urinary catheter placed to drain your urine. A basic metabolic panel, complete blood count, urinalysis with microscopic, reflex culture and urine culture were completed. (Results not provided in record).Review of the progress note for Resident #20 dated 07/29/25 at 2:02 A.M. completed by Registered Nurse (RN) #512 revealed Resident #20 returned from the hospital. Resident #20 had a new indwelling urinary catheter 16 French (16fr)/10cc balloon placed by the hospital for urinary retention. On 08/01/25 there was a physician order for Cipro (antibiotic) oral tablet 500 milligrams (mg) give one tablet by mouth two times a day for a UTI for seven days.A progress note dated 08/02/25 at 3:07 P.M. completed by RN #333 revealed an alert from the pharmacy regarding the new order entered for Cipro 500 mg give one tablet by mouth two times a day for UTI for seven days had triggered possible drug to drug interactions.Interview on 08/06/25 at 1:39 P.M. with Resident #20 revealed staff were supposed to straight catheterize her every four to six hours, but they did not do this. Resident #20 stated staff make excuses and tell her she doesn't need to be straight catheterized because she does urinate. Resident #20 stated sometimes she does urinate and sometimes she doesn't. Resident #20 stated staff provide straight catheterization about three times a day, but she was scheduled four times a day. Resident #20 stated the previous Monday (07/28/25) she had chills, back and abdominal pain, she requested to see the CNP, but she never came. That night she was supposed to be catheterized at 11:00 P.M. but the nurse did not come until 3:00 A.M. She requested several times to see the nurse, but she never came. Resident #20 revealed she was shivering and the abdominal pain continued, she was yelling and still no one came. She called the facility, and no one answered the telephone. Resident #20 stated she became nauseous, needed help, so she called 911. She was then taken to the hospital. Resident #20 stated the ER nurses had to clean her up, and they placed a (urinary) catheter and got 700 cubic centimeters (cc) urine return. The ER physician said she was correct to come to the ER as that was too much urine. Resident #20 stated she received an order for Cipro because she had a UTI that was found from

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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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and interview the facility failed to ensure Resident #2 received adequate, necessary and timely treatment following a fall with major injury. Actual Harm occurred on 05/20/25 when the facility failed to ensure Resident #2 was provided timely and necessary medical intervention/treatment following a fall. Approximately 12.5 hours after the fall occurred, Resident #2's daughter identified the resident was in excruciating pain. The resident was subsequently transported to the hospital where she was diagnosed with a fractured femur (as a result of the fall) requiring surgical repair. This affected one resident (#2) of three residents reviewed for incidents. The facility census was 70. Findings include: Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including dementia and senile degeneration of the brain. A plan of care for Resident #2 dated 06/19/23 revealed the resident tended to wander due to cognitive impairment and restlessness. The care plan also identified Resident #2 would hide in closets, wander into other resident's room, would attempt to use their restroom or lay in their bed and/or would attempt to get on the elevator looking for her ride. Interventions included to provide assistance in locating own room and an additional intervention was noted to provide one on one. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was severely cognitively impairment. The assessment revealed Resident #2 had no impairment of the upper or lower extremities, was dependent on staff for toileting hygiene, required substantial/maximal staff assistance with chair/bed to chair transfer and required staff supervision or touching assistance for ambulation. A Nursing - Fall Risk Observation/assessment dated [DATE] revealed Resident #2 was at moderate risk for falls. The assessment revealed Resident #2's vision was highly or severely impaired and Resident #2 ambulated without problem and without devices. Review of an Interdisciplinary Team (IDT) note dated 05/20/25 at 5:21 P.M. completed by Unit Manager (UM) #293 revealed the IDT team reviewed Resident #2's fall which occurred on 05/20/25. Resident #2's daughter notified UM #293 Resident #2 was in bed when she arrived, and she attempted to assist the resident out of bed when the resident screamed in pain. The physician was