STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366458	A. Building B. Wing	08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landerbrook Transitional Care	2108 Lander Road Mayfield Heights, OH 44124

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 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38621 Based on interview and record review and emergency department summary notes, the facility failed to assess and provide medical care/treatment for Resident #30 for observed seizure activity. Actual harm occurred when Resident #30 was found having seizures and the licensed nursing staff failed to assess her and obtain prompt medical treatment as evidenced by waiting approximately 45 minutes to call the emergency squad (911) for transport to the emergency department. Resident #30 was admitted to the intensive care unit for seizures and diabetic ketoacidosis. This affected one resident (Resident #30) of three residents reviewed for seizures. The facility census was 45. Findings include: Review of the medical record revealed Resident #30 was admitted on [DATE] with diagnoses including type two diabetes mellitus, seizures, dementia, and chronic kidney disease. Admission documentation on 06/29/21 indicated Resident #30 was identified as being alert with confusion and oriented only to herself. The comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #30 was not able to be evaluated for cognition or memory. She was totally dependent on two staff for bed mobility and toilet use and was totally dependent on one staff person for dressing, eating and personal hygiene. Review of the plan of care dated 07/14/21 revealed Resident #30 was at risk for injury related to seizure disorder with interventions for staff to administer medications as ordered, assess characteristics before, during and after seizure, assess resident after seizure for vital signs, complete neurological checks and assess length of seizure and involved body part as well as level of consciousness with seizure activity. This care plan indicated Resident #30 had severe cognitive impairment with a diagnosis of advanced dementia. Resident #30 was documented as at risk for complications related to her diagnosis of diabetes mellitus with interventions to include staff to administer medications as ordered, monitor blood glucose levels as ordered, and to monitor for signs of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). (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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(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	Review of nursing progress notes revealed a note dated 08/08/21 at 4:08 P.M., in which Licensed Practical Nurse (LPN) #302 documented Resident #30 had seizure like symptoms that morning and was shaking and blinking [her] eyes. She was noted to be clammy and when her blood sugar was checked, the testing machine read HI (a HI reading for this glucometer indicated the blood sugar was greater than 600). The nurse indicated the physician was called via the answering service and the physician was paged, but no response from the physician was received. The nurse spoke with Resident #30's daughter and attempted to call the facility's Director of Nursing (DON) twice but there was no answer and no return call. LPN #302 documented she was unable to assess vital signs due to Resident 30's shaking and then called 911 for transport to the local emergency room . There were no specific times recorded as to when these notifications and blood sugar testing were completed for Resident #30 earlier that morning. Review of the hospital emergency department (ED) provider notes dated 08/08/21 revealed, on 08/08/21 at 11:25 A.M., Resident #30 arrived at the emergency department while having a seizure and was treated with Ativan 1 mg, a medication used to treat seizures. The note indicated Resident #30 also had a seizure enroute to the hospital and emergency medical staff administered Versed 5 mg, a medication to increate sedation/relaxation, prior to arrival at the ED. This note revealed Resident #30's blood sugar in the ED remained very elevated at 511 and other laboratory testing was normal (blood chemistry, blood counts, blood cultures and urinalysis). The emergency room physician documented on 08/08/21 at 4:41 P.M. that Resident #30 had diabetic ketoacidosis, seizures and metabolic encephalopathy (a neurological disorder and alteration in consciousness caused by diffuse or global brain dysfunction from impaired cerebral metabolism resulting from systemic illness such as diabetes which can result in delirium, loss of memory, impaired coordination for motor tasks, jaundice, coma, seizures, tremors, breathing problems, heart rhythm disorders, agitation and nausea/vomiting) and was admitted to the hospital intensive care unit (ICU). Interview on 08/17/21 at 10:56 A.M. with the DON revealed in her preliminary investigation, she discovered on 08/08/21 around 9:15 A.M., State tested Nurse Aide (STNA) #500 witnessed Resident #30 shaking all over, sweating and blinking her eyes rapidly and had a white substance around her mouth and immediately notified LPN) #302 (an agency nurse). The DON stated STNA #500 also contacted the Director of Human Resources (DHR) #201 who was the manager on duty and in the building at the time. The DON stated STNA #500 and DHR #201 reported Resident #30 was having seizure activity from 9:15 A.M. until about 10:00 A. M. LPN #302 called 911 to transport Resident #30 to the hospital and the ambulance departed with Resident #30 at 10:26 A.M. The DON stated, according to information provided by the ambulance service, they received a call from the facility requesting assistance and an ambulance on 08/08/21 at 10:02 A.M. At 10:06 A.M., the ambulance arrived at the facility and departed the facility to the local hospital at 10:26 A.M. The ambulance arrived at the hospital at 10:31 A.M. The DON stated there was at least a 45 minute delay between Resident #30 first observed having seizure activity and when LPN #302 called 911/ambulance for transport to the hospital. The DON verified there was no documentation of the care and services in the Situation, Background, Assessment and Recommendation (SBAR) communication records or the resident's nursing progress notes until 08/08/21 at 4:08 P.M. when LPN #302 entered a vague note about Resident #30's seizure and transfer to the hospital. The DON stated 45 minutes was too long