STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365129	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastbrook Healthcare Center	17322 Euclid Ave Cleveland, OH 44112

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42013 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the shower room on the ground floor nursing unit and the north nursing unit shower room on the first floor were clean and sanitary. The facility failed to ensure call lights were working in the south nursing unit shower room on the first floor, the second floor secured unit shower room, and Resident #37, #69 and #74's room. This had the potential to affect all 82 residents residing in the facility. Findings include: 1. Interview on 09/10/21 at 10:30 A.M. of Family Member (FM) #689 revealed she was visiting an unidentified resident on 08/22/21 and walked into bathroom in the shower room on the ground floor by the vending machines and it was very dirty. FM #689 stated the shower room was a large room and there were pop cans, water bottles, paper towels and trash covering the floor. FM #689 stated the bathtub was filled with trash and dirty clothing. FM #689 began to cry and stated why do the residents have to live like this and no one should live under these conditions. Observation on 09/11/21 at 9:47 A.M. of Resident #34 in the ground floor shower room revealed he washing himself and no staff were in the room with him. Observation revealed towels, paper towels, and a bedspread was on the floor. Interview on 09/11/21 at 9:47 A.M. with Housekeeping Supervisor (HS) #655 revealed she was employed by the facility about three months ago, and was working with the staff to ensure resident rooms, common areas, and shower rooms were clean and sanitary. HS #655 stated she knew there was room for improvement, she had to work to get the cooperation of the staff, and it was not going to get better overnight because it did not get this way overnight. HS #655 revealed she arrived to the facility about five minutes ago because it was the weekend and she wanted to make sure the cleaning was proceeding the way it was supposed to. Observation on 09/11/21 at 10:00 A.M. of the ground floor shower room revealed the large tub had a used mask crumpled up inside of it, dirty paper towels, dirty jeans and a shirt, and about six or seven dirty towels in the bottom of it. There were several towels and a bedspread on the floor soaking up a moderate amount of water covering the floor. There were dirty paper towels and various other pieces of trash laying on the floor. There was a pair of dark pants laying on the floor covered in liquid brown material. The shower room had a strong unpleasant odor lingering in the air. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 09/11/21 at 10:40 A.M. of Licensed Practical Nurse (LPN) #647 confirmed the above observation. LPN #647 stated the tub should not have dirty clothes, trash and towels in it, and she would get the housekeeping staff and a State tested Nursing Assistant (STNA) to clean the room before the next resident used it. Interview on 09/11/21 at 10:42 A.M. of STNA #602 revealed she was assigned to the nursing unit the shower room was located in. STNA #602 stated the clothes, towels and trash in the tub was probably from last night, and had not been removed this morning before Resident #34 took a shower. STNA #602 did not know if the bedspread, towel, and clothing on the floor was from last night or this morning because she had not been in the shower room since she arrived for work. STNA #602 confirmed there was an odor in the room. Interview on 09/11/21 at 10:48 A.M. of Resident #34 revealed the tub had towels, trash and dirty clothes in it when he entered the room for a shower. Resident #34 stated the floor had a bedspread, towels, and trash on it when he entered the room. Resident #34 stated the dark pants on the floor covered with the brown material were his, he had an accidental bowel movement, and needed to clean himself up. Resident #34 stated everyday when he entered the shower room there were dirty linens on the floor along with trash, and the tub was filled with dirty towels, trash and clothes. HS #655 walked by and Resident #34 waved her into his room and stated she knows how dirty the shower room is everyday. HS #655 confirmed the shower room was often dirty when she went in, and stated she was working to make things better. 2. Observation on 09/11/21 at 11:02 A.M. of the first floor (north) shower room revealed a dirty pillow and slippers were inside the tub, and there were many dark streaks and drip marks running down the side of the tub and the bottom of the tub. The seat of the tub had a crusty, reddish brown material on it with bits of trash laying next to it. Interview on 09/11/21 at 11:02 A.M. of LPN #682 confirmed the above observation of the first floor (north) shower room. LPN #682 stated there should not be a dirty pillow and slippers in the tub. Interview on 09/11/21 at 11:25 A.M. of Housekeeper #657 revealed she cleaned the shower room, but did not clean the bathtub. Housekeeper #657 stated she did not think it was used by the residents and did not clean it. Housekeeper confirmed the presence of the crusty reddish brown material on the seat of the tub, the dark streaks and drip marks running down the side of the tub, and the bits of trash laying in the tub. 3. Observation on 09/11/21 at 11:05 A.M. of the first floor (south) shower room revealed the call light near the toilet had the front panel hanging from two wires, and the cord for the call light did not turn the call light on when it was pulled. Interview on 09/11/21 at 11:05 A.M. of LPN #606 confirmed the call light panel in the first floor (south) shower room was hanging from two wires and the cord did not turn the call light on when it was pulled, but if the button was pressed on the panel hanging from wires the call light could be turned on. LPN #606 stated the call light had been like this for about a month and a half and maintenance was aware it needed fixed. LPN #606 stated alert and oriented residents used this shower and were not supposed to be left alone in the room, but did not know if they were ever left alone since she did not give resident's showers. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 09/11/21 at 11:15 A.M. of STNA #683 revealed sometimes independent residents were left alone in the first floor (south) shower room, and they would call if they needed help. 4. Observation on 09/11/21 at 11:10 A.M. of the second floor secured unit shower room revealed the call light did not work at all, either when the cord was pulled or the button on the panel was pressed. Interview on 09/11/21 at 11:10 A.M. of LPN #606 confirmed the above observation. LPN #606 stated the residents were never left alone in the bathroom on the secured unit. 5. Observation on 09/11/21 at 1:30 P.M. of Resident #37 and #74's room revealed the call light did not come on when the button was pressed for both residents. Interview on 09/11/21 at 1:30 P.M. with LPN #682 confirmed Resident #37 and #74's call light did not work. 6. Observation on 09/11/21 at 1:32 P.M. of Resident #69's room revealed the call light did not work when the button was pressed. Interview on 09/11/21 at 1:32 P.M. of LPN #606 and STNA #683 confirmed Resident #69's call light did not turn on when the button was pressed. Interview on 09/11/21 at 2:02 P.M. of Resident #69 stated his call light was not working for five days, he had to scream out for help when he needed it, and that couldn't be good for him. Observation of the call light laying on the floor, out of Resident #69's reach, and he stated what does it matter, the call light does not work. Review of an email sent on 09/21/21 at 8:37 A.M. from the Administrator revealed the facility did not have a policy for cleaning the shower rooms or for call lights. This deficiency substantiates Complaint Number OH00125243.