notified, and a verbal order was given to transfer Resident #2 to the emergency department (ED). Upon investigation, UM #293 was notified from Resident #24 that on 05/20/25 at approximately (blank) Resident #24 witnessed Resident #2 lying on the floor in her room at the foot of her bed attempting to pull herself up from the floor using the footboard. Resident #24 [Resident #36 was the actual witness to Resident #2 falling and this was confirmed with the Administrator on 07/09/25 at 3:29 P.M. The facility incorrectly documented the wrong resident in their fall investigation.] Resident [#36] stated she pulled the call light for help and as Resident #2 stood up the Certified Nursing Assistant (CNA) entered the room and escorted Resident #2 back to her room. Review of Resident #2's medical record revealed there was no documentation or assessment on 05/20/25 during night shift. There were no vital signs obtained or a physical assessment at the time of the resident's fall. There was no documentation of any injuries sustained status post fall including an injury to Resident #2's left arm (the daughter identified a treatment on left arm on 05/20/25). Review of the documentation survey report for 05/20/25 revealed Resident #2 was turned and repositioned each shift, but the report did not state how many times Resident #2 was turned and repositioned or provided incontinence care. An interview on 08/07/25 at 8:45 A.M., with CNA #211 revealed she provided Resident #2 incontinence care once in the morning during her day shift and explained she didn't need to reposition the resident, so she was not aware of any pain or injuries. There were no as needed pain medications administered and no pain assessment completed on 05/20/25. Review of the facility Investigation Report for Resident #2 dated 05/20/25 completed by the Director of Nursing (DON) revealed on 05/20/25, Resident #2 had a witnessed fall with major injury. The report included on 05/20/25 UM #293 revealed Resident #24 reported Resident #2 wandered into her room at 2:30 A.M. Resident #24 yelled out for help and put on her call light when she noticed Resident #2 on the floor. When Resident #2 finally got up, CNA #246 entered the room and took Resident #2 away. CNA #246 reported he escorted Resident #2 back to her room and he did not notice anything unusual. Review of a typed statement completed by the Director of Nursing (DON) dated 05/20/25 revealed CNA #246 reported he answered Resident [#36]'s call light and noticed Resident #2 was in her room. CNA #246 reported he escorted Resident #2 back to her room. CNA #246 reported that he did not notice anything unusual at that time. CNA #246 reported it was not unusual for Resident #2 to wander. The typed report included Resident [#36] reported to UM #293 that she observed Resident #2 lying on the floor at the foot of the bed around 2:30

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure wound care was completed as per the physician orders for one resident, Resident #57 of three residents reviewed for wound care. The facility census was 70.Findings include:Record review for Resident #57 revealed an admission date of 10/23/23. Diagnoses included multiple sclerosis, sepsis, chronic osteomyelitis, colostomy, neuromuscular disfunction of the bladder, pressure ulcer stage IV (Full thickness loss with exposed bone, tendon or muscle), and paraplegia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was severely cognitively impaired. Resident #57 had impairment on one side of the upper extremity and both sides of the lower. Resident #57 was dependent on staff for all activities of daily living (ADL). Resident #57 was at risk for pressure ulcers, had one stage IV pressure ulcer and one unstageable pressure ulcer (slough and/or eschar: known but not stageable due to coverage of wound bed by slough and/or eschar). Review of the physician orders for Resident #57 revealed on 05/23/25, an order for the right dorsum foot to cleanse right dorsum foot with Dakin's 0.25% solution, blot dry, apply calcium alginate with silver, ABD and kerlix. Change daily and as needed every day shift for wound management. Observation 07/08/25 at 4:30 P.M. revealed Wound Care Nurse (WCN) #292 and Unit Manager (UM) #293 were going to provide wound care for Resident #57. WCN #292 and UM #293 confirmed the date on the dressing to Resident #57's wound on the right foot was dated 07/06/25 the initials were [Licensed Practical Nurse (LPN) #283]. Observation after removal of the dressing revealed the old dressing had a heavy drainage and foul odor. The tissue surrounding the edges of the wound bed was white/emaciated. The appearance and odor was verified by WCN #292. Record review of the nursing staff assignment sheets and timecards and interview on 07/09/25 at 9:00 A.M. with the Administrator and UM #293 confirmed LPN #283 worked at the facility on 07/06/25. LPN #283 did not work on 07/07/25 or 07/08/25. The Administrator and UM #293 confirmed LPN #283 completed the dressing change on 07/06/25 and the dressing change was not completed again until 07/08/25. Review of the facility's undated policy titled Wound Care revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Dress the wound and mark tape with initials, time, and date and apply to dressing. This deficiency represents non-compliance investigated under Complaint Number OH00167210 (1381513).