to wait to send Resident #30 to the hospital and thinking about this delay makes her feel sick to her stomach. (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	Interview on 08/23/21 at 8:11 A.M. with DHR #201 revealed on 08/08/21 around 8:00 A.M., she arrived at the facility for her manager on-duty rounds. DHR #201 stated, while she was visiting with a resident, she received a telephone call from STNA #500 asking her to check on Resident #30, who was shaking all over. DHR #201 stated, around 9:15 A.M., she entered Resident #30's room and found her shaking all over, sweating and with white foam coming from her mouth. DHR #201 stated LPN #302 was in the room and was asking if Resident #30 had a history of seizures or was a hospice patient. DHR #201 stated she then wiped Resident #30's mouth and took LPN #311 to assist her with accessing the medical records and had STNA #500 stay with the resident. DHR #201 stated she then returned to the resident's room and Resident #30 continued having seizures. DHR #201 stated she directed the nurse to call the DON and physician. DHR #201 stated she also directed LPN #302 to call 911 and send Resident #30 to the emergency department for evaluation for her prolonged seizure. DHR #201 stated she then left the facility believing the nurse was sending Resident #30 to the hospital. Interview on 08/23/21 at 3:28 P.M. with LPN #302 verified, on 08/08/21 at 4:08 P.M., she wrote a brief note on assessment and care of Resident #30 at the end of her shift. LPN #302 stated she did not include the times of her assessments and notifications in the resident's record as she was busy with care of other residents and had not had the time to document on Resident #30 earlier in the day. LPN #302 stated, on 08/08/21, she was working at the facility as an agency nurse and had no information of the residents at the facility. LPN #302 stated around 9:00 A.M., 9:30 A.M. or 10:00 A.M., she had not been able to pass medications to Resident #30 or any other residents due to computer issues. She said an STNA came and reported Resident #30, didn't look right. LPN #302 stated she went and checked Resident #30 and found her to be shaking and her eyes were twitching and blinking. LPN #302 stated she went and checked Resident #30's chart and found she had a history of seizures and diabetes, so she checked the resident's blood sugar and the meter read HI. LPN #302 stated she attempted to call the physician, left messages on his answering machine and made two attempts to call the DON without success. LPN #302 stated she then called the resident's daughter to ask about hospice care, but the daughter reported Resident #30 was not in hospice care. LPN #302 stated Resident #30 then calmed down a little bit and she went to check her medications. LPN #302 said the STNA came back and reported Resident #30 started seizing again, so she decided to call 911 and send Resident #30 to the hospital for evaluation. LPN #302 stated around 4:08 P.M., she started documenting the events from earlier in the day related to Resident #30 but could not recall the times of the events. Interview on 08/24/21 at 7:45 A.M. with LPN #311 revealed on 08/08/21 around 9:43 A.M., she returned to the facility and was informed by the other agency nurse on duty, LPN #302, that Resident #30 had been having seizures for about 20 minutes and LPN #302 wasn't sure what to do. LPN #311 stated she told LPN #302 if the resident was seizing for an extended period, she needed to send the resident to the emergency department for evaluation. LPN #311 stated she then went to resident's room and observed Resident #30 in a full tonic/clonic seizure with shaking all over, blinking her eyes quickly and having white foam coming from her mouth. LPN #311 stated the DHR #201 was also helping with Resident #30. LPN #311 stated, around 10:00 A.M., she called 911 and handed the telephone to LPN #302 for her to provide report on Resident #30's status to the ambulance personnel. LPN #311 stated Resident #30 was having a shaking all over, seizures with a slight lessening of the shaking at one point, then the heavy shaking resumed. LPN #311 stated she then left the facility because she was not punched in and working. LPN #311 stated, when she first observed Resident #30 having a seizure, she informed LPN #302 that she should call 911 and send her out to the hospital. LPN #311 stated LPN #302 told her she did not know if Resident #30 was a hospice resident or if Resident #30 had a history of seizures. LPN #311 stated at 10:00 A.M., she decided to call 911 herself and then handed the telephone to LPN #302 to provide report to the ambulance company. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 08/24/21 at 8:19 A.M. with STNA #500 revealed on 08/08/21, she entered Resident #30's room at approximately 9:00 A.M. and found the resident to be shaking all over, her eyes were blinking quickly, she was sweaty and had a white substance coming from her mouth. STNA #500 stated she immediately went and notified LPN #311. STNA #500 stated she also called DHR #201 who was the manager on duty for her to help with Resident #30. STNA #500 stated she then went to answer call lights and provide care for other residents. STNA #500 stated, between 9:45 A.M. and 10:00 A.M. she went back to check on Resident #30, who was still shaking all over and sweating. She said she again notified LPN #311. STNA #500 stated LPN #311 then called 911 and the ambulance arrived and transported Resident #30 to the hospital. Review of the facility, Notification of Change, policy last reviewed on 07/2021, the resident's physician and responsible party must be notified when an event involving the resident occurs or when the resident experiences a change in condition, potential discharge, room transfer or death. Also, when a licensed nurse is made aware of a resident change in condition, the licensed nurse will assess the resident, call the physician and document using Situation, Background, Assessment and Recommendation (SBAR) Communication Form and/or progress notes. If the situation is emergent or becomes emergent, the licensed nurse may initiate the 911 system. The licensed nurse is to provide frequent checks on the resident's condition while waiting for return call backs from the physician or nurse practitioner. This deficiency substantiates Complaint Number OH00124928. This is an example of continued noncompliance from the survey dated 07/19/21.