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, medical record review, interviews with facility staff, review of facility policy, and review of American Heart Association guidelines, the facility failed to ensure a 911 call was immediately placed for Emergency Medical Services (EMS) when Resident #92 was found in his bed unresponsive and without vital signs. Cardiopulmonary Resuscitation (CPR) was initiated, but a 911 call for Emergency Medical Services (EMS) was not placed until 5:39 A.M., 39 minutes after Resident #92 was found unresponsive. The EMS crew arrived at 5:47 A.M. and at 5:54 A.M. Resident #92 was pronounced dead on arrival. This affected one resident (Resident #92) of three residents reviewed for CPR. On [DATE] at 4:51 P.M. the Administrator and [NAME] President/Administrator/Registered Nurse (VP/Administrator/RN) #684 were notified Immediate Jeopardy began on [DATE] at 5:00 A.M. when the facility failed to call 911 for 39 minutes after Resident #92 was discovered unresponsive and without vital signs in his bed. Licensed Practical Nurse (LPN) #673 entered the room at 5:00 A.M. and observed Resident #92 in his bed unresponsive and without vital signs. LPN #673 called out for Respiratory Therapist (RT) #633 to assist her. RT #633 ran to Resident #92's room and CPR was initiated. There was no indication a back board was used for CPR. LPN #673 did not activate Resident #92's call light, did not retrieve the Automated External Defibrillator (AED) or crash cart, or yell out for other staff to come to the room to assist her. State tested Nursing Assistant (STNA) #650 observed RT #633 running into Resident #92's room, did not see a call light on, did not hear calls for help, and did not enter Resident #92's room to see if there was a problem. CPR was initiated but a 911 call was not immediately placed for EMS services. LPN #673 did not call 911 until 5:39 A.M., 39 minutes after Resident #92 was found unresponsive. The EMS crew arrived at 5:47 A.M. and at 5:54 A.M. Resident #92 was pronounced dead on arrival, with observations of rigor mortis around his mouth and jaw, pupils were dilated and he was non-responsive. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective action: Beginning [DATE] all resident code statuses have been reviewed for all residents by Director of Nursing (DON) for auditing purposes. On [DATE] and [DATE], five STNA's and one RN completed a CPR certification class by Certified CPR Instructor. On [DATE], starting at 5:30 P.M., two mock code drills were completed on separate floors of the facility. One on B floor at 5:30 P.M., and one on C floor at 6:00 P.M. The Summary of Mock Code indicated all elements of the mock code were demonstrated and executed. Mock code drill conducted by DON and Administrator. On [DATE], education provided to all facility nursing staff by DON on Codes policy and procedure, including calling 911 and what to do if you're alone and have to initiate CPR. All nurses not in the facility were educated via phone. All agency staff educated prior to working at the facility. Facility staff educated: 5 RN's, 5 LPN's and 13 STNA's. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], Human Resources Director (HRD) #640 and the Administrator audited current nursing staff for CPR certification and any uncertified nurses were removed from the schedule until certification is obtained. On [DATE], a mock code drill conducted by DON and Administrator on night shift at 6:00 A.M. Mock code [NAME] to be completed three times a week for four weeks with random mock code drill thereafter to be completed by DON or designee. All real codes will be reviewed by the DON to ensure code ran accordingly. Education to follow as needed and mock code [NAME] increased if needed by DON or designee. HRD #640 or designee will verify CPR certification upon hire and audit HR files weekly for four weeks, and randomly thereafter to ensure certifications are current. Results of audits will be reviewed in Monthly QAA meeting. Although the Immediate Jeopardy was removed on [DATE], the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure continued compliance. Findings include: Review of Resident #92's medical record revealed an admitted [DATE] and diagnoses included acute and chronic respiratory failure, tracheostomy, and quadriplegia. Review of Resident #92's Minimum Data Set (MDS) 3.0 assessment, dated [DATE], revealed the resident was cognitively intact. Resident #92 was totally dependent on and required the assistance of two staff for bed mobility, transfers, toilet use, and personal hygiene. Review of Resident #92's care plan included the resident had chosen Full Code measures and CPR would be initiated during cardiac/pulmonary arrest. The care plan included resident choices would be honored through the next review date on [DATE]. Interventions revealed to initiate 911, provide full resuscitative measures and verify resident choice quarterly. Review of Resident #92's progress notes written on [DATE] at 7:47 A.M. revealed LPN #673 entered Resident #92's room at 5:00 A.M. and found him unresponsive. LPN #673 immediately called Respiratory Therapist (RT) #633 for assistance, 911 was called (time not specified) and compressions started. CPR was continued until the ambulance arrived. There was no indication a back board was used. The note stated CPR was unsuccessful and Resident #92 was pronounced dead at 5:45 A.M. The family and Administrator were notified, and Resident #92's physician and nurse practitioner were unable to be contacted. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #92's EMS Patient Care Report revealed on [DATE] at 5:39 A.M. a call was received for a Cardiac/Respiratory Arrest. The EMS crew was dispatched and arrived on scene at 5:47 A.M., was at the patient at 5:51 A.M., and the outcome was Resident #92 was dead on arrival. Further review of the report revealed Resident #92 was found unresponsive, pulseless, apneic, laying supine with a staff member performing CPR. Resident #92 was last seen approximately 3:00 A.M. when he was suctioned. Staff stated they checked on Resident #92 at approximately 5:40 A.M. and the resident would not respond. Staff stated Resident #92 was found in cardiac arrest, CPR was started, and 911 was called. Resident #92 had a history of quadriplegia from a cervical spine injury, and respiratory failure with a tracheostomy. A heart monitor was placed, and asystole (no heartbeat) was confirmed, skin was pale, cool, and dry, onset of rigor mortis around mouth and jaw, pupils were dilated and non-reactive. Resident #92 was pronounced dead on arrival at 5:54 A.M. and left in the care of the nursing home staff. Review of Respiratory Therapist's (RT) #633 statement written on [DATE] revealed Resident #92 activated his call light at 3:45 A.M. because he wanted to be suctioned, then went back to sleep. The statement revealed at 5:00 A.M. LPN #673 had RT #633 come to Resident #92's room because she felt something was wrong. Resident #92 had no pulse, the nurse left the room to call 911 (time not specified), and RT #633 assembled the oxygen equipment and began to manually administer oxygen to the resident until the paramedics arrived at around 5:40 A.M. Review of LPN #673's statement undated, stated at 3:00 A.M. Resident #92 asked for pain medication, was told it was too soon for him to receive it, and she would give it to him between 5:00 A.M. and 6:00 A.M. The statement included LPN #673 entered Resident #92's room at 5:00 A.M. and the resident was unresponsive. RT #633 was called to help, 911 was called (time not specified), and CPR was initiated and continued until the ambulance arrived. CPR was unsuccessful and Resident #92's mother was notified. There was no indication a back board was used for CPR. Review