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of a facility Self-Reported Incident (SRI) report, facility policy review and interview, the facility failed to provide residents who have wandering and/or sexual aggressive behaviors with adequate supervision. This affected two residents (#1 and #2) and the potential to affect three residents (#23, #41, and #70) who the facility identified to be independently mobile, confused and residing in the same hall as Resident #1. Findings included:Record review for Resident #2 revealed an admission date of 06/11/19 with diagnoses including dementia and senile degeneration of the brain. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had a Brief Interview for Mental Status Score (BIMS) of one indicating Resident #2 was severely cognitively impaired. Resident #2 required the use of a wheelchair for mobility and stated Resident #2 did not wander during the review period. A care plan dated 06/11/19 and revised 07/07/25 revealed Resident #2 was at risk for falls due to impaired mobility, impaired balance, unsteady gait at times, fracture of unspecified part of neck of left femur. Interventions included physical therapy to evaluate and treat dated 05/23/25 and to offer the resident to lay in bed after all meals dated 06/06/25. A care plan dated 05/02/23 revealed Resident #2 had potential for impaired vision as evidenced by diagnosis of glaucoma. Interventions included to encourage to wear glasses. A care plan dated 06/19/23 included Resident #2 tended to wander due to cognitive impairment and restlessness. The care plan included Resident #2 may wander into other resident's room, will attempt to use their restroom or lay in their bed. Interventions included aid in locating own room (last revised 04/12/23) and to provide one-on-one as needed (last revised 07/31/25).Review of Resident #2 progress notes and medical record from 01/01/25 through 07/29/25 revealed no written evidence that the resident exhibited any type of sexual behaviors. Review of a facility SRI created 07/06/25 revealed an allegation of sexual abuse involving Resident #1 and #2 was reported to the State Survey Agency. Resident #1 with Resident #1's penis out and Resident #2 sucking on it. Review of a facility Witness Statement dated 07/06/25 (untimed) and signed by Certified Nursing Assistant (CNA) #217 revealed CNA #217 was taking Resident #1's roommate into his room from the dining room. When CNA #217 entered Resident #1's room, Resident #1 was lying in bed with just a shirt on and Resident #2 had her head down near Resident #1's private area. Resident #1 had his hand on her (Resident #2's) arm and head as Resident #2's mouth was on his (Resident #1's) private area. The statement included CNA #217 immediately secured each resident and informed the nurse. Review of a facility Witness Statement dated 07/06/25 (untimed) and signed by Licensed Practical Nurse (LPN) #283 revealed she was called down to the room and saw Resident #1 with his hand over his private part looking shocked. LPN #283 observed CNA #217 attempting to move Resident #2 who was being combative at the time. LPN #283 assisted CNA #217 removing Resident #2 from the room. Observation on 07/08/25 at 9:23 A. M. revealed Resident #2 was eating breakfast in the dining room using her fingers only. An attempt to interview Resident #2, revealed the resident rambled incoherently unrelated to the conversation. An interview with Unit Manager #293 at the time of the observation revealed Resident #2 was unable to answer questions appropriately or make independent decisions. The unit manager revealed Resident #2 had dementia, could walk but also used a wheelchair. Resident #2 had poor vision and ate all her meals in the dining room. Interview on 07/08/25 at 3:51 P.M. with CNA #211 stated Resident #2 can walk, the staff try to keep her in her wheelchair, but she walks. CNA #211 stated when she arrived at work in the morning on 07/06/25, Resident #2 was wandering the hallway, and she used her hands to feel around. CNA #211 denied trying to redirect Resident #2 to sit in a chair or go to her own room on 07/06/25 and the