STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366274	A. Building B. Wing	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Chagrin Falls	150 Cleveland Street Chagrin Falls, OH 44022

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interviews, observation, open and closed record review, and review of the facility policy and procedure regarding abuse and neglect prohibition the facility failed to implement an effective and appropriate process to meet the care planned needs of six residents residing on the COVID-19 positive unit (Resident's #8, #15, #18, #31, #37 and #43) on 10/31/21 from 7:00 A.M. to 7:00 P.M. when no licensed nursing staff addressed the administration of medications, pain management, skin treatments, assessments of respiratory status or vital signs that were ordered by the physician. The facility administration failed to resolve the situation, and the COVID-19 unit remained without a licensed nurse on 10/31/21 from 7:00 A.M. to 7:00 P.M. This resulted in Immediate Jeopardy that was actual harm when the facility failed to ensure Resident #15 was assessed due to complaints of shortness of breath, did not receive his cardiac medications or have his blood pressure or pulse checked prior to medication administration as ordered, Resident's #8 and #18 did not have their blood glucose levels checked and they were not given insulin as ordered resulting in elevated blood glucose levels, Resident #18 did not receive an anti-coagulant medication, Resident #43 did not receive ant-seizure medication, Resident's #8 and #31 were not provided pain medications as ordered resulting in crying and moaning for an extended period due to intolerable pain, Resident #8 did not have treatments completed as ordered to bilateral ulcers to the heels, Resident #37 did not receive her cardiac, diabetic, or arthritic pain medications as well as her topical medication to her skin impairment. In addition, all residents (Resident #8, #15, #18, #31, #37, and #43) residing on the COVID-19 unit did not receive a respiratory screen or vital signs as ordered. On 11/08/21 at 5:08 P.M., the Administrator and RN Clinical Coordinator #600 were notified Immediate Jeopardy began on 10/31/21 when the facility only had one nurse, RN #611, who was assigned to the entire resident population of 43 residents in the facility and was not able to administer medications, complete respiratory assessments, blood glucose monitoring, pain assessment and pain management, anticoagulant medication and complete vital signs and treatments per physician orders for six residents (Resident's #8, #15, #18, #31, #37 and #43) residing on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. This affected six residents (Resident's #8, #15, #18, #31, #37 and #43) residing on the COVID-19 unit on 10/31/21. The facility census was 43. The Immediate Jeopardy was removed on 11/09/21 when the facility implemented the following corrective actions: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #8 was reviewed for medication administration and skin treatments; any identified issues were addressed. Resident #8 had skin evaluation completed Clinical Transitional Specialist/ RN #606 on 11/09/21 at 10:22 A.M. Resident #18 was reviewed for medication administration and skin treatments; any identified issues were addressed. Resident #18 is no longer at the facility. Resident # 15 was reviewed for medication administration and skin treatments; any identified issues were addressed. Resident #15 is no longer at the facility. Resident #31 was reviewed for medication administration and skin treatments; any identified issues were addressed. Resident #31 had skin evaluation completed Clinical Transitional Specialist/ RN #606 on 11/06/21 at 4:30 P.M, and Resident #37 was reviewed for medication administration and skin treatments; any identified issues were addressed. Resident #37 had skin evaluation completed Clinical Transitional Specialist/ RN #606 on 11/09/21 at 3:00 P.M. and no new areas of concern were noted. All care plans were reviewed by RN/ Corporate Float Minimum Data Set (MDS) #624 on 11/09/21 at 4:00 P. M. and updated as deemed necessary. Resident #43 is no longer in the facility as of 11/02/21. Review on 11/10/21 at 1:00 P.M. verified Clinical Transitional Specialist/ RN #606 completed skin sweeps on all residents. The audit was reviewed with no concerns. All residents (Resident's #8, #15, #18, #31, #37 and #43) on the Covid unit have the potential to be affected by this allegation of deficiency. There is currently one resident (Resident #44) on the COVID-19 unit that was reviewed by RN/ Corporate Clinical Coordinator #600 to ensure medications and skin treatments were administered. One medication was not administered on 11/09/21 at 9:00 A.M., and PA #602 was notified at 11/09/21 at 9:27 A.M. A new order was received on 11/09/21 at 9:27 A.M. per PA #602 to hold the medication until the evening dose. Review on 11/10/21 at 1:10 P.M. verified the corrective action plan was completed. The abuse and neglect policy and procedure were reviewed and deemed appropriate by the Quality Assurance Performance Improvement (QAPI) meeting on 11/09/21 at 1:30 P.M. In attendance were the Administrator, RN/ Corporate Clinical Coordinator #600, Medical Director #628, and Regional Director of Operation (RDO) #627. Education was provided on 11/09/21 at 2:00 P.M. to all licensed nursing staff (one) in the facility by RN/ Corporate Clinical Coordinator #600 on abuse and neglect. The other facility licensed nurse has had a voicemail left by RN/ Regional Clinical Coordinator #625 and will be educated prior to the start of her next shift. The abuse and neglect policy and procedure education was provided to the Director of the Primary Staffing Agency #629 on 11/09/21 at 3:03 P.M. by the Administrator and will be provided to agency nurses prior to being sent to the facility. Any licensed nurses sent to the facility without education validation will receive the education by the RN/Corporate Clinical Coordinator #600 or the Director of Nursing (DON) upon hire/designee prior to start of their shift. Review of in-service training records verified licensed nurses were educated on 11/08/21 at 7:00 P.M., 11/09/21 at 7:00 A.M., 11/09/21 at 3:30 P.M., 11/09/21 at 5:10 P.M., and 11/10/21 at 7:15 A.M. at the beginning of their shift as well as the two facility nurses Licensed Practical Nurse (LPN) #630 and RN #619. Interview on 11/10/21 at 12:04 P.M. with RN #631 and RN #632 verified they received the training prior to the start of their shift, and they were knowledgeable regarding the abuse and neglect policy and procedure. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Audits will be conducted five times weekly for one month, then weekly for one month, and then monthly for three months. Audits will be conducted via observation relative to pain medication administration and insulin administration by the RN/ Corporate Clinical Coordinator #600, DON (when hired)/designee of residents on a pain management program and/or insulin to ensure that pain medication and insulin administration is completed timely. Any identified issues will be addressed immediately. Results of the audits will be forwarded monthly to the QAPI committee monthly for review and recommendations. The Administrator is responsible for sustained compliance. Although the Immediate Jeopardy was removed on 11/09/21, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings included: 1. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] and discharged to the hospital on 11/03/21. Resident #15's diagnoses included COVID-19, pneumonia due to COVID-19, acute respiratory failure with hypoxia, atrial fibrillation, tremors, and diabetes. Review of the care plan dated 10/28/21 revealed Resident #15 was at risk for cardiac complications related to multiple cardiovascular diseases. Interventions included vital signs as ordered, and observe, document, and report any signs of cardiac distress. Review of the physician orders for 10/31/21 revealed Resident #15 was to receive Dexamethasone tablet 6 milligram (mg) by mouth one time a day for inflammation ordered for 9:00 A.M., Digoxin 125 microgram (mcg) tablet by mouth for heart failure ordered for 5:00 P.M. take pulse rate prior to administering, Metoprolol Tartrate tablet 50 mg one tablet by mouth ordered for 9:00 A.M. for hypertension take blood pressure and pulse prior to administering and hold if pulse rate below 60 and systolic blood pressure less than 100, and Gabapentin (anticonvulsant) 300 mg one capsule by mouth ordered for 9:00 A.M., 1:00 P.M. and 5:00 P.M. Also, Resident #15 had orders for a respiratory screener to be completed on dayshift, vital signs including blood pressure, pulse, temperature, and oxygen saturation level to be completed on dayshift. Review of the October 2021 Medication Administration Record (MAR) revealed Resident #15 did not receive any of his ordered medications on 10/31/21 from 7:00 A.M. to 7:00 P.M as well as he did not have an assessment of his respiratory status and vital signs completed on dayshift as ordered. Interview on 11/03/21 at 10:37 A.M. and 11/08/21 at 8:27 A.M. with RN Corporate Clinical Coordinator #600 verified Resident #15 did not receive any of his ordered medications on 10/31/21 from 7:00 A.M. to 7:00 P.M. as there was not a nurse on the COVID-19 unit. RN Corporate Clinical Coordinator #600 also verified Resident #15 did not have an assessment of his respiratory status or vital signs completed as ordered on dayshift on 10/31/21. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/04/21 at 11:05 A.M. with STNA #612 revealed on 10/31/21 from 7:00 A.M. to 7:00 P.M. he was the only staff that worked on the COVID-19 unit, and there was not a nurse to provide care. STNA #612 revealed Resident #15 continued to state that he could not breath. STNA #612 revealed he attempted to provide comfort but was concerned as he had no idea how Resident #15's vital signs were, especially his oxygen saturation level. STNA #612 revealed he notified the Administrator and RN #611 of Resident #15's complaints of difficulty breathing, and STNA #612 stated, again, they did nothing. STNA #612 revealed he felt he was stuck on the COVID-19 unit in an unsafe situation with residents in pain and having respiratory issues, and he felt helpless as he could do nothing since he was not a nurse. 2. Review of the medical record for Resident #18 revealed an admitted [DATE] and discharge date of [DATE] to another facility. Resident #18's diagnoses included COVID-19, dementia, diabetes, history of pulmonary embolism, and hypertension. Review of the care plan dated 10/28/21 revealed Resident #18 did not have a care plan regarding management of his diabetes. Review of the physician orders for 10/31/21 revealed Resident #18 was to receive Dexamethasone 6 mg by mouth ordered for 9:00 A.M. for inflammation, Lisinopril 5 mg one tablet by mouth for hypertension ordered for 9:00 A.M., Lovenox solution (anticoagulant) 40 mg per 0.4 milliliter (ml) inject subcutaneously ordered for 10:00 A.M., Tradjenta 5 mg tablet by mouth ordered for 9:00 A.M. for diabetes, Metformin 1000 mg one tablet by mouth ordered for 9:00 A.M. and 5:00 P.M. for diabetes, Benzonatate capsule 100 mg give one capsule by mouth for cough at 9:00 A.M., 1:00 P.M. and 5:00 P.M., obtain glucose level at 8:00 A.M., 12:00 P.M. and 5:00 P.M. and inject Humalog-solution 100 units per ml subcutaneously per sliding scale. Resident #18 also had orders for a respiratory screen to assess his respiratory status ordered for lunch time due to confirmed COVID-19 and vital signs including blood pressure, pulse, respirations, temperature, and oxygen saturation level ordered for lunch time. Review of the October 2021 MAR revealed Resident #18 did not receive medications, glucose levels, insulin, respiratory screen, vital signs, and oxygen saturation checks as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Review of the nursing note dated 10/31/21 at 7:23 P.M. and authored by RN #609 revealed a random blood sugar was obtained, and Resident #18's blood sugar was elevated at 397 milligrams (mg) per deciliter (dL). The nursing note revealed RN #609 notified PA #602 and received a new order to administer one dose of eight units of regular insulin immediately to cover the elevated blood sugar. Interview on 11/03/21 at 10:37 A.M. and 11/08/21 at 8:27 A.M. with RN Corporate Clinical Coordinator #600 verified Resident #18 did not receive any of his medications, glucose levels, insulin, anti-coagulant medication, respiratory screen, vital signs, and oxygen saturation checks as ordered on 10/31/21 from 7:00 A. M. to 7:00 P.M. as there was not a nurse on the COVID-19 unit. RN Corporate Clinical Coordinator #600 verified Resident #18's blood sugar was taken on 10/31/21 at 7:23 P.M. and was elevated at 397 mg dL requiring a one-time dose of regular insulin that was ordered by PA #602 to cover the elevated blood sugar. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/03/21 at 11:45 A.M. with PA #602 revealed on 10/31/21 at approximately 7:30 P.M. she was notified by RN #609 that there had not been a nurse on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. The facility only had an STNA on the unit, and Resident #18 did not receive any medications during this time including his insulin. PA #602 revealed RN #609 checked Resident #18's blood sugar and it was 397 mg dL, and she ordered a one-time dose of eight units of regular insulin due to the elevated blood sugar. 3. Review of the medical record revealed Resident #8 had an admitted [DATE] with diagnoses including COVID-19 , pneumonia due to COVID-19, diabetes, chronic kidney disease, atrial fibrillation, gangrene not classified, completed traumatic amputation of left great toe, chronic osteomyelitis, pain in right foot, pain in left foot, pain in unspecified shoulder and low back pain. Review of the admission physician orders for October 2021 revealed Resident #8 had an order for Furosemide (Lasix) 40 mg by mouth ordered for 9:00 A.M. for fluid retention and to have his blood pressure checked; hold the Lasix if the systolic blood pressure was below 110, Gabapentin 100 mg give one capsule my mouth ordered for 5:00 P.M. for nerve pain, Guaifenesin extended release 600 mg by mouth for cough ordered for 9:00 A.M., NPH insulin suspension 100 units per ml give 10 ml subcutaneously one time a day before breakfast for diabetes ordered for 7:30 A.M., NPH insulin suspension 100 units per ml give 11 units subcutaneously in the evening before dinner for diabetes ordered for 5:00 P.M., Carvedilol 25 mg tablet by mouth two times a day for hypertension; check blood pressure and hold if the systolic blood pressure was less than 110 or if heart rate was less than 50 was ordered for 9:00 A.M., check blood glucose level and administer Lispro insulin 100 units per ml subcutaneously per sliding scale before meals for diabetes ordered for 11:00 A.M. and 4:00 P.M., Oxycodone- Acetaminophen 10-325 mg tablet by mouth every four hours as needed for pain, Acetaminophen 325 mg tablet administer two tablets every four hours as needed for mild pain. Resident #8 also had an order for a respiratory screen to check his respiratory status due to COVID-19 at lunch time, and vital signs including blood pressure, pulse, temperature, respirations, and oxygen saturation level was to be completed at lunch time. Resident #8 had treatment orders that included cleanse the right heel with normal saline, apply betadine(antiseptic) and calcium alginate (dressing for heavily draining wounds) and cover with foam dressing ordered to be completed at 5:00 P.M., and cleanse the left heel with normal saline, pat dry, apply betadine, cover with abdominal (ABD) pad, and wrap with Kerlix gauze ordered to be completed at 5:00 P.M. Review of the October 2021 MAR revealed Resident #8 received Oxycodone- Acetaminophen 10-325 mg tablet by mouth on 10/31/21 at 5:54 A.M. for a pain level of seven on a pain scale of zero to ten. Resident #8 did not receive any further Oxycodone- Acetaminophen until 10/31/21 at 7:15 P.M. when his pain level was documented as a ten on a pain scale of zero to ten. The MAR revealed Resident #8 did not receive any of the ordered medications on 10/31/21 from 7:00 A.M. to 7:00 P.M., and did not have his blood glucose level checked, respiratory assessment, vital signs, oxygen saturation, and treatments to his bilateral heels completed as ordered. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the admission assessment for Resident #8 labeled Nursing Comprehensive Evaluation V1-V13, dated 10/28/21, and completed by RN #618 revealed Resident #8 required two-staff assistance with transfers and bed mobility. The evaluation revealed Resident #8 had skin issues described as right heel sores and left heel sores, but there was no description of the affected areas or any measurements. The assessment also revealed Resident #8 was currently having pain and had pain in the last five days. Resident #8 revealed his pain was in his lower back and bilateral heels. Resident #8 revealed his present pain was an eight on a pain scale of zero to ten. Resident #8 indicated his pain could get as bad as a 10 on a pain scale of zero to ten. Review of the care plan dated 10/28/21 revealed Resident #8 had actual impairment to his skin integrity. Interventions included observe location, size and treatment of skin injury, and report abnormalities, failure to heal, signs of infection to the physician. Review of the care plan dated 10/28/21 revealed Resident #8 was at risk for pain. Interventions included anticipate resident's need for pain relief as needed and respond immediately to any complaint of pain, notify the physician if interventions were unsuccessful or if current complaint was a significant change from resident's experience of pain. Resident #8 did not have a care plan related to management of diabetes. Review of the admission Brief Interview for Mental Status (BIMS) dated 10/29/21 revealed Resident #8 was cognitively intact with a BIMS score of a 15. Review of the facility form labeled Braden Scale for Predicting Pressure Sore Risk, dated 10/29/21, for Resident #8 revealed it was in progress and not completed. Review of the nursing note dated 10/31/21 at 8:29 P.M. and authored by RN #609 revealed she completed a random blood sugar check, and Resident #8's blood sugar was 374 mg dL. RN #609 notified PA #602 and received an order to give NPH insulin 11 units now. Interview on 11/03/21 at 10:37 A.M. and 11/08/21 at 8:27 A.M. with RN Corporate Clinical Coordinator #600 verified there was only one STNA on the COVID-19 unit, and there was not a nurse on 10/31/21 from 7:00 A.M. to 7:00 P.M. RN Corporate Clinical Coordinator #600 verified Resident #8 did not receive any medications, blood sugar checks, respiratory screen, vital signs, glucose levels, oxygen saturation level, or treatments to the bilateral heels as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. RN Corporate Clinical Coordinator #600 revealed the DON walked out, and the Administrator was aware and tried to get a nurse but was unable. Interview on 11/03/21 at 11:45 A.M. with PA #602 revealed on 10/31/21 at approximately 7:30 P.M. she was notified by RN #609 that there had not been a nurse on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. The facility only had an STNA on the unit, and Resident #8 did not receive any medications during this time. PA #602 revealed she was aware Resident #8 did not receive any pain medications all day and was in severe pain when RN #609 had arrived on duty. PA #602 revealed Resident #8 had chronic back pain and received medications as needed to control his pain. PA #602 revealed RN #609 administered Resident #8's pain medication when she arrived on the unit at approximately 7:00 P.M. PA #602 also revealed she was aware Resident #8 had not had his blood glucose level checked or any ordered insulin on 10/31/21 from 7:00 A.M. to 7:00 P.M. PA #602 revealed RN #609 checked Resident #8's blood glucose level and it was 374 mg dL, and she ordered NPH insulin 11 units to be given right away and recheck his blood glucose level. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview and observation on 11/03/21 at 2:09 P.M. with Resident #8, who is cognitively intact, revealed he did not receive any of his pain medications all day one day when he was on the COVID-19 unit and was in severe pain to the point he thought he was dying from the pain. Resident #8 also revealed he had a dressing to his right calve area that was not dated. Resident #8 did not appear to have a dressing to his right heel as ordered and Resident #8 had a sock on his left foot preventing observation of the left heel dressing. Resident #8 revealed the nurses do not change his dressing daily. Resident #8 revealed he thought the nurse changed the dressing two days ago. Observation of Resident #8's dressing change on 11/03/21 at 2:35 P.M. with Clinical Corporate Transitional Specialist/ RN #606 revealed Resident #8 had a dressing to his right calve area that was undated and a dressing to his left heel that was undated. Resident #8 did not have a dressing to his right heel as ordered. Observation of Resident #8's wound care and interview on 11/03/21 at 4:10 P.M. completed by Clinical Corporate Transitional Specialist/ RN #606 revealed Resident #8 had an open area to his right outer leg that measured 2.0 centimeter (cm) in length by 4.0 cm in width by 0.1 cm in depth. Clinical Corporate Transitional Specialist/ RN #606 verified Resident #8 did not have an open area or wound to the right heel. Observation revealed Resident #8 had an undated dressing to the left foot but not the left heel. Clinical Corporate Transitional Specialist/ RN #606 removed the dressing to the upper left foot revealing gangrene to the left fourth and fifth toes and an open area to the great toe area that measured 4.0 cm in length by 2.0 cm in width by and 0.1 cm in depth. The area had yellow drainage in the center. Interview on 11/03/21 at 4:15 P.M. with Clinical Corporate Transitional Specialist/ RN #606 verified the admission Nursing Comprehensive Evaluation dated 10/28/21 contained inaccurate documentation as Resident #8 did not have wounds to the bilateral heels, instead Resident #8 had one wound to the right calve area and a wound to the left great toe area as well as gangrene to the fourth and fifth toes which were not identified on the admission assessment. Clinical Corporate Transitional Specialist/ RN #606 verified the admission assessment should have included measurements and a description of the areas and not documented as sores. Clinical Corporate Transitional Specialist/ RN #606 verified the treatment orders were inaccurate as they both read for the heels instead of the proper location of the wounds. The RN also verified there was no documented evidence the treatments were completed on 10/31/21 and the dressings were not dated. Clinical Corporate Transitional Specialist/ RN #606 verified Resident #8 did not have a Braden Scale Risk Assessment completed on admission. She stated she would contact Resident #8's Primary Care Physician #900 for new treatment orders. Review of the nursing note dated 11/03/21 at 7:40 P.M. and authored by Clinical Corporate Transitional Specialist/ RN #606 revealed Resident #8 had wounds to the left foot and two black toes, and Resident #8's great toe area status post amputation areas had a minimal amount of serosanguinous drainage and measured 4.0 cm in length by 2.0 cm in width by and 0.1 cm in depth. The wound bed had 80 percent granulation tissue and had no signs of infection. Resident #8's outer calf was noted to have an abrasion that was superficial. The area measured 2.0 cm in length by 4.0 cm in width by 0.1 cm in depth. The orders were clarified. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #8 revealed it was still in progress. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/04/21 at 11:05 A.M. with STNA #612 revealed on 10/31/21 from 7:00 A.M. to 7:00 P.M. he was the only staff that worked on the COVID-19 unit, and there was not a nurse. STNA #612 revealed Resident #8 stated he had severe pain to his back and requested pain medication. STNA #612 revealed Resident #8 moaned out continuously which began mid-morning on 10/31/21. STNA #612 revealed he contacted the Administrator multiple times regarding no nurse and Resident #8's pain, and each time the Administrator stated he was working on getting a nurse. STNA #612 revealed Resident #8 continued to be in severe pain, moaning out continuously and holding his back until 10/31/21 at 7:00 P.M. when RN #609 came on duty. STNA #612 revealed he felt terrible as there was nothing, he could do except try to reposition Resident #8 and make him more comfortable. Interview on 11/04/21 at 9:57 A.M. with RN #609 revealed Resident #8 was in severe pain when she arrived on the Covid unit on 10/31/21 at 7:00 P.M. Resident #8 was crying and had a pain level assessed as a 10 on a pain scale of zero to ten. RN #609 revealed she reviewed the MAR and was aware Resident #8 had not received Oxycodone-Acetaminophen since early that morning at approximately 5:00 A.M. RN #609 revealed she medicated Resident #8 with Oxycodone- Acetaminophen 10-325 mg tablet per the as needed order and notified PA #602. 4. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including fracture of unspecified part of neck of left femur, congestive heart failure, chronic obstructive pulmonary disease (COPD), and Alzheimer's disease. Review of the physician orders for 10/31/21 revealed Resident #31 had the following orders: Amiodarone 200 mg by mouth ordered for 9:00 A.M. for atrial fibrillation, Finasteride 5 mg tablet by mouth for prostate hyperplasia ordered for 9:00 A.M., Fluticasone Furoate aerosol 100-25 mcg to administer one inhalation was ordered for 9:00 A.M. for COPD, Lidocaine patch 4 percent apply to affected area due to left femur fracture which was to be applied at 9:00 A.M., Zoloft 25 mg by mouth for depression ordered for 9:00 A.M., Spiriva hand held inhaler 18 mcg one capsule inhale orally for COPD ordered for 9:00 A.M., Budesonide-Formoterol Fumarate aerosol 160-4.5 mcg two puffs for COPD ordered for 9:00 A.M Resident #31 also had an order for Tramadol 50 mg give 0.5 (half) tablet by mouth every 12 hours as needed for pain for up to five days, an order dated 11/02/21 for Tylenol 325 mg give two tablets by mouth every six hours as needed for pain and Oxycodone HCL 5 mg by mouth four times a day for pain for left hip fracture. Resident #31 also had physician orders to have a respiratory screen completed at lunch every day, vital signs including blood pressure, temperature, pulse, respirations, and oxygen saturation rate to be completed at 2:00 P.M. every day. Review of the admission assessment labeled Nursing Comprehensive Evaluation, dated 10/30/21, completed by RN #621 revealed Resident #31 was not having pain and had not had pain in the last five days. (continued on next page)