of Resident #92's Code Blue Bedside Documentation for [DATE] included CPR was initiated at 5:05 A.M. by LPN #673 and RT #633, the arrest was unwitnessed, the time of the 911 call was not recorded, absence of vital signs was recorded at 5:00 A.M. and 5:05 A.M., CPR was ongoing, and no pulse established. RT #633 administered oxygen via an Ambu (self-inflating bag) bag through Resident #92's tracheostomy. The documentation revealed EMS arrived at 5:40 A.M. and the code was called by EMS/emergency room physician at approximately 6:00 A.M. The time of death was not recorded, and Resident #92's physician and family were notified. Observation on [DATE] at 12:00 P.M. of the nursing unit Resident #92 resided on, revealed Resident #92's room was directly across from the nurse's station, only a few steps away. An AED was located in a clear case attached to the wall inside the nurse's station. A crash cart was located to the right of Resident #92's room along the side of the hall. Interview on [DATE] at 3:42 P.M. with LPN #673 revealed Resident #92 asked her for pain medication around 3:00 A.M., it was too early for him to receive pain medication, and she told him she would give him his pain medication at 5:00 A.M. LPN #673 stated at 5:00 A.M. she entered Resident #92's room to give the pain medication, noticed his color was off, shook him, called his name but he did not respond. LPN #673 stated she called out for RT #633 to assist her because she knew RT #633 was close to Resident #92's room. LPN #673 stated CPR was initiated when RT #633 entered the room, and 911 was called (time not specified) when RT #633 was bagging (administering oxygen through his tracheostomy) the resident. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 7:30 A.M. and 12:39 P.M. with LPN #673 revealed she was sure she entered Resident #92's room at 5:00 A.M. because she started her med pass at 5:00 A.M., and she made sure he was the first resident to have medications administered because she knew he wanted pain medication. LPN #673 stated CPR was initiated, continued for 45 minutes, and it was around 5:30 A.M. to 5:45 A.M. when 911 was called. LPN #673 stated we worked on him awhile before 911 was called. LPN #673 stated there was another nurse assigned to the nursing unit, but she left work early and was not available to help. LPN #673 stated she did not activate the call light and did not bring the AED and crash cart to the room. LPN #673 stated she panicked and did not call for the STNA to assist her. LPN #673 stated the STNA's were on the other hall providing resident care and would not be able to help. LPN #673 stated she and RT #633 took turns providing chest compressions until EMS arrived. There was no indication a back board was used during the chest compressions. Interview on [DATE] at 6:12 P.M. with RT #633 revealed she was sure it was 5:00 A.M. when LPN #673 called her to assist in Resident #92's room because she wore a watch and looked at the time. RT #633 stated the time was 5:00 A.M., that was the time she started her rounds, and she was getting ready to start her rounds when she was called into Resident #92's room. RT #633 stated when she entered Resident #92's room, he was unresponsive, and CPR was started. Interview on [DATE] at 2:45 P.M. with STNA #650 revealed on [DATE] she was working on the nursing unit Resident #92 resided on, but his room was not part of her assignment. STNA #650 stated she did not hear LPN #673 scream for RT #633 to help her in Resident #92's room, but she saw RT #633 running into the room. STNA #650 stated she did not know if RT #633 saw her, but RT #633 did not say anything was wrong or call out for help. STNA #650 stated she did not know anything was wrong and did not go in Resident #92's room to see if RT #633 needed assistance. STNA #650 stated she continued providing care for the residents on her assignment. Interview on [DATE] at 2:32 P.M. with the Administrator and the DON revealed although there were no identified problems with how the code was conducted on [DATE] an education on cardiac/respiratory arrest was conducted on [DATE]. The Administrator and DON stated they were not aware a 911 call was not placed for 39 minutes after Resident #92 was found unresponsive on [DATE] at 5:00 A.M. Review of the facility Cardiopulmonary Resuscitation (CPR) certifications revealed the facility was unable to provide evidence LPN #673 (involved in Resident #92's cardiac/respiratory arrest) was certified in CPR. Review of the facility Cardiopulmonary Resuscitation (CPR) certifications revealed Registered Nurse (RN) #630, and Licensed Practical Nurse's (LPN) #647 and #676 had online certification only and did not have hands-on skills assessment as part of their certification. Review of the facility Cardiopulmonary Resuscitation (CPR) certifications revealed the facility was unable to provide evidence LPN #608 was certified in CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 8:40 A.M. with Human Resources Director (HRD) #640 revealed it was the nurse's responsibility to make sure their CPR certification was renewed. HRD #640 stated she was new to the facility in ,d+[DATE] and had a lot of things to catch up on. HRD #640 stated when nurses were hired, she asked for their CPR certification card to make a copy of it for their file, but she was not always able to get it because the nurse's said they had a hard time getting the card from their CPR instructor. HRD #640 stated from now on she would make sure CPR certifications were up to date. HRD #640 stated LPN #673 was newly hired in , d+[DATE] but her employee file did not contain evidence of CPR certification. Interview on [DATE] at 12:00 P.M. with the DON and Administrator confirmed RN #630 and LPN's #647 and #676 had online CPR certification only and did not have hands-on skills assessment. The DON and Administrator confirmed there was no evidence of CPR certification for LPN's #608 and #673. Review of a facility in-service titled, Mock Code Blue Survey, dated [DATE] and [DATE] included steps to assess resident, check scene, call 911, check pulse, crash cart, AED, chest compressions, and notify nursing management and the Administrator. The code checklist included crash cart obtained, 911 called, AED used, and backboard utilized. Review of the facility policy titled Emergency Procedure-Cardiopulmonary Resuscitation, revised, ,d+[DATE], included Policy Statement: Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. The policy further included if an individual was found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest was likely, begin CPR and instruct a staff member to activate the emergency response system and call 911, verify or instruct a staff member to verify the DNR or code status of the individual, and initiate the basic life support (BLS) sequence of events. Review of American Heart Association guidelines, dated [DATE], included Part 5: Adult Basic Life Support 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Basic Life Support (BLS) was the foundation for saving lives following cardiac arrest. Fundamental aspects of BLS include immediate recognition of sudden cardiac arrest (SCA) and activation of the emergency response system, early cardiopulmonary resuscitation, and rapid defibrillation with an AED. The guidelines included a core set of actions provides a universal strategy for achieving successful resuscitation. These actions were termed links in the chain of survival. For adults they include, immediate recognition of cardiac arrest and activation of the emergency response system, early CPR that emphasizes chest compressions, rapid defibrillation if indicated, effective advanced life support, and integrated post-cardiac arrest care. This deficiency substantiates Complaint Number OH00125661.

