STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366443	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belpre Landing Nursing and Rehabilitation	1915 Hill Street Belpre, OH 45714

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, observation and interview, the facility failed to ensure dependent residents received assistance with activities of daily living (ADL) and grooming as needed. This affected two residents (#7, #53) of three sampled residents. The census was 48. Findings include: 1. Medical record review revealed Resident #7 was admitted on [DATE] with diagnoses including chronic respiratory failure with hypercapnia, end stage renal disease, hemodialysis and ventilator dependence. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #7 was cognitively intact for daily decision-making. Review of the Shower Sheets and Bathing Daily Task List dated April and May 2024 revealed Resident #7 receives a bed bath daily. There was no documentation of her hair being washed or assistance provided to remove her facial hair. Review of the care plan: Require Assistance with ADL's related to debility and weakness dated 03/13/24 revealed Resident #7's ADL goal was to remain well-groomed and free of odors at all times. Interventions included weight bearing assistance with care including personal hygiene. On 05/06/24 at 8:55 A.M., observation revealed Resident #7 had long black facial hairs extending from her chin, around her mouth and sides of her face. Her black hair had large white dandruff-like skin loosely scattered throughout her hair that was readily observed. Interview with Resident #7 at the time of the observation revealed it had been at least three weeks since staff washed her hair, she requires medicated shampoo and she wanted her facial hair removed. Resident #7 further stated sometimes she will wear a hat when out of her room or at the dialysis center to cover up the loose, white flakes of skin in her hair from being seen. On 05/08/24 at 4:36 P.M., interview with State tested Nurse Aide #10 stated showers were completed on day shift and Resident #7 required assistance with shaving and washing her hair. STNA #10 verified she had noticed the above observations prior to today. On 05/08/24 at 4:45 P.M., observation of Resident #7 revealed her facial hair was removed and hair washed. Resident #7 voiced appreciation to have her facial hair removed and hair washed. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review revealed Resident #53 was admitted on [DATE] with diagnoses including unspecified dementia, hypertension, hyperlipidemia, GERD, osteoporosis, anxiety disorder and depression. Review of the 5-day MDS assessment dated [DATE] revealed Resident #53 was severely impaired for daily decision-making. Review of the Task List revealed Resident #53 required supervision or touching assist with hygiene. Review of the care plan: Requires Assistance with ADL's dated 02/26/24 revealed goals included for Resident #53 to remain well-groomed and free of odors at all times. Resident #53's interventions included non-weight bearing assistance with personal hygiene. On 05/06/24 at 10:23 A.M., observation revealed Resident #53 was sitting in a chair in the lounge area. Observation of the fourth and fifth digit on her right hand revealed her fingernails were broken and jagged. The resident stated it had been like that for three days and she did not have a file or clippers to trim her nails. On 05/06/24 at 10:27 A.M., interview with Therapy #14 verified the observation and stated she would inform the aide because the resident required staff assistance with nail care. This deficiency represents non-compliance investigated under Complaint Number OH00152983.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review and interview, the facility failed to ensure competent nursing staff administered intravenous medications. This affected one (#47) of five residents observed for medication admininstration. The census was 48. Findings include: Medical record review revealed Resident #47 was admitted on [DATE] with diagnoses including sepsis, diabetes mellitus, and history of embolism. Review of the electronic Physician Orders dated May 2024 revealed intravenous medications including Meropenem (antibiotic) 1000 milligrams (mg) intravenous (IV) every 12 hours. On 05/06/24 at 10:53 A.M., observation revealed Licensed Practical Nurse (LPN) #4 flushed Resident #47's left upper extremity PICC line (peripherally inserted central catheter) with 10 cc of normal saline and then administered Meropenem 1000 mg IV. Review of the eLicense Ohio Professional Licensure dated 05/09/24 revealed LPN #4's license was issued on 04/24/17 and was currently active for sub-category: medications. There was no evidence LPN #4 was certified for IV administration. On 05/06/24 at 10:53 A.M., interview with Licensed Practical Nurse #4 verified the Meropenem IV was scheduled to be administered at 8:00 A.M. and it was administered late due to training new staff and being behind. On 05/09/24 at 12:01 P.M., electronic interview with the Director of Nursing (DON) revealed LPN #4 received her training on 08/17/23 through the company staff educator. The facility provided check marked skill competency from the company staff educator; however, the facility did not provide evidence the IV training provided met the Ohio Board of Nursing requirements. The DON further provided an electronic quote stating the following, On April 6, 2023 House [NAME] 509: The implication of 4723.17 being rescinded, and the rule being eliminated, is that LPNs will no longer be required to take education specific to IV skills and knowledge in order to perform specific IV skills. In other words, performing IV skills as outlined in the LPN scope is now a default ability for all LPN's. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00152983.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure medications were stored appropriately and administered when dispensed. This affected two residents (#1, #3) from one of three medication carts observed during medication administration. The census was 48. Findings include: Medical record review revealed Resident #1 was admitted on [DATE] with diagnoses including asthma and atrial fibrillation. Medical record review revealed Resident #3 was admitted on [DATE] with diagnoses including arteriosclerotic heart disease. On 05/06/24 between 7:12 A.M. and 7:16 A.M., interview and observation revealed the 100 hall medication cart top drawer was opened by Registered Nurse (RN) #2 and she stated unfortunately she had already pre-poured several resident medications for the morning medication administration. RN #2 stated she sometimes did this depending on what kind of day it was going to be and what all was going on. Observation of the top medication drawer revealed two clear medication cups labeled with a number written in black marker on the outside of the cup. The medication administration cup labeled '#3' contained five tablets and one capsule. A second medication administration cup labeled '#4' contained eight tablets. The medications were unable to be identified and there was no resident name or date/time on the cup to identify who's medications they were. On 05/06/24 at 7:16 A.M., interview with Registered Nurse #2 verified she dispensed the medications earlier that morning. RN #2 was observed removing the medication cup out of the drawer and then administered it to the resident. Review of the policy: Medication Administration General Guidelines (dated December 2012) revealed medications were to be administered at the time they were prepared. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00152983.