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	366274	A. Building B. Wing	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Chagrin Falls	150 Cleveland Street Chagrin Falls, OH 44022

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the October 2021 MAR revealed Resident #31 had not received any medications ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Resident #31 had a physician order for Tramadol 50 mg give 0.5 tablet by mouth every 12 hours as needed for pain. Review of the MAR revealed Resident #31 received Tramadol on 10/30/21 at 8:37 P.M. for a pain level of seven on a pain scale from zero to ten that was effective. The MAR revealed Resident #31 was administered Tramadol on 10/31/21 at 6:32 A.M. and it was documented Resident #31's pain level was an eight on a pain scale from zero to ten, and the Tramadol was ineffective for Resident #31's pain. Resident #31 also had physician orders to have a respiratory screen completed at lunch every day, vital signs including blood pressure, temperature, pulse, respirations, and oxygen saturation rate completed at 2:00 P.M. every day that were not completed on 10/31/21 from 7:00 A.M. to 7:00 P.M. Review of the nursing notes dated 10/31/21 at 8:07 P.M. and authored by RN #609 revealed she assessed the effectiveness of the Tramadol that was provided to Resident #31 on 10/31/21 at 6:32 A.M. and revealed the Tramadol was ineffective as Resident #31's pain level was a seven on a pain scale from zero to ten. There was no documented evidence in the nursing notes of any intervention provided for Resident #31's pain. There was no documented evidence he received additional pain management medication or that PA #602 was notified regarding his pain level being a seven. Review of the physician orders dated 11/02/21 revealed Resident #31 had an order for Oxycodone HCL 5 mg give one tablet by mouth four times a day for right hip fracture pain. Interview on 11/04/21 at 11:05 A.M. with STNA #612 revealed on 10/31/21 from 7:00 A.M. to 7:00 P.M. he was the only staff that worked on the Covid-19 unit, and there was not a nurse. STNA #612 revealed Resident #31 was recently admitted to the facility with a fractured hip. STNA #612 revealed Resident #31 was in pain as he was moaning and showed signs of discomfort. STNA #612 revealed he knew Resident #31 could receive Tramadol for pain but because there was no nurse on the COVID-19 unit, Resident #31 could not be assessed or receive pain medication as he should have. STNA #612 revealed he contacted the Administrator multiple times regarding no nurse and Resident #31 being in pain, and each time the Administrator stated he was working on getting a nurse. STNA #612 revealed he was frustrated as he knew Resident #31 was in pain, and he was a STNA unable to give medications and all he could do was try to make Resident #31 comfortable by repositioning him in bed for comfort. Review of the Admission MDS 3.0 assessment dated [DATE] revealed it was still in progress. Observation and interview on 11/09/21 at 11:24 A.M. revealed Resident #31 was up in the recliner visiting with Resident #31's daughter and displayed no signs of pain or discomfort. Resident #31 revealed his pain level was about a four on a pain scale from zero to ten. Resident #31 could not provide any information regarding concerns of pain while on the COVID-19 unit. Resident #31's daughter revealed she was not able to visit when he was on the COVID-19 unit and was not able to communicate with him on the phone, so she had no information regarding his pain management when Resident #31 resided on the COVID-19 unit. Interview on 11/03/21 at 10:37 A.M. and 11/08/21 at 8:27 A.M. with RN Corporate Clinical Coordinator #600 verified Resident #43 did not receive any of his ordered medications, respiratory assessment, or vital signs on 10/31/21 from 7:00 A.M. to 7:00 P.M. as there was not a nurse on the COVID-19 unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Review of the medical record for Resident #43 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #43's diagnoses included esophageal varices, severe alcohol use, epilepsy, upper gastrointestinal bleed, and COVID-19. Review of the care plan dated 10/28/21 revealed Resident #43 was at risk for seizure disorder. Interventions included labs as ordered and seizure precautions. Review of the care plan dated 10/28/21 revealed Resident #43 was at risk for cardiac complications related to cardiovascular disease. Interventions included labs as ordered and vital signs as ordered. Review of the physician orders for 10/31/21 revealed Resident #43 had orders including: Aldactone (diuretic) 50 mg tablet by mouth ordered for 9:00 A.M., Celexa 20 mg by mouth for depression ordered for 9:00 A.M., Coreg 3.125 mg tablet for hypertension ordered for 8:00 A.M., Keppra 500 mg tablet for epilepsy ordered for 9:00 A.M., Gabapentin 300 mg capsule by mouth for epilepsy ordered for 9:00 A.M., 1:00 P.M. and 5:00 P.M. Resident #43 also had physician orders to have a respiratory screen completed at lunch every day, and vital signs including blood pressure, temperature, pulse, respirations, and oxygen saturation rate completed at lunch time every day that were not completed on 10/31/21 from 7:00 A.M. to 7:00 P.M. Review of the October 2021 MAR revealed Resident #43 did not receive any medications, includin [TRUNCATED]