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F 0684 Level of Harm - Minimal harm or potential for 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** 42013 Based on interview, record review, and review of the facility policy, the facility failed to ensure prompt and appropriate care and services were provided for Resident #91's right hand wound. This affected one resident (Resident #91) out of three residents reviewed for physician orders and appropriate care and services. Findings include: Review of Resident #91's medical record revealed an admitted [DATE] and diagnoses included sepsis, end stage renal disease, type two diabetes mellitus, and peripheral vascular disease. Review of Resident #91's Minimum Data Set (MDS) 3.0 assessment, dated 07/21/21, revealed the resident was cognitively intact. Further review revealed Resident #91 was totally dependent and required two staff to assist with bed mobility and transfers. Resident #91 was totally dependent and required one staff for assistance with activities of daily living. Review of Resident #91's care plan, revised 09/01/21, revealed resident had actual impairment to skin integrity including partial thickness wound present at the webspace of fifth and fourth metacarpals of right hand. Interventions included to monitor weekly and document location, size, treatment of skin injury, report abnormalities, failure to heal, and report signs and symptoms of infection. Review of Resident #91's Wound Evaluation Flow Sheet on 07/15/21 for right hand web space of fifth and fourth metacarpal (long slender bones which connect the wrist to the fingers), revealed the wound was acquired in-house. The flow sheet revealed the wound measured a length 1.5 centimeters (cm), width 1 cm, and depth 0.1 cm. The flow sheet documented mild edema, erythema, a pain intensity of three, 100 percent slough (yellow, tan dead tissue), and Resident #91 was in dialysis and was not seen by the Wound Nurse Practitioner. There was no documentation of odor or drainage. There was no documentation MD #681 was notified of mild edema, erythema, and pain intensity of three. Review of Resident #91's physician orders written on 07/19/21 at 5:29 P.M. by Medical Doctor (MD) #681 revealed to give Doxycycline Hyclate tablet 100 mg by mouth two times a day for infection for ten days. Review of Resident #91's progress notes on 07/19/21 at 5:33 P.M. written by Registered Nurse (RN) #685 revealed Medical Doctor (MD) #681 was notified of a suspected right hand wound infection. The note stated the right hand wound had swelling, redness, warmth, and odor, and Resident #91 complained of pain and discomfort. The note further stated the dressing was changed and intact, a new order was received to culture the wound upon the next scheduled dressing change and start Doxycycline 100 mg (antibiotic by mouth) for ten days. The unit nurse (unidentified) was made aware. Review of Resident #91's progress notes on 07/19/21 at 10:24 P.M. written by Licensed Practical Nurse (LPN) #686 revealed Doxycycline Hyclate 100 mg, give one tablet by mouth two times a day for infection for 10 days was not given and was en route to the facility. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Inventory Replenishment report on 07/13/21 revealed Doxycycline Hyclate 100 mg was available in the facility automated dispensing cabinet. Review of Resident #91's Medication Administration Record (MAR) on 07/19/21 revealed an order discontinued on 07/19/21 for Doxycycline Hyclate 100 mg tablet to be given by mouth two times a day for infection for ten days. Review of Resident #91's physician orders revealed an order electronically transmitted from the pharmacy on 07/19/21 at 11:22 P.M. written by MD #681 stating to give Doxycycline Monohydrate 100 mg capsule by mouth two times a day for right hand infection until 07/29/21 for ten days. Review of Resident 91's medical record from 07/19/21 through 07/28/21 did not reveal documentation why the antibiotic order for Doxycycline Hyclate 100 mg was changed to Doxycycline Monohydrate 100 mg when Doxycycline Hyclate 100 mg was available in the facility automated medication dispensing cabinet and could be started right away. The facility was unable to provide documentation from the pharmacy regarding the reason for the change. Review of Resident #91's medical record revealed a right hand wound culture was not ordered or collected on 07/19/21. Review of Resident #91's Pharmacy Delivery Manifest on 07/20/21 at 8:23 A.M. revealed Doxycycline Monohydrate 100 mg capsules were delivered to the facility. Review of Resident #91's lab report for a wound culture with no site documented, collected on 07/20/21 at 5:00 P.M. revealed heavy growth of escherichia coli (bacteria found in human feces), morganella morgani ((bacteria found in feces of humans), and enterococcus faecalis (bacteria found in human feces). Further review of the culture revealed many gram negative bacilli, many gram positive bacilli, many gram positive cocci in pairs and chanins. Review of Resident #91's MAR revealed starting on 07/22/21 at 7:00 A.M. the resident began Doxycycline Monohydrate 100 mg capsule by mouth two times a day for right hand infection until 07/29/21 for ten days (ten days would be 08/01/21). The antibiotic was started three days after it was ordered on 07/19/21. Review of Resident #91's Wound Evaluation Flow Sheet on 07/22/21 for right hand web space of fifth and fourth metacarpal revealed the wound measured a length of 2.3 cm, width 2 cm, and depth 0.1 cm. The documentation revealed the wound was warm and painful to touch, was edematous, erythematous, had minor malodorous odor, 100 percent markable eschar (black, brown dead tissue that shreds or falls off from the skin). The flow sheet stated on 07/20/21 Doxycycline 100 mg was administered two times a day for ten days, which was inaccurate. Review of Resident #91's Wound Evaluation Flow Sheet on 07/22/21 revealed a new wound for right hand lateral proximal to fifth digit. The wound was a bruise and was acquired in-house and measured a length of 5. 