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38621 Based on interview, record review and emergency department summary notes, the facility failed to ensure residents were free from significant medication errors when one resident (Resident #30) was not administered physician ordered medications including an anti-seizure medications, a blood thinner, insulin and other medications as prescribed. This resulted in Immediate Jeopardy and serious life-threatening harm when on 08/08/21 at 9:15 A.M., Resident #30 experienced seizures and an undetectable, high blood sugar level requiring hospitalization and admission to the intensive care unit (ICU). Admitting diagnoses at the hospital included high blood sugar and diabetic ketoacidosis (a serious, potentially life-threatening condition due to a build-up of acids or ketones in the blood when blood sugar levels remain elevated for too long) which can result in diabetic coma and death. This affected one resident (Resident #30) of five residents reviewed for medication administration. The facility census was 45. On 08/17/21 at 3:09 P.M., the Administrator and the Interim Director of Nursing (DON) were notified the Immediate Jeopardy began on 07/30/21 at 9:00 A.M. when Vimpat (anti-seizure medication) was not available for scheduled administration to Resident #30. This medication continued to be unavailable for administration through 08/08/21, for a total of 19 missed doses. On 08/07/21 at 7:00 A.M., Resident #30 did not receive Keppra (anti-seizure medication), Eliquis (anti-coagulant or blood thinning medication), Lantus Solostar insulin 24 units and Lispro insulin per sliding scale based on blood sugar level checks which were ordered before meals and at bedtime. On 08/07/21 at 6:00 P.M., Resident #30 had a blood sugar reading of 220 with 2 units of Lispro insulin administered per sliding scale and at 8:30 P.M. Resident #30 had an elevated blood sugar reading of 379 and 5 units of Lispro insulin was administered per sliding scale. Normal blood sugar levels per the facility are between 70 to 110. There was no evidence Resident #30's blood sugar was checked the morning of 08/08/21 before breakfast. On 08/08/21 at 9:15 A.M., Resident #30 was found by Licensed Practical Nurse (LPN) #302 (an agency nurse) having seizure-like activity and a blood sugar reading of HI on the facility blood glucose meter (blood glucose meters read HI when the blood sugar level exceeds the level detectable) and was sent to the local emergency department by ambulance for evaluation. On arrival at the emergency department on 08/08/21, Resident #30 was still having seizures and had an elevated blood glucose level of 511. She was admitted to the ICU with diagnoses of diabetic ketoacidosis and seizures, where she remained until 08/19/21 when she was readmitted to the facility. The Immediate Jeopardy was removed on 08/18/21 when the facility implemented the following corrective action: On 08/13/21, the contracted Pharmacy Registered Nurse (RN) #314 conducted a whole house medication availability audit and provided the results to the Interim DON on 08/17/21 at 9:00 A.M. Quarterly audits by Pharmacy RN #314 would be completed for one year and would be reviewed by the Quality Assurance/Performance Improvement (QAPI) Committee. All identified concerns would be reported to and addressed immediately by the DON or designee. On 08/17/21 at 3:00 P.M., the Medical Director, Administrator and Interim DON reviewed the facility's policies and procedures for medication administration, documentation and ordering of medications. No revisions to these policies and procedures were required. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/17/21 at 4:30 P.M., the Interim DON started individual in-service training with licensed nursing staff on medication administration, documentation and medication ordering processes. The in-service training of all licensed nursing staff was completed on 08/18/21 at 7:30 A.M. On 08/17/21 and 08/18/21, individual training on medication administration, documentation and medication ordering processes was provided by the Interim DON to licensed nursing staff to include RN #301, RN #307; RN #308, Licensed Practical Nurse (LPN) #305, the nurses who did not administer the Vimpat to Resident #30, and RN #309. On 08/17/21 at 3:00 P.M., the Interim DON started in-service training of all agency nurses upon arrival for their scheduled shifts at the facility. Additional agency nurses will be in-serviced upon arrival at the facility prior to their shift and off-going nurses will provide nurse login and orientation to agency nurses prior to their assumption of duties at the facility. On 08/17/21 at 3:30 P.M., the Interim DON, Regional Nurse LPN #313 and LPN Supervisor #305 conducted an audit of all resident stock medication to ensure medications were available for administration as per the physician's orders. The medication audit was completed on 08/18/21 at 9:00 A.M. with one medication discrepancy identified and immediately corrected for Resident #27. On 08/17/21 the Interim DON reviewed the agency nurse computer login system and orientation process and implemented an updated process in which the facility human resources staff will be responsible for setting up computer logins prior to agency staff arriving for their scheduled shifts and for orientation to be completed upon arrival for their scheduled shifts. On 08/17/21, the DON and/or designee started daily audits of medication availability for residents and 10% or five residents on each unit will be audited daily for two weeks, then randomly for 10% of five residents weekly for four weeks, then monthly for 10% or five residents for one year. Identified concerns from audits will be addressed immediately by the DON or designee and be reviewed by the facility Quality Assurance Performance Improvement (QAPI) Committee for additional direction. Starting on 08/17/21, the DON or designee will conduct daily nurse schedule audits to ensure dedicated agency nurses with computer log in credentials are assigned and orientation conducted. Identified concerns from audits will be addressed immediately by the DON or designee and be reviewed by the facility QAPI Committee for additional direction. On 08/18/21 at 11:00 A.M., the Administrator notified the nurse staffing agency to place agency LPN #302 on a Do Not Return list for their facility because of the medication/nurse practice issues and documentation issues on 08/08/21 for Resident #30. On 08/19/21 at 12:37 P.M., agency nurse in-service training on medication administration, documentation and medication ordering processes was verified via interviews with RN #310, LPN #311, LPN #312, LPN #303, and LPN #304. In-service training on medication administration, documentation and medication ordering processes was also confirmed via interviews with the Interim DON, RN #301, RN #307; RN #308, RN #309, and LPN #305. On 08/19/21 at 1:00 P.M., the Administrator contacted the nurse staffing agency to coordinate consistent agency staff assignments at the facility starting immediately. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/19/21, the Interim DON provided verbal warnings to RN #300, RN #308, RN #307, and LPN #305 for not following medication protocols for Resident #30. On 08/23/21 at 3:00 P.M., the Administrator and Interim DON transitioned from electronic Medication Administration Records (MARs) and Electronic Treatment Administration Records (TARs) to paper MARs and TARs for all residents due to system issues with agency nurses' ability to access MARs and TARs in their electronic medical record system. On 08/23/21 at 3:00 P.M., the Interim Director of Nursing provided education to all facility staff and agency nurses regarding the use of paper MARs and TARs for all residents. The facility will still provide agency nurses with login and password access for the computers for documentation in progress notes and documentation of observations/assessments. Although the Immediate Jeopardy was removed, the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the medical record revealed Resident #30 was admitted on [DATE] with diagnoses including type two diabetes mellitus, seizures, dementia, and chronic kidney disease. Admission documentation on 06/29/21 indicated Resident #30 was identified as being alert with confusion and oriented only to herself. The comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #30 was not able to be evaluated for cognition or memory. The medication section indicated she received insulin, anticoagulant therapy, and seizure medications. Resident #30 was totally dependent on two staff for bed mobility and toilet use and was totally dependent on one staff person for dressing, eating and personal hygiene. Review of the plan of care dated 07/14/21 revealed Resident #30 was at risk for injury related to seizure disorder with staff interventions to include administer medications as ordered, assess characteristics before, during and after seizure, assess resident after seizure for vital signs, neurological checks and assess time, length, involved body part and level of consciousness if seizure occurs. This care plan indicated Resident #30 had severe cognitive impairment with a diagnosis of advanced dementia and was at risk for injury and bleeding related to anticoagulant therapy (blood thinner medication). Interventions included nursing staff to administer anticoagulants as ordered and observe for signs of active bleeding. Resident #30 was documented as at risk for complications related to her diagnosis of diabetes mellitus with interventions to include staff to administer medications as ordered, monitor blood glucose levels as ordered, and to monitor for signs of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Physician orders for July and August 2021 revealed Resident #30 was prescribed Vimpat (antiseizure medication) 200 milligrams (mg) twice a day via gastric tube or G-tube (a tube inserted through the abdominal wall into the stomach for provision of nutrition and/or medication administration), Keppra (antiseizure medication) 250 mg twice a day via G-tube, Eliquis (blood thinning medication) 5 mg twice a day via G-tube, Lantus Solostar insulin (diabetic medication) 24 units subcutaneously (SQ) every morning, Lispro insulin (diabetic medication) per sliding scale with blood sugar checks before meals and bedtime as follows: blood sugar of 111 to 150, no insulin; blood sugar of 151 to 200, give 1 unit; blood sugar of 201 to 250, give 2 units; blood sugar of 251 to 300, give 3 units; blood sugar of 301 to 350, give 4 units; blood sugar of 351 to 400, give 5 units; and if the blood sugar was greater than 400 or less than 70, nursing staff were to call the physician for notification and any additional orders. Review of the Medication Administration Records (MARs) for July and August 2021 revealed the Vimpat seizure medication was not marked as administered on 07/30/21 at 9:00 A.M. and 8:00 P.M., 07/31/21 at 9:00 A.M. and 8:00 P.M., 08/01/21 at 9:00 A.M. and 8:00 P.M., 08/02/21 at 9:00 A.M. and 8:00 P.M., 08/03/21 at 9:00 A.M. and 8:00 P.M., and on 08/04/21 at 9:00 A.M. On 08/04/21 at 8:00 P.M. and 08/06/21 at 8:00 P.M., the nurse documented the Vimpat was administered to Resident #30, however the medication had not been delivered to the facility from the pharmacy and would not have been available. There was no reason documented why the Vimpat was not given for some of these doses and some doses were marked as not available for administration. The progress note authored by CNP #300 on 08/04/21 1:44 P.M. indicated Resident #30 had advanced dementia with a history of seizures and had not had the Vimpat seizure medication for quite a while per nursing staff. CNP #300 indicated Resident #30 was ordered Keppra medication, also for seizures, and discussed with the primary care physician, to increase the Keppra medication to 500 mg twice a day. They also discussed having the facility staff contact the family to find out which neurologist had been treating Resident #30 for her seizure disorder. The CNP and physician were reluctant to modify the VIMPAT orders without a neurologist's input. There were no orders to hold or discontinue the Vimpat medication. The CNP indicated the nursing progress notes were silent regarding the Vimpat medication not being available and not administered as ordered. There was no evidence found to indicate the family was contacted for this information. The MAR for August 2021 revealed the Vimpat was not administered on 08/05/21 at 9:00 A.M. and 8:00 P.M. , on 08/06/21 at 9:00 A.M., on 08/07/21 at 9:00 A.M. and 8:00 P.M., and on 08/08/21 at 9:00 A.M. In addition to the Vimpat not administered, on 08/07/21 at 7:00 A.M., the MAR revealed LPN #306 also failed to administer Keppra 500 mg, Lantus Solostar insulin 24 units, Lispro insulin per sliding scale according to blood sugar level, Eliquis 5 mg, metoprolol (for high blood pressure) 75 mg; oxycodone (narcotic pain reliever) 5 mg; omeprazole (for acid reflux) 20 mg; and a multivitamin. There was no documentation Resident #30's blood sugar level was obtained before breakfast in order to give the correct dose of Lispro insulin via sliding scale coverage. On 08/07/21 at 11:00 A.M., LPN #306 did not complete the ordered blood sugar testing for Resident #30 prior to the lunch meal and did not administer Lispro insulin per sliding scale. On 08/07/21 at 5:57 P.M. Resident #30's blood sugar was 220 and on 08/07/21 at 8:29 P.M. her BS was 379. These blood sugars were covered with Lispro insulin administered according to the sliding scale orders by a different nurse. No further blood sugar testing or insulin administration was completed after 08/07/21 at 8:29 P.M. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of nursing progress notes revealed a note on 08/08/21 at 4:08 P.M., in which LPN #302 documented Resident #30 had seizure like symptoms that morning and was shaking and blinking [her] eyes. She was noted to be clammy and when her blood sugar was checked, the testing machine read HI (a HI reading for this glucometer indicated the blood sugar was greater than 600). The nurse indicated the physician was called via the answering service and the physician was paged, but the physician did not respond. The nurse spoke with Resident #30's daughter and attempted to call the DON twice but there was no answer. LPN #302 documented she was unable to assess vital signs due to Resident 30's shaking and then later called 911 for transport to the local emergency room . There were no specific times recorded as to when these notifications were done, blood sugar testing was completed, time the emergency transport arrived and when they transported Resident #30 to the hospital earlier that morning. Review of the hospital emergency department (ED) provider notes dated 08/08/21 revealed, on 08/08/21 at 11:25 A.M., Resident #30 arrived at the emergency department