reason provided was that this was her usual behavior. Interview on 07/08/25 between 3:52 P.M. and 4:00 P.M. with CNA #216 and CNA #238 revealed Resident #2 was able to ambulate and frequently wandered in other residents' rooms. Interview on 07/09/25 at 1:10 P.M. with Physical Therapy Assistant (PTA) #501 confirmed she worked with Resident #2 in therapy. PTA #501 revealed Resident #2 was not safe to ambulate independently.Interview with MDS Nurse #510 on 07/31/25 at 12:49 P.M. stated the resident's plan of care interventions were considered active if the intervention was still listed on the care plan after the revision date. MDS Nurse #510 verified Resident #2's care plan stated to provide Resident #2 1:1 supervision. Interview on 08/12/25 at 4:15 P.M. with Administrator revealed the care plan with 1:1 supervision for Resident #2 was from a previous incident and should have been removed, it was no longer active and discontinued out of the care plan today. 2. Record review revealed Resident #1 had a re-admission date of 02/17/16 with diagnoses including

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility policy review and interview with resident, facility staff, pharmacy staff and nurse practitioner the facility failed to implement a comprehensive and individualized plan of treatment for Resident #20 to ensure the resident was catheterized timely and as ordered for urinary retention and provided timely and necessary treatment for a urinary tract infection (UTI). Actual harm occurred on 07/28/25 when Resident #20 demanded to be transferred to the emergency room for uncontrolled pain. The resident was subsequently treated for urinary retention and a UTI. Prior to the hospitalization, the resident had physician orders to be straight catheterized for urine retention every six hours; however, this was not being completed as ordered. Following the hospital treatment the facility failed to administer Resident #20's oral antibiotics per the physician orders and continued not to straight catheterize as ordered resulting in the need for intravenous medications. This affected one resident (#20) of three residents reviewed for UTIs. The census was 70. Findings include: Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, UTI, and retention of urine. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact. The assessment revealed Resident #20 required supervision or touch assistance with toileting hygiene. Resident #20 had no indwelling catheter or intermittent catheter noted on the MDS assessment. Record review revealed the facility had not developed/implemented a plan of care for Resident #20 for the care and treatment for urinary retention or history of urinary tract infections. Review of the physician's orders revealed an order dated 03/31/25 to straight catheterize every six hours for urinary retention four times a day. The procedure was scheduled to be completed at 5:00 A.M., 11:00 A.M., 5:00 P.M. and 11:00 P.M. Review of the progress note for Resident #20 dated 07/21/25 at 2:32 A.M. revealed Licensed Practical Nurse (LPN) #275 documented completed straight catheterization two times with no visible output. The note included the resident was able to urinate on her own and does it every time she was straight catheterized. The note also included this had been a recurrent issue with Resident #20 and her straight catheterization ordered may need to be revised. However, there was no evidence the physician or certified nurse practitioner (CNP) were contacted to report this or discuss the ongoing care needs of the resident related to her urinary status/urinary retention and/or straight catheterization order. A progress note dated 07/27/25 at 10:42 A.M. completed by LPN #511 revealed Resident #20 was to be straight catheterized every six hours for urinary retention. The procedure was not completed; the supplies were pending order. There was no documentation of notification to the physician/CNP the nurse was unable to complete the procedure, and no documentation Resident #20 requested to speak to the CNP on this date (07/27/25) A progress note dated 07/28/25 at 8:44 P.M. completed by Unit Manager (UM) #293 revealed UM #293 was informed by staff the resident placed call to 911 demanding to be sent to the emergency room (ER) related to uncontrolled pain. The note included Resident #20 was assessed by floor nurse, and all vital signs were within normal limits and no other areas of concern noted. Resident #20 continued to demand to go to ER for further evaluation. Call placed to the CNP making the CNP aware and a verbal order was given to transfer Resident #20 to ER for further evaluation. Review of the hospital After Visit Summary dated 07/28/25 revealed the reason for visit was urinary problem. Diagnosis