8 cm, width 3.2 cm, depth 0.1 cm, and the skin was intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #91's antibiotic timeline provided by the facility included on 07/19/21 at 5:31 P.M. Doxycycline Hyclate 100 mg was ordered by MD #681, and at 5:33 P.M. a progress note was written regarding obtaining a wound culture and administering antibiotics. The timeline included on 07/19/21 at 11:25 P.M. the Doxycycline Hyclate 100 mg was discontinued by the pharmacist and a new order for Doxycycline Monohydrate 100 mg as a pharmacy interchange was written pending MD #681's approval. Pharmacy delivered Doxycycline Monohydrate 100 mg on 07/20/21 at 12:23 P.M. The antibiotic was not started because the right hand wound culture was not obtained, and the culture was not obtained on 07/19/21 due to Santyl ointment (used to remove dead tissue from wounds to promote healing) was in the wound bed and a good culture was unable to be collected. The wound culture was obtained 07/20/21 on night shift. The Doxycycline Monohydrate 100 mg was not confirmed on 07/21/21 by MD #681 and was not started until 07/22/21 at 9:36 A.M. after MD #681's confirmation. Review of Resident #91's progress notes by RN #685 on 07/28/21 at 8:56 P.M. revealed suspected worsening of right hand wound, Doxycycline was given since 07/22/21, and resident had increased lethargy, decreased appetite, significant right hand swelling, warmth and pain. MD #681 was notified and stat (immediate) bloodwork including a complete blood count (CBC) was ordered and results included white blood cells were elevated 20.7 (normal 3.7 to 11,000 per microliter). Resident #91 was transported to the local emergency department for evaluation. Review of Resident #91's progress notes on 07/29/21 at 11:09 A.M. written by RN #622 revealed Resident #91 was transported from the local hospital to the local hospital main campus and was in the surgical intensive care unit (SICU). Resident #91 was status post amputation of a phalange for necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin). Review of Resident #91's local hospital note on 07/29/21 included Resident #91 presented with right hand necrotizing fasciitis, had a surgical procedure for incision and drainage of dorsal hand abscess, index finger amputation, right upper extremity exploration and fasciotomies (limb-saving procedure). Resident #91 was transported to the surgical intensive care unit (SICU) to be monitored postoperatively for low blood pressure and a fever. Interview on 09/09/21 at 3:34 P.M. of the Director of Nursing (DON) revealed she did not know why Doxycycline Hyclate 100 mg for Resident #91 was not started on 07/19/21. The DON stated Doxycycline Hyclate 100 mg was immediately available in the automated medication dispensing cabinet in the facility. The DON stated there might have been a therapeutic interchange. Interview on 09/09/21 at 2:35 P.M. of Family Member (FM) #687 revealed Resident #91 had a right hand wound for quite a few months. FM #687 was not sure when Resident #91 first developed the wound, but thought it was in January 2021. FM #687 stated she called the DON, the Administrator, and RN #685 sometime in May to discuss Resident #91's hand wound but did not receive return phone calls. FM #687 stated at the end of July Resident #91 was delirious and was sent to the hospital and needed to have her index finger amputated, and the surgeon told her it was one of the worst infections he had seen in a long time. A few weeks later Resident #91 needed to have her arm amputated from the elbow down. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/10/21 at 9:34 A.M. of Nurse Practitioner (NP) #601 revealed she was not called about Resident #91's right hand infection, did not order antibiotics or a wound culture for her, and was not called to clarify antibiotic orders or wound culture orders. NP #601 stated she did not know why the antibiotics were ordered on 07/19/21 and not administered until 07/22/21 because the facility nurse should call her or Medical Doctor (MD) #681 to clarify the orders if there were any questions. NP #601 stated a long wait before antibiotics were started could lead to sepsis. NP #601 stated if a wound looked nasty, had drainage and an odor the wound culture should be obtained right away, worry about the dressing after the culture was taken, and start the antibiotics. NP #601 stated Santyl ointment (removed dead tissue from wounds so they could heal) was not an antibiotic and should not delay obtaining a wound culture. NP #601 stated she was not called by any facility staff for guidance related to obtaining a wound culture when Santyl ointment was used. Interview on 09/10/21 at 10:30 A.M. of MD #681 revealed Resident #91's right hand wound had been a continuing problem for quite a few months. MD #681 stated it would open up, would be healed, then would open up again. MD #681 stated Resident #91 was transported to the local hospital at the end of July and had a finger amputated, the wound progressively deteriorated and recently she had a partial forearm amputation. MD #681 stated July was a while ago, and he did not remember receiving a call from the facility about Resident #91's right hand. MD #681 revealed he did not remember ordering Doxycycline (antibiotic) on 07/19/21, or a wound culture for Resident #91. MD #681 stated it should not take three days to start antibiotics when they were ordered, and if there was a change in the Doxycycline order by pharmacy it was a minor change. MD #681 stated if facility staff needed clarification regarding the order it would be a simple matter to adjust the medication, and he or NP #601 should have been called to clarify the order. MD #681 stated he was not called by any facility staff for guidance to obtain a wound culture if Santyl ointment was used for dressing changes. MD #681 confirmed it should not take long to get a wound culture. Interview on 09/13/21 at 2:30 P.M. of the Administrator and the DON confirmed there was no order for a right hand wound culture in the hard chart or the electronic record. The Administrator stated RN #685 was no longer an employee of the facility and was not available be interviewed. Review of the facility policy titled, Administering Medications, undated, included medications were administered in a safe and timely manner, and as prescribed. The policy included medications were administered in accordance with the prescriber orders, including any required time frame. This deficiency substantiates Complaint Number OH00125344 and Complaint Number OH00125317.