while having a seizure and was treated with Ativan 1 mg, a medication used to treat seizures. The note indicated Resident #30 also had a seizure enroute to the hospital and emergency medical staff administered Versed 5 mg, a medication to increase sedation/relaxation, prior to arrival at the ED. This note revealed Resident #30's blood sugar in the ED remained very elevated at 511 and other laboratory testing was normal (blood chemistry, blood counts, blood cultures and urinalysis). There was no indication of specific medication levels being tested for seizure medications. The emergency room physician documented on 08/08/21 at 4:41 P.M. that Resident #30 had diabetic ketoacidosis, (seizures and metabolic encephalopathy- a neurological disorder and alteration in consciousness caused by diffuse or global brain dysfunction from impaired cerebral metabolism resulting from systemic illness such as diabetes, which can result in delirium, loss of memory, impaired coordination for motor tasks, jaundice, coma, seizures, tremors, breathing problems, heart rhythm disorders, agitation and nausea/vomiting). Resident #30 was admitted to the hospital ICU. Interview on 08/17/21 at 7:15 A.M. with RN #301 stated she believed Resident #30 was having her blood sugar tested and recalled several occasions when the Vimpat medication ordered for Resident #30 was not available for administration. RN #301 stated she would have sent a facsimile to the prescriber to notify of the medication not being available however she did not receive a response from the prescriber when she sent the facsimiles. RN #301 stated she also notified the DON when the Vimpat medication was not available. RN #301 confirmed she did not document these notifications to the physician or the DON in the medical record. (continued on next page)

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	366458	A. Building B. Wing	08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landerbrook Transitional Care	2108 Lander Road Mayfield Heights, OH 44124

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/17/21 at 10:56 A.M. with the Interim DON revealed she was currently investigating the Vimpat and other medication issues and the seizure activity that required Resident #30 to be sent to the hospital on 08/08/21. The DON stated her preliminary investigation was not available at that time. The Interim DON verified between 07/30/21 and 08/08/21, Resident #30 did not receive any doses of the Vimpat medication for her seizure disorder because the medication was not available from the pharmacy. The Interim DON verified the nurses were documenting in the MARs that the Vimpat was not available, but there was no documentation regarding the nurses notifying the prescribers or facility nurse administrators of this concern. The DON said she reviewed Resident #30's medical record documentation on 08/08/21 at 7:00 A. M. and 11:00 A.M., and the agency nurse, LPN #302, did not document the administration of all medications including Eliquis, Vimpat, Keppra and insulin and she did not document blood sugar levels were tested to provide insulin per the sliding scale orders. According to the Interim DON, the facility utilized a glucometer where the HI reading indicated the blood sugar level was over 600. The Interim DON verified there was no documentation in the medical record to indicate any facility staff contacted the family for the name of the neurologist for Resident #30. Interview by telephone on 08/17/21 at 11:17 A.M. with LPN #306 verified she was assigned to work on 08/07/21 from 6:00 A.M. to 3:00 P.M. on the unit where Resident #30 resided. LPN #306 stated she could not recall any specifics of the medication administration on 08/07/21 at 7:00 A.M. and 11:00 A.M., but she believed she would have administered the medications as ordered and obtained blood sugar readings. LPN #306 stated she did not document the blood sugar readings in Resident #30's medical record. LPN #306 stated she routinely administered medications to residents and did not document their administration until the end of her shift, instead of at the time of the administration per nursing standards. Interview by telephone on 08/17/21 at 11:33 A.M. with the Former DON, who was employed at the facility at the time of this incident, revealed at the time of the concerns for Resident #30, she was on vacation and was not available to respond to staff communications about resident care. The Former DON stated, when she returned from vacation, she was informed of the issue with Resident #30 having a seizure and transfer to the hospital. She said she felt there was no reason for an investigation to be completed. Interview on 08/19/21 at 12:37 P.M. with LPN #305 stated when Resident #30 was out of Vimpat medication, he sent a facsimile to the prescriber's office to notify them of the missing medication and received no response from the prescriber. LPN #305 stated he also left a voice message for the Former DON regarding this issue. LPN #305 admitted he did not document these notifications to the prescriber or Former DON in Resident #30's medical record. Interview on 08/23/21 at 8:11 A.M. with Director of Human Resources (DHR) #201 stated, on 08/08/21 around 8:00 A.M., she arrived at the facility for her manager on duty rounds. DHR #201 stated, while she was visiting with a resident, she received a telephone call from State tested Nurse Aide (STNA) #500 asking her to check on Resident #30 who was shaking all over. DHR #201 stated, around 9:15 A.M., she entered the resident's room and found Resident #30 shaking all over, sweating and having white foam coming from her mouth. DHR #201 stated LPN #302 was in the room and was asking if Resident #30 had a history of seizures or was a hospice patient. DHR #201 stated she then wiped off Resident #30's mouth and took LPN #311 to assist her with accessing the medical records and had STNA #500 stay with the resident. DHR #201 stated she then returned to the resident's room and the seizures continued. DHR #201 directed the nurse to call the DON and physician. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/24/21 at 7:45 A.M. with LPN #311 stated, on 08/07/21 from 11:00 P.M. to 08/08/21 at 8:00 A. M., she worked as an agency nurse at the facility. LPN #311 stated, on 08/08/21 around 9:43 A.M., she returned to the facility and was informed by the agency nurse on duty (LPN #302) that Resident #30 had been having a seizure for about 20 minutes and LPN #302 wasn't sure of what to do. LPN #311 stated she told LPN #302 if the resident was seizing for an extended period, she needed to send the resident to the emergency department for evaluation. LPN #311 stated she then went to resident's room and observed Resident #30 in a full tonic/clonic seizure with shaking all over, blinking her eyes quickly and having white foam coming from her mouth. LPN #311 stated DHR #201, who was the manager on duty, was also helping with Resident #30. LPN #311 stated, around 10:00 A.M., she called 911 and handed the telephone to LPN #302 for her to provide report on Resident #30's status to the ambulance personnel. LPN #311 stated Resident #30 was having a shaking all over seizure with slight lessening of the shaking at one point, then the heavy shaking resumed. LPN #311 stated she then let the facility because she was not on the clock. Interview on 08/24/21 at 8:19 A.M. with State tested Nurse Aide, (STNA) #500 revealed on 08/08/21, she entered Resident #30's room