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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** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure medications were administered without error. This affected two (#5, #47) of five residents observed during 25 medication opportunities with four medications errors. The medication administration error rate was 16%. The census was 48. Findings include: 1. Medical record review revealed Resident #5 was admitted on [DATE] with diagnoses including atrial fibrillation, unspecified sequelae of cerebral infarction and constipation. Review of the electronic Physician Orders dated May 2024 revealed an order for Resident #5 to receive senna (laxative) 8.6 milligrams (mg) for bowel management. On 05/06/24 at 7:19 A.M., observation of Resident #5's morning medication administration revealed Registered Nurse (RN) #2 administered lisinopril, Hydralazine, toprol xl, benicar and senna plus (combination of a stool softener and laxative) 8.6 mg/50 mg. On 05/06/24 at 7:23 A.M., interview with RN #2 verified the above medications were administered to Resident #5. RN #2 verified the resident was ordered a laxative (senna) and received a stool softener and a laxative (senna plus). 2. Medical record review revealed Resident #47 was admitted on [DATE] with diagnoses including sepsis, diabetes mellitus, and history of embolism. Review of the electronic Physician Orders dated May 2024 revealed scheduled orders including lispro flexpen (insulin) 16 units before meals, Meropenem (antibiotic) 1000 milligrams (mg) intravenous every 12 hours and Lactobacillus 100 mg orally every morning. On 05/06/24 at 10:53 A.M., observation revealed Resident #47 was administered her morning medications including her insulin that was scheduled to be administered between 7:00 A.M. and 8:00 A.M., IV antibiotic that was scheduled to be administered at 8:00 A.M. and only 50 mg of Lactobacillus was administered. On 05/06/24 at 10:53 A.M., interview with Licensed Practical Nurse #4 verified the above medications were not administered as ordered (insulin was administered after breakfast and not before a meal, IV antibiotic was not administered within 12 hours of the previous dose, and Lactobacillus was only administered at 50 mg instead of the physician ordered 100 mg). Review of the policy: Medication Administration General Guidelines dated December 2012 revealed medication were to be administered in accordance with written orders of the prescriber This deficiency represents non-compliance investigated under Complaint Number OH00152983.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to initiate enhanced barrier precautions as required. This affected one (Resident #37) of three sampled residents and the potential to affect all 48 residents. The facility identified 21 residents on enhanced barrier precautions (EBP). Findings include: Medical record review revealed Resident #37 was admitted on [DATE] with diagnoses including Parkinson's disease, diabetes mellitus and a history of Extended-spectrum beta-lactamases (ESBL). Review of the Physician Orders dated 04/01/24 revealed the resident was on enhanced barrier precautions due to a history of ESBL and multi-drug resistant organism E-coli. On 05/06/24 at 9:00 A.M., observation revealed no EBP sign was posted outside Resident #37's room. On 05/08/24 at 10:01 A.M., observation revealed EBP sign was posted outside Resident #37's room and Licensed Practical Nurse (LPN) #16 was observed in the room removing a trash bag of soiled items without the use of gloves or gown. Soiled bed linens and a hospital-like gown was observed on the floor just inside the resident's room by the door. As LPN #16 was leaving Resident #37's room, she asked State tested Nurse Aide (STNA) #18 to gather up the soiled linen and remove it from the room. At that time, STNA #18 was observed entering Resident #37's room without washing her hands or applying personal protective equipment. STNA #18 proceeded to gather the soiled linens with her bare hands, placed them in a clear bag, left the room without washing her hands and walked down the hallway. At the time of the observation, Housekeeping Supervisor (HSKP) #20 was walking down the hallway and was informed of the observation. HSKP #20 verified Resident #37's EBP were not implemented as ordered for Resident #37. Review of the policy Enhanced Barrier Precautions revised March 2024 revealed the purpose was to reduce the transmission of multidrug resistant organism (MDRO) during high contact resident care activities for residents with colonized or infected, as well as, those at increased risk to acquire MDRO. This deficiency represents non-compliance investigated under Complaint Number OH00152983.