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F 0686 Level of Harm - 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** 42013 Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure appropriate care and services were provided for one resident (Resident #37) to prevent a deep tissue injury to the left plantar foot. Actual harm occurred when care planned interventions were not implemented, physician orders were not followed, and a pressure injury to Resident #37's foot was not treated or documented before it was identified as an unstageable deep tissue injury. This affected one resident (Resident #37) out of three residents reviewed for pressure injury. Findings include: Review of Resident #37's medical record revealed an admitted [DATE] and diagnoses included schizoaffective disorder, bipolar type, type two diabetes mellitus, and severe protein-calorie malnutrition. Review of Resident #37's care plan, dated 06/21/21, revealed the resident had actual impairment to skin integrity related to Stage 3 decubitus ulcer of left calcaneous, and Resident #37 would maintain or develop clean and intact skin through the review date of 09/19/21. Interventions included to encourage Resident #37 to comply with turning side to side and document non-compliance, head to toe skin assessments to be performed weekly on shower days by the nurse, and document and report new areas to the physician, wound nurse, and dietician, notify physician of any redness, and observe for skin injury on shower days and while performing care. Review of Resident #37's physician orders on 07/13/21 revealed an order for head to toe skin assessments and documentation weekly in the electronic record. Document skin assessments and shower refusals with progress notes. Review of Resident #37's Braden Scale Assessment for Predicting Pressure Sore Risk, dated 08/05/21, revealed resident was at a moderate risk for developing pressure ulcer injury. The assessment included Resident #37 was bedfast and confined to his bed, was completely immobile and did not make even slight changes in body or extremity position without assistance. Resident #37 required moderate to maximum assistance in moving, and complete lifting without sliding against sheets was impossible. The assessment revealed Resident #37 frequently slid down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation led to almost constant friction. Review of Resident #37's Minimum Data Set (MDS) 3.0 assessment, dated 08/19/21, revealed the resident had moderate cognitive impairment. The assessment revealed Resident #37 required extensive assistance of two staff for bed mobility and transfers, was at risk for developing a pressure ulcer injury, and had one or more unhealed pressure ulcers. Review of Resident #37's wound round notes on 08/04/21, 08/12/21, 08/17/21, 08/26/21 revealed the resident had a Stage 3 decubitus pressure ulcer of left calcaneous (heel). Resident #37's feet were noted to be wrapped and padded and elevated by pillow. The notes included a plan to keep heels elevated off of the bed with foam padding and pillows (the plan was highlighted in big, bold, black letters). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #37's physician orders revealed an order for a left heel dressing on 08/20/21 to cleanse the left heel with normal saline, pat dry, apply xeroform to wound base, cover with an abdominal dressing (ABD) and wrap with kerlix daily and as needed in the morning every Monday, Wednesday and Friday for wound management. There were no orders to elevate the resident's heels. Review of Resident #37's left heel wound round assessment, dated 08/26/21, revealed daily dressing changes were recommended. The medical record contained no evidence the daily dressing change recommendation was addressed. Observation on 09/09/21 at 10:16 A.M. of Resident #37 revealed the resident's heels were elevated by a pillow but not by foam padding. Observation of Wound Physician Assistant (PA) #688 and DON completing Resident #37's left foot dressing for Stage 3 decubitus ulcer of left calcaneous revealed the dressing being changed was dated 09/02/21. Removal of the dressing revealed a Stage 3 decubitus ulcer of left calcaneous and a new deep tissue injury of left plantar foot (sole of foot). The left plantar foot was deep purple in color, black around the edge and did not blanche. Wound PA #688 measured the injury and length was 3 cm, width 1.5 cm, depth unable to be measured. Review of Resident #37's Treatment Administration Record (TAR) revealed a left heel dressing change was not documented as completed on 09/03/21 or 09/06/21. It was documented the dressing change was completed on 09/08/21, however observation revealed the dressing was not changed since 09/02/21. Review of Resident #37's medical record from 06/21/21 through 09/09/21 did not reveal documentation Resident #37's heels were elevated or evidence of a deep tissue injury to the left plantar foot. Review of Resident #37's assessments from 08/10/21 through 09/09/21 revealed a weekly skin assessment on 08/10/21 and no further weekly skin assessments were documented. Review of Resident #37's progress notes from 08/20/21 through 09/09/21 did not reveal Resident #37 declined to be turned side to side, declined showers, or declined weekly skin assessments. Review of Resident #37's Wound Round documentation by Wound Physician Assistant (PA) #688 on 08/04/21, 08/12/21, 08/17/21 and 08/26/21 did not reveal documentation of a deep tissue injury of left plantar foot. Review of Resident #37's wound round documentation on 09/02/21 did not reveal documentation of a deep tissue injury to the left plantar foot. Review of Resident #37's Wound Round documentation on 09/09/21 revealed the resident has a pressure induced deep tissue injury of left plantar foot. The measurements were length 3 centimeters (cm), width 1.5 cm, and depth was unable to be determined. The documentation revealed skin was deep purple, non-blanchable, no surrounding redness or swelling and no break in skin. Review of Resident #37's left heel wound round assessment, dated 09/09/21, revealed daily dressing changes were recommended. The medical record contained no evidence the daily dressing change recommendation was addressed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/22/21 at 9:42 A.M. with the Director of Nursing (DON) revealed Wound Nurse (WN) #632 managed all resident wounds, including documentation and communications with the physician. The DON did not know why the dressing changes were recommended daily. The DON stated WN #632 resigned on 09/09/21 and since her resignation the DON was managing the wounds. The DON stated her observations of Resident #37's wound did not reveal dressing changes should be done daily, three times a week were sufficient, but she would investigate the progress notes recommending daily changes. Interview on 09/09/21 