at approximately 9:00 A.M. and found the resident shaking all over, her eyes were blinking quickly, she was sweaty and had a white substance coming from her mouth. STNA #500 stated she immediately went and notified LPN #311. STNA #500 stated she also called DHR #201 who was the manager on duty for her to help with Resident #30. STNA #500 stated she then went to answer call lights and provide care for other residents. STNA #500 stated, between 9:45 A.M. and 10:00 A.M. she went back to check on Resident #30, who was alone in her room and she was still shaking all over and sweating. STNA #500 said she again notified LPN #311. STNA #500 stated LPN #311 then called 911 and the ambulance arrived and transported Resident #30 to the hospital. Interview on 08/24/21 at 2:21 P.M. with CNP #300 revealed she made rounds on 08/04/21 and the facility nurses reported Resident #30 was ordered Vimpat, but she had not been receiving the Vimpat as ordered for a while. CNP #300 stated she reviewed Resident #30's medical records and was not able to find the name of a neurologist who would have ordered the Vimpat for the resident. CNP #300 stated she contacted the former DON to see if they could contact the family and find out who Resident #30's neurologist was, and she never heard back from the DON or any other nurse. CNP #300 stated she was informed Resident #30's insurance would not cover the Vimpat medication, so she contacted primary care physician (PCP) for Resident #30, and they decided to increase the Keppra dose. CNP #300 stated since the Vimpat was not available per insurance and the resident was not getting the medication, she could not discontinue or hold the order. CNP #300 stated no facility staff had ever informed her that Resident #30 was not receiving the Vimpat medication prior to the 08/04/21 visit. CNP #300 stated she could not state whether or not Resident #30's seizures on 08/08/21 were due to the seizure medication administration or insulin medication not being given. She said the lack of seizure medications and high blood sugar could lead to increased seizure activity. (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview by telephone and email correspondence on 08/25/21 at 10:44 A.M. with Consulting Pharmacist (RPh) #202 revealed on 07/29/21, the pharmacy received a telephone/verbal order from a nurse at the facility requesting a new prescription for Vimpat for Resident #30. RPh #202 stated the Vimpat order was canceled due to the third-party payor (insurance) requirement for prior authorization and a supporting diagnosis needed to be provided with the prescription order. RPh #202 stated the pharmacy then sent a notification of the order being canceled and the request for prior authorization and diagnoses to the facility by facsimile and by the computer medication ordering system the facility utilized, but they received no response from the facility or the prescriber. RPh #202 stated they also could not fill the prescription because the facility had already exceeded their allowance for facility instructions for non-covered medications. RPh #202 stated they sent a notification to the facility on [DATE] regarding the non-covered medication allowance and no response was received from the facility. RPh #202 stated the pharmacy always goes through the facility for clarification of physician orders. Review of the facility General Dose Preparation and Medication Administration, policy revised 01/01/13; the facility Reordering, Changing, and Discontinuing Orders, policy revised 10/31/16; and the Medication Shortages/Unavailable Medication, policy revised 01/01/13 revealed facility staff should verify medications are administered to ensure it is the correct medication at the correct dose, the correct route, correct rate, and time and for the correct resident. Facility staff should re-order medications using the electronic list of residents and medications that are due or by using the barcode technology. Upon discovery that the facility has an inadequate supply of medication to administer to a resident, the facility staff should immediately initiate action to obtain the medication from the pharmacy. The staff should contact the pharmacy to determine the status of the medication orders. If the medication is not available for administration, the nurse should notify the nurse supervisor and the Medical Director for orders and directions. This deficiency substantiates Complaint Number OH00124928. This is an example of continued noncompliance from the survey dated 07/19/21.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38621 Based on interviews and record reviews, the facility failed to ensure complete, accurate and timely documentation of assessments and care provided to a resident experiencing a seizure. This affected one resident (Resident #30) of ten residents reviewed for documentation. The facility census was 45. Findings include: Review of the medical record for Resident #30 revealed Resident #30 was admitted on [DATE] with diagnoses to include type two diabetes mellitus, seizures, dementia and chronic kidney disease. On admission documentation on 06/29/21, Resident #30 was identified as having confusion and only oriented only to self. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 was not evaluated for cognition or memory issues. Resident #30 received insulin, anticoagulant therapy and seizure medications. Resident #30 was totally dependent on two staff persons for bed mobility and toilet use and totally dependent on one staff person for dressing, eating and personal hygiene and transfers did not occur. Prescriber orders for July and August 2021 revealed Resident #30 was prescribed the following medications: Vimpat (antiseizure) 200 milligrams (mg) twice a day via Gastric tube (G-tube), Keppra (antiseizure) 250 mg twice a day via G-tube, Eliquis 5 mg twice a day via G-tube, Lantus Solostar insulin 24 units subcutaneously (SQ) once every morning, and Insulin Lispro per sliding scale 111 to 150, 0 (zero) units depending on blood sugar levels obtained before meals and at bed time. For blood sugars of 151 to 200, give 1 unit; for blood sugars of 201 to 250, give 2 units; for blood sugars of 251 to 300, give 3 units; for blood sugars of 301 to 350, give 4 units; for blood sugars of 351 to 400, give 5 units; and if blood sugar is greater than 400 or less than 70 nurses were to call the physician. On 08/04/21 at 1:44 P.M., Certified Nurse Practitioner (CNP) #300 increased the orders for Keppra to 500 mg twice a day since the Vimpat medication was not available from the pharmacy. Review of the Medication Administration Records (MARs) for July and August 2021 revealed, on 07/30/21 at 9:00 A.M. and 8:00 P.M., and 07/31/21 at 9:00 A.M. and 8:00 P.M. Vimpat 200 mg was not available for administration to Resident #30. Also, on 08/01/21 at 9:00 A.M. and 8:00 P.M., on 08/02/21 at 9:00 A.M. and 8:00 P.M., on 08/03/21 at 9:00 A.M., on 08/04/21 at 9:00 A.M., on 08/05/21 at 9:00 A.M. and 8:00 P.M., on 08/06/21 at 9:00 A.M., on 08/07/21 at 8:00 P.M., and on 08/08/21 at 9:00 A.M. the Vimpat medication was marked by nursing staff as not available for administration. On 08/03/21 at 8:00 P.M. and 08/07/21 at 9:00 A.M. there was no documentation related to the administration of or availability of the Vimpat medication. On 08/04/21 at 8:00 P.M. and 08/06/21 at 8:00 P.M. a nurse documented the Vimpat medication was administered to Resident #30., when it had never been delivered to the