was urinary retention. The summary included: You had an indwelling urinary catheter placed to drain your urine. A basic metabolic panel, complete blood count, urinalysis with microscopic, reflex culture and urine culture were completed. (Results not provided in record). Review of the progress note for Resident #20 dated 07/29/25 at 2:02 A.M. completed by Registered Nurse (RN) #512 revealed Resident #20 returned from the hospital. Resident #20 had a new indwelling urinary catheter 16 French (16fr)/10cc balloon placed by the hospital for urinary retention. On 08/01/25 there was a physician order for Cipro (antibiotic) oral tablet 500 milligrams (mg) give one tablet by mouth two times a day for a UTI for seven days. A progress note dated 08/02/25 at 3:07 P.M. completed by RN #333 revealed an alert from the pharmacy regarding the new order entered for Cipro 500 mg give one tablet by mouth two times a day for UTI for seven days had triggered possible drug to drug interactions. Review of the medication administration record from 08/01/25 to 08/06/25 revealed Cipro was to be administered at 9:00 P.M. and 9:00 A.M. for seven days and it was to start on 08/02/25 at 9:00 P.M. On 08/02/25 at 9:00 P.M., the number nine was documented in the timeframe, which indicated to see the nurses' notes. From 08/02/25 through 08/06/25 for the scheduled dose at 9:00 P.M. the boxes all documented a number nine. The MAR indicated Resident #20 received the Cipro on

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff and pharmacy, the facility failed timely respond and act upon the pharmacy's notification regarding irregularity with a new order to start an antibiotic. This affected one (#20) of one resident reviewed for pharmacy services.Findings included: Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI) and retention of urine. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact. On 08/01/25 there was a physician order for Cipro (antibiotic) oral tablet 500 milligrams (mg) give one tablet by mouth two times a day for a UTI for seven days. A progress note dated 08/02/25 at 3:07 P.M. completed by RN #333 revealed an alert from the pharmacy regarding the new order entered for Cipro 500 mg give one tablet by mouth two times a day for UTI for seven days had triggered possible drug to drug interactions. Interview on 08/06/25 at 3:40 P.M. with the Director of Nursing (DON) revealed the DON reviewed Resident #20's Medication Administration Record (MAR) and confirmed Cipro was ordered on 08/01/25 and was scheduled to start on 08/02/25 at 9:00 P.M. The DON confirmed from 08/02/25 through 08/06/25 for the scheduled doses at 9:00 P.M. the boxes all had a number nine; and documented Resident #20 received Cipro three of 10 doses on 08/03/25, 08/04/25, and 08/06/25 at 9:00 A.M. only. Telephone interview on 08/06/25 at 4:55 P.M. with Certified Pharmacy Technician (CPHT) #515 with the DON present revealed the Cipro for Resident #20 was never sent because the pharmacist reached out for a drug interaction. CPHT #515 revealed the note stated an RN would clarify. The pharmacy never received the response, so they never sent the Cipro. The DON verified LPN #275 documented on the MAR she gave Resident #20 the Cipro from the prepackaged medications this A.M. Interview on 08/07/25 at 10:16 A.M. with CNP #514 revealed she was not made aware until just a couple minutes ago that Resident #20 was not receiving the Cipro as ordered. On 08/07/25 there was an order by CNP #514 to hold Cipro and start Ceftriaxone sodium solution reconstituted two grams use 2.0 grams intravenously in the morning for infection for three days. Flush peripherally inserted central catheter (PICC) line/midline/central line with 10 cubic centimeters (cc) normal saline (NS) before and after medication administration. Interview on 08/07/25 at 10:39 A.M. with the DON and record review of the Pharmacy Communication request received 08/04/25 at 11:54 A.M. revealed the request stated to Please Respond. Medication Cipro had a drug interaction with (medication) tizanidine. Please consider changing the antibiotic to something else or hold all tizanidine while on this antibiotic. The DON revealed she also gets emails from the pharmacy, but the recommendations also come through the fax. The pharmacy also calls the nurses who need to update the physician with the pharmacy information. The DON confirmed the pharmacy recommendation was not completed and revealed any nurse could do it. This was an incidental finding discovered during the course of the complaint investigation.

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	366419	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinsburg Post Acute	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.