at 10:16 A.M. with Wound PA #688 revealed the deep tissue injury to Resident #37's left plantar foot was not there two weeks ago when she did wound rounds. Wound PA #688 stated she did not do wound rounds on 09/02/21 and the last wound rounds were 08/26/21. Wound PA #688 was standing near the foot of the bed, patted the footboard and stated Resident #37's deep tissue injury of the left plantar foot was caused by the pressure of his foot against the footboard. Interview on 09/09/21 at 10:16 A.M. with the DON confirmed the dressing on Resident #37's left foot was dated 09/02/21. Interview on 09/09/21 at 3:45 P.M. with State tested Nursing Assistant (STNA) #683 revealed she worked second shift and was usually assigned to the nursing unit Resident #37 resided on. STNA #683 stated Resident #37 tended to slide down in bed with his feet pressing against the footboard, she did not like to see him in that position and would pull him up in bed when she noticed it. STNA #683 stated this happened often. STNA #683 stated Resident #37 had dressings on his feet, the nurse did the dressing changes, and she could not see his feet when she assisted him with his care. Review of the facility policy titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised 04/2018 included the nursing staff will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on interview, record review and review of the facility policy the facility failed to ensure medications were administered per physician orders. This affected one resident (Resident #91) out of three residents reviewed for physician orders. Findings include: Review of Resident #91's medical record revealed an admitted [DATE] and diagnoses included sepsis, end stage renal disease, type two diabetes mellitus, and peripheral vascular disease. Review of Resident #91's Minimum Data Set (MDS) 3.0 assessment, dated 07/21/21, revealed the resident was cognitively intact. Further review revealed Resident #91 was totally dependent and required two staff to assist with bed mobility and transfers. Resident #91 was totally dependent and required one staff for assistance with activities of daily living. Review of Resident #91's care plan, revised 09/01/21, revealed resident had actual impairment to skin integrity including partial thickness wound present at the webspace of fifth and fourth metacarpals of right hand. Interventions included to monitor weekly and document location, size, treatment of skin injury, report abnormalities, failure to heal, and report signs and symptoms of infection. Review of Resident #91's Wound Evaluation Flow Sheet on 07/15/21 for right hand web space of fifth and fourth metacarpal (long slender bones which connect the wrist to the fingers), revealed the wound was acquired in-house. The flow sheet revealed the wound measured a length 1.5 centimeters (cm), width 1 cm, and depth 0.1 cm. The flow sheet documented mild edema, erythema, a pain intensity of three, 100 percent slough (yellow, tan dead tissue), and Resident #91 was in dialysis and was not seen by the Wound Nurse Practitioner. There was no documentation of odor or drainage. There was no documentation MD #681 was notified of mild edema, erythema, and pain intensity of three. Review of Resident #91's physician orders written on 07/19/21 at 5:29 P.M. by Medical Doctor (MD) #681 revealed to give Doxycycline Hyclate tablet 100 mg by mouth two times a day for infection for ten days. Review of Resident #91's progress notes on 07/19/21 at 5:33 P.M. written by Registered Nurse (RN) #685 revealed Medical Doctor (MD) #681 was notified of a suspected right hand wound infection. The note stated the right hand wound had swelling, redness, warmth, and odor, and Resident #91 complained of pain and discomfort. The note further stated the dressing was changed and intact, a new order was received to culture the wound upon the next scheduled dressing change and start Doxycycline 100 mg (antibiotic by mouth) for ten days. The unit nurse (unidentified) was made aware. Review of Resident #91's progress notes on 07/19/21 at 10:24 P.M. written by Licensed Practical Nurse (LPN) #686 revealed Doxycycline Hyclate 100 mg, give one tablet by mouth two times a day for infection for 10 days was not given and was en route to the facility. Review of the Inventory Replenishment report on 07/13/21 revealed Doxycycline Hyclate 100 mg was available in the facility automated dispensing cabinet. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #91's Medication Administration Record (MAR) on 07/19/21 revealed an order discontinued on 07/19/21 for Doxycycline Hyclate 100 mg tablet to be given by mouth two times a day for infection for ten days. Review of Resident #91's physician orders revealed an order electronically transmitted from the pharmacy on 07/19/21 at 11:22 P.M. written by MD #681 stating to give Doxycycline Monohydrate 100 mg capsule by mouth two times a day for right hand infection until 07/29/21 for ten days. Review of Resident 91's medical record from 07/19/21 through 07/28/21 did not reveal documentation why the antibiotic order for Doxycycline Hyclate 100 mg was changed to Doxycycline Monohydrate 100 mg when Doxycycline Hyclate 100 mg was available in the facility automated medication dispensing cabinet and could be started right away. The facility was unable to provide documentation from the pharmacy regarding the reason for the change. Review of Resident #91's medical record revealed a right hand wound culture was not ordered or collected on 07/19/21. Review of Resident #91's Pharmacy Delivery Manifest on 07/20/21 at 8:23 A.M. revealed Doxycycline Monohydrate 100 mg capsules were delivered to the facility. Review of Resident #91's lab report for a wound culture with no site documented, collected on 07/20/21 at 5:00 P.M. revealed heavy growth of escherichia coli (bacteria found in human feces), morganella morgani ((bacteria found in feces of humans), and enterococcus faecalis (bacteria found in human feces). Further review of the culture revealed many gram negative bacilli, many gram positive bacilli, many gram positive cocci in pairs and chanins. Review of Resident #91's MAR revealed starting on 07/22/21 at 7:00 A.M. the resident began Doxycycline Monohydrate 100 mg capsule by mouth two times a day for right hand infection until 07/29/21 for ten days (ten days would be 08/01/21). The antibiotic was started three days after it was ordered on 07/19/21. Review of Resident #91's Wound Evaluation Flow Sheet on 07/22/21 for right hand web space of fifth and fourth metacarpal revealed the wound measured a length of 2.3 cm, width 2 cm, and depth 0.1 cm. The documentation revealed the wound was warm and painful to touch, was edematous, erythematous, had minor malodorous odor, 100 percent markable eschar (black, brown dead tissue that shreds or falls off from the skin). The flow sheet stated on 07/20/21 Doxycycline 100 mg was administered two times a day for ten days, which was inaccurate. Review of Resident #91's Wound Evaluation Flow Sheet on 07/22/21 revealed a new wound for right hand lateral proximal to fifth digit. The wound was a bruise and was acquired in-house and measured a length of 5. 8 cm, width 3.2 cm, depth 0.1 cm, and the skin was intact. (continued on next page)