facility from pharmacy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress notes revealed a note on 08/08/21 at 4:08 P.M., in which Licensed Practical Nurse (LPN) #302 documented Resident #30 had seizure like symptoms that morning and was shaking and blinking [her] eyes. She was noted to be clammy and when her blood sugar was checked, the testing machine read HI (a HI reading for this glucometer indicated the blood sugar was greater than 600). The nurse indicated the physician was called via the answering service and the physician was paged, but the physician did not respond. The nurse spoke with Resident #30's daughter and attempted to call the DON twice but there was no answer. LPN #302 documented she was unable to assess vital signs due to Resident 30's shaking and then later called 911 for transport to the local emergency room . There were no specific times recorded as to when these notifications were done, that blood sugar testing was completed, that any physical assessments were completed, the time the emergency transport arrived and when they transported Resident #30 to the hospital earlier that morning. Interview on 08/17/21 at 7:15 A.M. with Registered Nurse (RN) #301 revealed she recalled several occasions were the Vimpat medication was ordered for Resident #30, but the medication was not available for administration to the resident. RN #301 stated she recalls sending facsimiles of notifications to the prescriber, but she did not receive any responses from the prescriber. RN #301 stated she also attempted to contact the Director of Nursing (DON) to notify her of the medication not being available for administration, but received no response. RN #301 stated she documented the Vimpat was not available on the MARs. RN #301 stated she never documented the attempts of notifications to the prescriber or to the DON in the medical records. RN #301 stated she could not recall the dates the Vimpat was not available for Resident #30. Interview on 08/17/21 at 10:56 A.M. with the Interim Director of Nursing (DON) stated, on 08/08/21, there was a lack of documentation of assessments and care for Resident #30 who had a seizure and needed sent out to the hospital for evaluation. The DON stated LPN #302 did not provide timely, accurate documentation for Resident #30 on 08/08/21 when the resident had a seizure and needed sent to the hospital for evaluation. Interview by telephone on 08/17/21 at 11:17 A.M. with LPN #306 stated, verified, on 08/07/21 at 7:00 A.M. and 11:00 A.M., she did not document medications administration or blood sugar test results with insulin sliding scale results in Resident #30's MARs or medical record. LPN #306 stated, on 08/07/21 at 7:00 A.M. and 11:00 A.M., she believes she administered scheduled medications to Resident #30 per the prescriber orders, but could not recall the blood sugar test results or the amount of insulin per sliding scale that she administered. LPN #306 stated she remembers documenting the results on her 24-hour sheet, but did not transfer the data into the resident's medical files. LPN #306 stated she usually administered the medications to the residents, then she would document her administrations of the medications and treatments at the end of her shift so she could ensure she was able to administer all of the resident medications in a timely manner. LPN #306 stated she could not recall any issues with Vimpat or other seizure medications. LPN #306 stated, if she had to document her administrations at the time she administered the medications, she would never get her medication pass done, timely. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/19/21 at 12:37 P.M. with LPN #305 stated he recalls several occasions where he worked and Vimpat was not available for administration to Resident #30. LPN #305 stated he sent a facsimile of a notification of the Vimpat missed doses to the prescriber, but did not receive a response from the prescriber. LPN #305 stated he also attempted to contact the DON to notify her of the medication discrepancy, but he did not receive a response from the DON. LPN #305 stated he documented the Vimpat was not available in the MARs but never documented the notifications of the prescriber or the DON in the medical records. LPN #305 stated he could not recall the dates of when the Vimpat was not available for Resident #30. Interview on 08/23/21 at 3:28 P.M. with LPN #302 (an agency nurse) verified, on 08/08/21 at 4:08 P.M., she wrote a brief note on assessments and care of Resident #30 at the end of her shift. LPN #302 stated she did not include the times of her assessments and notifications in the resident's records as she was busy with care of other residents and had not had the time to document on Resident #30 earlier. LPN #302 stated, on 08/08/21, she was working at the facility as an agency nurse and had no information of the residents at the facility. LPN #302 stated there was another agency nurse working on the other side of the facility. LPN #302 stated she was having difficulty accessing the computer for her medication pass because her login was not working and she needed the scheduler to try to help her out. LPN #302 stated around 9:00 A.M. or 9:30 A.M. or 10:00 A.M., she had not been able to pass medications to Resident #30 or any other residents when one of the STNA came and reported Resident #30 didn't look right. LPN #302 stated she went and checked Resident #30 and found her to be shaking and her eyes were twitching and blinking. LPN #302 stated she went and checked Resident #30's chart and found she had a history of seizures and diabetes, so she checked the resident's blood sugar and the meter read HI, too high to be detected by their glucometer. LPN #302 stated she made attempts to call the doctor, left messages on his answering machine and made two attempts to call the Director of Nursing without success. LPN #302 stated she then called the resident's daughter to ask about hospice care, but the daughter reported Resident #30 was not in hospice care. LPN #302 stated Resident #30 then calmed down a little bit and she went to check her medications. Then the STNA came back and reported Resident #30 started seizing again, so she made a decision to call 911 and send Resident #30 to the hospital for evaluation. LPN #302 stated around 4:08 P.M., she sat down and started documenting on Resident #30, but could not recall all of the times for all of the events that morning. Review of the policy, General Dose Preparation and Medication Policy, revised 01/01/13, revealed nurses are to document necessary medication administration and treatment information to include when medications are given, injections sites of medications and any as needed medication administrations on appropriate forms. Review of the policy, Notification of Change, revised July 2021, revealed nurses are to document in the Situation, Background, Assessment and Recommendation (SBAR) communication forms and/or progress notes and document attempts to communicate with the prescribers and DON. Review of the policy, Documentation of Medication Administration, dated 09/2020, revealed nurses shall document all medications administered to each resident on the resident's MAR and the administration of the medication must be documented immediately after (never before) the medication is given. This deficiency substantiates Complaint Number OH00124928. This deficiency is an example of continued noncompliance from the survey dated 07/19/21.