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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. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews with resident, staff and Certified Nurse Practitioner (CNP), record review, review of insulin administration guidelines, and review of the facility policy, the facility failed to ensure residents were free from significant medication errors. This affected four (#7, #11, #20, and #68) of six residents reviewed for medication administration. The facility census was 70.Findings included: 1. Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI) and retention of urine. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact. On 08/01/25 there was a physician order for Cipro (antibiotic) oral tablet 500 milligrams (mg) give one tablet by mouth two times a day for a UTI for seven days. A progress note dated 08/02/25 at 3:07 P.M. completed by RN #333 revealed an alert from the pharmacy regarding the new order entered for Cipro 500 mg give one tablet by mouth two times a day for UTI for seven days had triggered possible drug to drug interactions. Review of the medication administration record from 08/01/25 to 08/06/25 revealed Cipro was to be administered at 9:00 P.M. and 9:00 A.M. for seven days and it was to start on 08/02/25 at 9:00 P.M. On 08/02/25 at 9:00 P.M., the number nine was documented in the timeframe, which indicated to see the nurses' notes. From 08/02/25 through 08/06/25 for the scheduled dose at 9:00 P. M. the boxes all documented a number nine. The MAR indicated Resident #20 received the Cipro on 08/03/25, 08/04/25, and 08/06/25 at 9:00 A.M. only (three of 10 doses documented as administered). However, review of the pharmacy delivery manifest with the Director of Nursing (DON) on 08/06/25 revealed Resident #20's Cipro had never been delivered to the facility (indicating the three doses documented as administered were not actually administered to Resident #20). Interview on 08/06/25 at 3:40 P.M. with the Director of Nursing (DON) revealed the DON reviewed Resident #20's Medication Administration Record (MAR) and confirmed Cipro was ordered on 08/01/25 and was scheduled to start on 08/02/25 at 9:00 P.M. The DON confirmed from 08/02/25 through 08/06/25 for the scheduled doses at 9:00 P.M. the boxes all had a number nine; and documented Resident #20 received Cipro three of 10 doses on 08/03/25, 08/04/25, and 08/06/25 at 9:00 A.M. only. Interview on 08/06/25 at 4:32 P.M. with Resident #20 and with the DON present revealed Resident #20 stated to the DON she was upset she had not been getting her Cipro like she was supposed to, and it started later than it was supposed to. Interview on 08/06/25 at 4:34 P.M. with LPN #275 with the DON present confirmed she administered Resident #20 her Cipro this morning and the Cipro was prepackaged by the pharmacy in the medication cart. Observation revealed the DON checked the medication cart with Resident #20's prepackaged medications, and confirmed Resident #20 did not have any Cipro present in any of the prepackaged medications or any other location of the medication cart. Telephone interview on 08/06/25 at 4:55 P.M. with Certified Pharmacy Technician (CPHT) #515 with the DON present revealed the Cipro for Resident #20 was never sent because the pharmacist reached out for a drug interaction. CPHT #515 revealed the note stated an RN would clarify. The pharmacy never received the response, so they never sent the Cipro. The DON verified LPN #275 documented on the MAR she gave Resident #20 the Cipro from the prepackaged medications this A.M. Interview on 08/07/25 at 10:16 A.M. with CNP #514 revealed she was not made aware until just a couple minutes ago that Resident #20 was not receiving the Cipro as ordered. CNP #514 stated she was going to order an intravenous (IV) antibiotic now and more laboratory values including a urinalysis because Resident #20 did not receive the Cipro that was ordered. CNP #514 stated she was not happy with the facility and stated she had received a call from the hospital, and the urinalysis results returned from when she went to the ER on [DATE] and showed she had a UTI, that was why the Cipro was ordered. On 08/07/25 there was an order by CNP #514 to hold Cipro and start Ceftriaxone sodium solution reconstituted two grams use 2.0 grams intravenously in the morning for infection for three days. Flush peripherally inserted central catheter (PICC) line/midline/central line with 10 cubic centimeters (cc) normal saline (NS) before and after medication administration. 2. Record review for Resident #11 revealed an admission date of 02/02/24. Diagnosis included type two diabetes mellitus (DM) with unspecified complications. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively intact, and had medically complex conditions including type two DM with unspecified complications. Resident #11 received injections daily. Review of the care plan for Resident #11 dated 01/11/25 revealed Resident #11 required hypoglycemic medication related to diabetes/hyperglycemia. Interventions included to administer medications as ordered. Review of the