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Eastbrook Healthcare Center	17322 Euclid Ave Cleveland, OH 44112

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #91's antibiotic timeline provided by the facility included on 07/19/21 at 5:31 P.M. Doxycycline Hyclate 100 mg was ordered by MD #681, and at 5:33 P.M. a progress note was written regarding obtaining a wound culture and administering antibiotics. The timeline included on 07/19/21 at 11:25 P.M. the Doxycycline Hyclate 100 mg was discontinued by the pharmacist and a new order for Doxycycline Monohydrate 100 mg as a pharmacy interchange was written pending MD #681's approval. Pharmacy delivered Doxycycline Monohydrate 100 mg on 07/20/21 at 12:23 P.M. The antibiotic was not started because the right hand wound culture was not obtained, and the culture was not obtained on 07/19/21 due to Santyl ointment (used to remove dead tissue from wounds to promote healing) was in the wound bed and a good culture was unable to be collected. The wound culture was obtained 07/20/21 on night shift. The Doxycycline Monohydrate 100 mg was not confirmed on 07/21/21 by MD #681 and was not started until 07/22/21 at 9:36 A.M. after MD #681's confirmation. Review of Resident #91's progress notes by RN #685 on 07/28/21 at 8:56 P.M. revealed suspected worsening of right hand wound, Doxycycline was given since 07/22/21, and resident had increased lethargy, decreased appetite, significant right hand swelling, warmth and pain. MD #681 was notified and stat (immediate) bloodwork including a complete blood count (CBC) was ordered and results included white blood cells were elevated 20.7 (normal 3.7 to 11,000 per microliter). Resident #91 was transported to the local emergency department for evaluation. Review of Resident #91's progress notes on 07/29/21 at 11:09 A.M. written by RN #622 revealed Resident #91 was transported from the local hospital to the local hospital main campus and was in the surgical intensive care unit (SICU). Resident #91 was status post amputation of a phalange for necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin). Review of Resident #91's local hospital note on 07/29/21 included Resident #91 presented with right hand necrotizing fasciitis, had a surgical procedure for incision and drainage of dorsal hand abscess, index finger amputation, right upper extremity exploration and fasciotomies (limb-saving procedure). Resident #91 was transported to the surgical intensive care unit (SICU) to be monitored postoperatively for low blood pressure and a fever. Interview on 09/09/21 at 3:34 P.M. of the Director of Nursing (DON) revealed she did not know why Doxycycline Hyclate 100 mg for Resident #91 was not started on 07/19/21. The DON stated Doxycycline Hyclate 100 mg was immediately available in the automated medication dispensing cabinet in the facility. The DON stated there might have been a therapeutic interchange. Interview on 09/09/21 at 2:35 P.M. of Family Member (FM) #687 revealed Resident #91 had a right hand wound for quite a few months. FM #687 was not sure when Resident #91 first developed the wound, but thought it was in January 2021. FM #687 stated she called the DON, the Administrator, and RN #685 sometime in May to discuss Resident #91's hand wound but did not receive return phone calls. FM #687 stated at the end of July Resident #91 was delirious and was sent to the hospital and needed to have her index finger amputated, and the surgeon told her it was one of the worst infections he had seen in a long time. A few weeks later Resident #91 needed to have her arm amputated from the elbow down. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/10/21 at 9:34 A.M. of Nurse Practitioner (NP) #601 revealed she was not called about Resident #91's right hand infection, did not order antibiotics or a wound culture for her, and was not called to clarify antibiotic orders or wound culture orders. NP #601 stated she did not know why the antibiotics were ordered on 07/19/21 and not administered until 07/22/21 because the facility nurse should call her or Medical Doctor (MD) #681 to clarify the orders if there were any questions. NP #601 stated a long wait before antibiotics were started could lead to sepsis. NP #601 stated if a wound looked nasty, had drainage and an odor the wound culture should be obtained right away, worry about the dressing after the culture was taken, and start the antibiotics. NP #601 stated Santyl ointment (removed dead tissue from wounds so they could heal) was not an antibiotic and should not delay obtaining a wound culture. NP #601 stated she was not called by any facility staff for guidance related to obtaining a wound culture when Santyl ointment was used. Interview on 09/10/21 at 10:30 A.M. of MD #681 revealed Resident #91's right hand wound had been a continuing problem for quite a few months. MD #681 stated it would open up, would be healed, then would open up again. MD #681 stated Resident #91 was transported to the local hospital at the end of July and had a finger amputated, the wound progressively deteriorated and recently she had a partial forearm amputation. MD #681 stated July was a while ago, and he did not remember receiving a call from the facility on 07/19/21 about Resident #91's right hand. MD #681 revealed he did not remember ordering Doxycycline (antibiotic) on 07/19/21, or a wound culture for Resident #91. MD #681 stated it should not take three days to start antibiotics when they were ordered, and if there was a change in the Doxycycline order by pharmacy it was a minor change. MD #681 stated if facility staff needed clarification regarding the order it would be a simple matter to adjust the medication, and he or NP #601 should have been called to clarify the order. MD #681 stated he was not called by any facility staff for guidance to obtain a wound culture if Santyl ointment was used for dressing changes. MD #681 confirmed it should not take long to get a wound culture. Interview on 09/13/21 at 2:30 P.M. of the Administrator and the DON confirmed there was no order for a right hand wound culture in the hard chart or the electronic record. Review of the facility policy titled, Administering Medications, undated, included medications were administered in a safe and timely manner, and as prescribed. The policy included medications were administered in accordance with the prescriber orders, including any required time frame. This deficiency substantiates Complaint Number OH00125344 and Complaint Number OH00125317.