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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** 44454 Based on observation, record review, interview, and policy review, the facility failed to ensure staff donned the appropriate personal protective equipment (PPE) prior to entering a resident room who was on transmission-based precautions for observation related to COVID-19. This had the potential to affect all 45 residents residing in the facility. Findings include: Review of Resident #2's medical record revealed an admission on 08/03/21 with diagnoses including type II diabetes mellitus, localized edema, osteoarthritis, and anemia. Review of a physician's orders dated 08/03/21, revealed Resident #2 was to be placed on droplet and contact isolation for 14 days following admission to the facility and monitored for signs or symptoms of COVID-19. There were also special instructions for staff to wear PPE including a gown, gloves, a mask, and a face shield or goggles when providing care to the resident. Observation during a facility tour on 08/04/21 at approximately 10:00 A.M. revealed there was Resident #2 was quarantined as a precaution for COVID-19 as a new admission. There were signs clearly posted next to the outside of the door instructing visitors were to see a nurse or staff member prior to entering the room. Signage was also posted related to the sequence for donning PPE and how to safely remove PPE, including a gown, a mask or respirator, goggles or a face shield, and gloves. There was a three drawer cart with adequate supplies of PPE located outside the door, at the entrance to the room. However, there were no face shields or goggles observed to be in or on the supply cart. Interview on 08/04/21 at 10:23 A.M. with State tested Nurse Aide (STNA) #201, revealed they were unaware Resident #2 was on transmission-based precautions and verified they had been in the room wearing just a surgical mask and without wearing a gown, gloves, a face shield, or an N95 mask. Interview on 08/04/21 at 10:31 A.M. with Registered Nurse (RN) #506, revealed Resident #2 was admitted to the facility on [DATE] and was on transmission-based precautions as a precaution for COVID-19. RN #506 reported the PPE which was required to enter Resident #2's room consisted of a disposable gown, gloves, and an N95 mask. RN #506 was unsure whether a face shield was required to enter the room. Interview on 08/04/21 at 10:55 A.M. with STNA #202, revealed Resident #2 was a new admission on transmission-based precautions as precaution for COVID-19. STNA #202 reported PPE required to enter Resident #2's room consisted of a disposable gown, gloves and an N95 mask. STNA #202 was unsure of whether a face shield was required to enter the room. Interview with the Administrator on 08/04/21 at 11:50 A.M. revealed there was one resident, Resident #2, on transmission-based precautions as a precaution for COVID-19. The Administrator reported PPE staff should wear in this room consisted of a gown, gloves, an N95 mask, and a face shield. (continued on next page)

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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 - Many	Observation on 08/07/21 at 9:13 A.M., revealed Certified Occupational Therapy Assistant (COTA) #610 was wearing a surgical mask, sanitized her hands and entered Resident #2's room after donning a disposable gown. COTA #610 was not wearing an N95 mask, gloves, a face shield, or goggles upon entering the resident's room. Interview at 9:15 A.M. with COTA #610, verified Resident #2 was new to the facility and on precautions. She said she was unsure why Resident #2 was on precautions. COTA #610 confirmed she wore only a surgical mask and a disposable gown into Resident #2's room and did not wear an N95 mask, gloves, goggles or a face shield into the room. Observation on 08/07/21 at 9:25 A.M. revealed STNA #203 donned an N95 mask and a disposable gown prior to entering Resident #2's room. STNA #203 was not wearing gloves, goggles, or a face shield when she entered the resident's room. Interview at 9:27 A.M. with STNA #203, confirmed staff were required to wear an N95 mask, gloves, a disposable gown, and a face shield or goggles when entering Resident #2's room. STNA #203 confirmed she was not wearing the required PPE. STNA #203 said there were no face shields or gloves in the supply cart outside of the resident's room and was unsure of where she could obtain this equipment but could have asked someone. Review of facility policy, 2019 Novel Coronavirus (COVID-19), dated 01/2021, revealed all recommended PPE should be worn during the care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or disposable face shield that covers the front and sides of the face), gloves, and gown. This deficiency substantiates Complaint Numbers OH00124364 and OH00125031. This deficiency is an example of continued noncompliance from the survey dated 07/19/21.