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, the facility failed to timely obtain a urinalysis ordered by the physician/certified nurse practitioner (CNP). This affected one (#20) of one resident reviewed for laboratory services.Findings included: Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI) during stay, and retention of urine. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact. The assessment revealed Resident #20 required supervision or touch assistance with toileting hygiene. Resident #20 had no indwelling catheter or intermittent catheter noted on the MDS assessment. On 08/04/25 an order was obtained to remove indwelling catheter today (08/04/25) and straight catheterize every four to six hours. On 08/07/25 there was an order by Certified Nurse Practitioner (CNP) #514 to hold Cipro and start Ceftriaxone sodium solution reconstituted two grams use 2.0 grams intravenously in the morning for infection for three days and a urinalysis. Interview on 08/07/25 at 10:16 A.M. with CNP #514 revealed she was not made aware until just a couple minutes ago that Resident #20 was not receiving the Cipro as ordered. CNP #514 stated, the facility never told her that Resident #20 not getting straight catheterized as physician ordered. And when they do straight catheterization, the staff were obtaining more than 250 cc of urine left in the bladder and this was retention. CNP #514 confirmed retention (a condition in which a person is unable to empty their bladder completely) can cause a UTI. CNP #514 stated she was going to order an intravenous (IV) antibiotic now and more laboratory values including a urinalysis because Resident #20 did not receive the Cipro that was ordered. CNP #514 stated she was not happy with the facility and stated she had received a call from the hospital, and the urinalysis results returned from when she went to the ER on [DATE] and showed she had a UTI, that was why the Cipro was ordered. Interview on 08/07/25 at 11:04 A.M. with Licensed Practical Nurse (LPN) #518 confirmed CNP #514 requested a urinalysis be obtained for Resident #20. Record review and interview on 08/11/25 at 3:00 P.M. with Director of Nursing (DON) confirmed there were no urinalysis results in the medical record for Resident #20 for the urinalysis ordered 08/07/25. The DON confirmed the urine was obtained on 08/07/25 and the urine was never sent to the laboratory. The DON stated she did not know why the urine was never sent and confirmed it should have been obtained and sent per the CNP orders. Telephone interview on 08/11/25 at 3:30 P.M. with CNP #514 confirmed she ordered a urinalysis on 08/07/25 for Resident #20 and revealed she was never notified the urinalysis was not completed as ordered. This was an incidental finding discovered during the course of the complaint investigation.

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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** Based on observation, resident and staff interview, record review, review of Centers for Disease Control and Prevention (CDC) guidance, and review of the facility policy, the facility failed to ensure staff wore personal protective equipment (PPE) for a resident on Enhanced Barrier Protection (EBP). This affected one (#20) of one resident reviewed for infection control. The facility census was 70. Findings include: Record review for Resident #20 revealed an admission date of 07/20/24. Diagnoses included Parkinson's disease and retention of urine. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 had no indwelling catheter or intermittent catheter. Review of the physician orders for Resident #20 revealed an order dated 03/31/25 to straight catheterize every six hours or urinary retention four times a day for urinary retention; an order dated 08/01/25 for Cipro (antibiotic) oral tablet 500 milligrams (mg) give one tablet by mouth two times a day for a urinary tract infection (UTI) for seven days; and an order dated 08/04/25 for EBP use gown and gloves for high contact resident care including dressing,, bathing, showering, transfers, hygiene care, changing linens, changing briefs, assisting with toileting, dressing changes and care of any device including trach, central line, tube feeding and catheter. Observation on 08/07/25 at 11:38 A.M. revealed Licensed Practical Nurse (LPN) #518 and Unit Manager (UM) #350 straight catheterized Resident #20. UM #350 assisted Resident #20 back to bed and repositioned her legs. Neither LPN #518 nor UM #350 donned an isolation gown. LPN #518 straight catheterized Resident #20 for a residual of 1,300 cubic centimeters (cc) during the second attempt. LPN #518 then provided peri care for Resident #20. Resident #20 stated when staff straight catheterized her, they never wear isolation gowns. UM #350 stated nurses would only wear an isolation gown if the resident had an infection Interview on 08/07/25 at 12:21 P.M. with DON revealed staff should wear Personal Protective Equipment (PPE) for wound care, peri care, indwelling catheter, or when providing care for a specific reason. DON confirmed staff should wear an isolation gown when providing hands on care for Resident #20. Review of the facility policy titled, Enhanced Barrier Precautions (EBP) revised February 2021 revealed EBP are utilized to prevent the spread of multi-drug resistant organisms (MDRO's) to residents. EBP refers to an infection control intervention designed to reduce the transmission of MDRO's during high contact resident care activities. EBP apply when a resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical device, and has secretions or excretions that are unable to be covered or contained. Indwelling medical devices include urinary catheters. EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities. Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status. This was an incidental finding discovered during the course of the complaint investigation.