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, review of facility policy and procedure related to pain management and interviews with facility staff the facility failed to address two residents' (Resident's #8 and #31) request for pain management resulting in Resident #8 and Resident #31 experiencing intolerable pain that caused them to cry out over an extended time period on 10/31/21 on the 7:00 A.M. to 7:00 P.M. shift. On 10/31/21 from 7:00 A.M.to 7:00 P.M. the facility had knowledge that one nurse, RN #611, was assigned to the entire resident population of 43 residents. RN #611 did not provide any care to the residents residing on the COVID-19 unit including assessment of pain for two residents (Residents #8 and #31) from 7:00A.M. through 7:00 P.M. This resulted in Immediate Jeopardy that resulted in actual harm on 10/31/21 when the only staff member on the COVID-19 unit was STNA #612 who indicated Resident #8 began mid-morning moaning out continuously and complaining of back pain. STNA #612 revealed on 10/31/21 Resident #31 also was crying out throughout the day and showing signs of pain due to his recent left hip replacement. STNA #612 revealed Resident #8 and Resident #31's pain was not assessed or addressed by a nurse as the facility did not have a nurse on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. STNA #612 revealed he had notified the Administrator of the COVID-19 unit not having a nurse and of Resident #8 and #31's pain. STNA #612 revealed Residents #8 and #31 remained in intolerable pain as the residents were not evaluated for their pain or provided pain medications as ordered. Registered Nurse (RN) #609 indicated she arrived on duty on 10/31/21 at 7:00 P.M. and Resident #8 was crying out in severe pain as his pain level was a ten on a pain scale of zero to ten. RN #609 revealed Resident #31's pain on 10/31/21 at 8:07 P.M. was a seven on a pain scale of zero to ten. This affected two of six residents on the COVID-19 unit. The facility census was 43. On 11/08/21 at 5:08 P.M., the Administrator and RN Clinical Coordinator #600 were notified Immediate Jeopardy began on 10/31/21 when the facility only had one nurse in the facility that did not address any needs of any of the residents on the COVID-19 unit including assessing Resident #8 and Resident #31's ongoing complaints of pain and administering pain medications as ordered from 7:00 A.M. to 7:00 P.M resulting in Resident #8 and Resident #31 having intolerable pain for an extended period of time. The Immediate Jeopardy was removed on 11/09/21 when the facility implemented the following corrective actions: Resident #8 was evaluated for pain on 11/09/21 at 11:32 A.M. by the Minimum Data Set (MDS)/ RN #623. Resident #8's pain was verified on 11/10/21 at 10:20 A.M. as being evaluated and form labeled, Pain Evaluation-V2 was completed on 11/09/21. Pain medication was administered per physician order, and Resident #8 was not having excruciating pain at this time. Resident #8's care plan was reviewed and updated on 11/09/21 at 11:00 A.M. by RN/ MDS Coordinator #622. Resident #8's care plan for pain was verified on 11/10/21 at 10:25 A.M. that it had been revised on 11/09/21. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #31 was evaluated on 11/09/21 by RN/ MDS #622 at 10:06 A.M. Resident #31's pain was verified on 10/10/21 at 10:28 A.M. as being evaluated and form labeled, Pain Evaluation-V2 was completed on 11/09/21. Resident #31 received pain medication as scheduled. Resident #31 refused his Lidocaine patch on 11/09/21 at 9:00 A.M., and Physician Assistant (PA) #602 was notified on 11/09/21 at 11:00 A.M. Resident #31's care plan was reviewed and updated as necessary on 11/09/21 at 11:00 A.M. by RN/ Corporate Float MDS #624. Resident #31's care plan was verified on 11/10/21 at 10:30 A.M. that it had been initiated on 11/09/21 as Resident #31 previously did not have a care plan for pain. All residents receiving pain management have the potential for uncontrolled pain. Pain evaluations were completed on 11/09/21 from 07:00 A.M. until 12:30 P.M. by RN/MDS #623 and #622 on residents receiving pain management, and any identified issues had their primary care physicians notified. On 11/10/21 at 10:29 A.M. pain evaluations were verified that they were completed on 11/09/21 and a sample of residents were reviewed including Resident's #5, #8, #23, #31 and #37 and no issues were noted. Pain management policy and procedure were reviewed by Quality Assurance Performance Improvement (QAPI) meeting on 11/09/21 at 1:30 P.M. In attendance were Administrator, RN/ Clinical Coordinator #600, Medical Director #628, and Regional Director of Operation (RDO) #627. Review on 11/10/21 at 10:32 A.M. revealed the QAPI meeting had occurred on 11/09/21 at 1:30 P.M. All Licensed nurses (three nurses) on duty 11/09/21 at 07:00 A.M. were re-educated on the pain management policy and procedure by RN/ Clinical Coordinator #600. All licensed staff will receive the same education prior to next scheduled shift by RN/ Clinical Coordinator #600 or designee. All facility licensed nurses (one nurse) have been educated as of 11/09/21 at 3:00 P.M. The other facility licensed nurse had a voicemail left by RN/ Regional Clinical Coordinator #625 and will be educated prior to the start of her next shift. (The facility only has two licensed nurses on staff, LPN #630, and RN #619). Any agency staff assigned to the facility will receive the same education prior to the start of their shift by the RN/Clinical Coordinator #600 or designee. All new hires will receive education by RN/ Clinical Coordinator #600 or designee on pain policy and procedure during new hire orientation. Pain management policy and procedure education was provided to the Director of the Primary Staffing Agency #629 on 11/09/21 at 3:03 P.M. by the Administrator and will be provided to agency nurses prior to sending to the facility. Any licensed nurses sent to the facility without education validation will receive the education by the RN/ Clinical Coordinator #600, Director of Nursing (when hired)/designee prior to start of their shift. Review of in-service training records on 11/08/21 at 7:00 P.M., 11/09/21 at 7:00 A.M., 11/09/21 at 3:30 P.M., 11/09/21 at 5:10 P.M. and 11/10/21 at 7:15 A.M. revealed licensed nurses prior to their beginning of their shift as well as the two facility nurses (RN #619 and #630) had been in-serviced. Interview on 11/10/21 at 12:04 P.M. with RN #631 and RN #632 verified they received the training prior to the start of their shift, and they were knowledgeable regarding the pain management policy and procedure. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Audits five times weekly, for one month, then weekly for one month, then monthly for three months, will be conducted of medication administration records relative to pain medication administration by the RN/ Clinical Coordinator #600, DON (when hired)/designee, of residents on a pain management program to ensure that pain medication is administered timely. Audits five times weekly, for one month, then weekly for one month, then monthly for three months, will be conducted via pain interviews and observations by the RN/ Clinical Coordinator #600, DON (when hired)/designee, of residents on a pain management program to ensure pain is controlled. Any identified issues with pain will be addressed immediately. The results will be submitted to the QAPI committee monthly for review and recommendations. The administrator is responsible for sustained compliance. Review on 11/10/21 at 12:15 P.M. of the pain management audit revealed it was conducted on 11/09/21 from 07:00 A.M. until 12:30 P.M. by RN/MDS #623 and #622. Although the Immediate Jeopardy was removed on 11/09/21, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings include: 1. Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including COVID-19, pneumonia due to COVID-19, diabetes, chronic kidney disease, atrial fibrillation, gangrene not classified, complete traumatic amputation of left great toe, chronic osteomyelitis, pain in right foot, pain in left foot, pain in unspecified shoulder and low back pain. Review of the admission physician orders for October 2021 revealed Resident #8 had an order for Oxycodone- Acetaminophen 10-325 milligram (mg) tablet by mouth every four hours as needed for severe pain, Acetaminophen 325 mg tablet administer two tablets every four hours as needed for mild pain and gabapentin 100 mg give one capsule my mouth in the evening for nerve pain. Review of the October 2021 Medication Administration Record (MAR) revealed Resident #8 received Oxycodone- Acetaminophen 10-325 milligram (mg) tablet by mouth on 10/31/21 at 5:54 A.M. as Resident #8's pain level was a seven on a pain scale of zero to ten. Resident #8 did not receive any further Oxycodone- Acetaminophen until 10/31/21 at 7:15 P.M. when his pain level was documented as a ten on a pain scale of zero to ten. The MAR revealed on 10/31/21 at 5:00 P.M. Resident #8 did not receive his gabapentin 100 mg one capsule by mouth in the evening as ordered for nerve pain. Review of the admission facility form labeled, Nursing Comprehensive Evaluation V1-V13 for Resident #8 dated 10/28/21 and completed by RN #618 revealed Resident #8 was currently having pain and had pain in the last five days. Resident #8 revealed his pain was in his lower back and bilateral heels. Resident #8 revealed his pain was an eight on a pain scale of zero to ten. Resident #8 revealed his pain got as bad as a ten on a pain scale of zero to ten. Review of the care plan dated 10/28/21 revealed Resident #8 was at risk for pain. Interventions included anticipate resident's need for pain relief as needed and respond immediately to any complaint of pain, and notify physician if interventions were unsuccessful or if current complaint was a significant change from resident's experience of pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the admission Brief Interview for Mental Status (BIMS) dated 10/29/21 revealed Resident #8 was cognitively intact with a BIMS score of a 15. Review of the Admission Minimum Data Set (3.0) assessment dated [DATE] for Resident #8 revealed it was still in progress. Interview on 11/03/21 at 10:37 A.M. and 11/08/21 at 8:27 A.M. with RN Corporate Clinical Coordinator #600 verified there was only one aide on the COVID-19 unit and there was not a nurse on 10/31/21 from 7:00 A.M. to 7:00 P.M. RN Corporate Clinical Coordinator #600 verified Resident #8 received Oxycodone-Acetaminophen 10-325 milligram as needed on 10/31/21 at 5:54 A.M. and had not received any further Oxycodone- Acetaminophen until 10/31/21 at 7:15 P.M. (over 13 hours later). RN Corporate Clinical Coordinator #600 revealed the Director of Nursing (DON) walked out, and the Administrator tried to get a nurse to cover the COVID-19 unit but was unable. Interview on 11/03/21 at 11:45 A.M. with PA #602 revealed on 10/31/21 at approximately 7:30 P.M. she was notified by RN #609 that there had not been a nurse on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. and that the facility only had an aide on the unit and residents residing on the unit did not receive any medications during this time. PA #602 revealed she was aware Resident #8 did not receive any pain medications all day and was in severe pain when RN #609 arrived on duty at 7:00 P.M. PA #602 revealed Resident #8 had chronic back pain and received medications routinely to control his pain. PA #602 revealed RN #609 administered his pain medication when she arrived on the unit at approximately 7:00 P.M. Interview on 11/03/21 at 2:09 P.M. with Resident #8 who is cognitively intact with a BIMS of 15 revealed he did not receive any of his pain medications all day one day when he was on the COVID-19 unit and was in severe pain to the point he thought he was dying from the pain. Interview on 11/04/21 at 9:04 A.M. with the Administrator revealed on 10/31/21 at approximately 8:00 A.M. he received a call from STNA #612 stating STNA #612 was the only staff on the COVID-19 unit and there was not a nurse. The Administrator revealed he only had one other nurse in the facility, RN #611, who was assigned on the non- COVID-19 unit so he was unable to pull her to the COVID-19 unit right away. The Administrator revealed he attempted to contact the director of nursing (DON) multiple times, as well as facility and agency staffing to fill in but was unable to find anyone. The Administrator revealed on 10/31/21 at 5:00 P.M. the DON came into the facility and cleaned out her office and resigned effective immediately. The Administrator revealed he assumed RN #611 had attempted at least at the end of her shift to go onto the COVID-19 unit to administer medications and really did not realize she had not administered any of the residents' medications on 10/31/21 that were scheduled from 7:00 A.M. to 7:00 P.M. and the Administrator indicated was not aware Resident #8 had not received his pain medication. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/04/21 at 10:42 A.M. with RN #611 revealed she was only scheduled at the facility on 10/31/21 from 7:00 A.M. to 11:00 A.M. but when she arrived, she was the only nurse on the non- COVID-19 unit when there were usually two nurses, and there was not a nurse on the COVID-19 unit. She revealed she was not able to get everything completed on the non-COVID-19 unit, so she would not have had time to go to the COVID-19 unit. RN #611 revealed she was never instructed by the Administrator or anyone else to go on the COVID-19 unit as that would have been an infection control issue going back and forth as well as she was not able to get everything done on the non-COVID-19 unit including administering medications. She indicated the Administrator was aware she was not going onto the COVID-19 unit. Interview on 11/04/21 at 11:05 A.M. with STNA #612 revealed on 10/31/21 from 7:00 A.M. to 7:00 P.M. he was the only staff member that worked on the COVID-19 unit, and there was no nurse. STNA #612 revealed Resident #8 stated he had severe pain to his back and requested his pain medication. STNA #612 revealed Resident #8 moaned out continuously in pain which began mid-morning on 10/31/21. STNA #612 revealed he contacted the Administrator multiple times regarding no nurse and Resident #8 moaning in pain and each time the Administrator just stated he was working on getting a nurse. STNA #612 revealed Resident #8 continued to be in severe pain, moaning out continuously and holding his back until 10/31/21 at 7:00 P.M. when RN #609 came on duty. STNA #612 revealed he felt terrible and there was nothing he could do except try to reposition Resident #8 and make him more comfortable. Interview on 11/4/21 at 9:57 A.M. with RN #609 revealed Resident #8 was in severe pain when she arrived on the COVID-19 unit on 10/31/21 at 7:00 P.M. as Resident #8 was crying and had a pain level assessed as a ten on a pain scale of zero to ten. RN #609 revealed she reviewed and was aware Resident #8 had not received any Oxycodone-Acetaminophen since early that morning at approximately 5:00 A.M. because there had not been a nurse on 10/31/21 from 7:00 A.M. to 7:00 P.M. on the COVID-19 unit. RN #609 revealed she medicated Resident #8 with Oxycodone-Acetaminophen 10-325 milligram (mg) tablet per his as needed order and notified Physician Assistant (PA) #602. 2. Review of the Operative Report dated 10/26/21 and authored per Orthopedic Surgeon #620 revealed Resident #31 had presented in the emergency department after a fall and sustained a left femoral neck fracture requiring a left hip hemiarthroplasty which was completed on 10/26/21. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including fracture of unspecified part of neck of left femur, congestive heart failure, chronic obstructive pulmonary disease, and Alzheimer's disease. Review of the physician orders for Resident #31 revealed he had an order dated 10/29/21 for Tramadol 50 mg give 0.5 tablet by mouth every 12 hours as needed for pain for up to five days, an order dated 10/30/21 for lidocaine patch four percent to apply to affected area topically once a day and remove as scheduled. Resident #31 had orders dated 11/02/21 for Tylenol 325 mg give two tablets by mouth every six hours as needed for pain and Oxycodone HCL five mg by mouth four times a day for pain to left hip fracture. Review of the admission Nursing Comprehensive Evaluation dated 10/30/21 completed by RN #621 revealed Resident #31 was not having pain and had not had pain in the last five days. (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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the October 2021 MAR revealed Resident #31 had a physician order dated 10/30/21 to apply lidocaine patch four percent to affected area topically once a day that was ordered to be applied at 9:00 A.M. that was not administered. The MAR also revealed Resident #31 had a physician order dated 10/29/21 for Tramadol 50 mg give 0.5 tablet by mouth every 12 hours as needed for pain. Review of MAR revealed Resident #31 was administered the Tramadol on 10/30/21 at 8:37 P.M. for a pain level of seven on a pain scale of zero to ten which was effective. The MAR revealed Resident #31 was administered Tramadol on 10/31/21 at 6:32 A.M. and it was documented Resident #31's pain level was an eight on a pain scale of zero to ten, and the Tramadol was ineffective for Resident #31's pain. The MAR revealed Resident #31 did not receive any further Tramadol on 10/31/21 per the as needed order. Review of the nursing notes dated 10/31/21 at 8:07 P.M. and authored by RN #619 revealed she assessed the effectiveness of the Tramadol that was provided to Resident #31 on 10/31/21 at 6:32 A.M. and on 10/31/21 at 8:07 P.M. and revealed the Tramadol was ineffective as Resident #31's pain level was a seven on a pain scale of zero to ten. There was no documented evidence in the nursing notes of any intervention that was provided for Resident #31's pain level being assessed as a seven on a pain scale of zero to ten. There was no documented evidence he received additional pain management medication or that the PA #602 was notified regarding his pain level being a seven on a pain scale of zero to ten. Review of the care plan dated 11/01/21 for Resident #31 revealed Resident #31 did not have a care plan regarding pain management. Review of the physician orders dated 11/02/21 revealed Resident #31 had a new order for Oxycodone HCL 5 mg give one tablet by mouth four times a day for left hip fracture pain. Review of the BIMS dated 11/01/21 revealed Resident #31 had severe cognitive impairment. Review of the Admission MDS 3.0 assessment dated [DATE] revealed it was still in progress. Interview on 11/04/21 at 11:05 A.M. with STNA #612 revealed on 10/31/21 from 7:00 A.M. to 7:00 P.M. he was the only staff member that worked on the COVID-19 unit, and there was not a nurse. STNA #612 revealed Resident #31 was recently admitted to the facility with a left hip fracture. STNA #612 revealed Resident #31 was in pain as he was moaning and showed signs of discomfort throughout the day on 10/31/21. STNA #612 indicated he knew Resident #31 had an order to receive pain medication but because there was no nurse on the COVID-19 unit, Resident #31 could not be assessed or receive pain medication as needed. STNA #612 revealed he contacted the Administrator multiple times regarding not having a nurse on the unit and Resident #31's pain and each time STNA #612 indicated the Administrator stated he was working on getting a nurse. STNA #612 revealed he was frustrated as he knew Resident #31 was in pain, and he was only an STNA and unable to give medications and all he could do was try to make Resident #31 comfortable by repositioning him for comfort. Observation and interview on 11/09/21 at 11:24 A.M. revealed Resident #31 was up in the recliner visiting with his daughter. He displayed no signs of pain or discomfort. Resident #31 indicated his pain level was about a four on a pain scale of zero to ten. Resident #31 could not provide any information regarding if he had any concerns regarding his pain not being assessed or managed on the COVID-19 unit. Resident #31's daughter revealed she had been not able to visit when he was on the COVID-19 unit and was not able to communicate with him on the phone, so she had no information regarding his pain management when Resident #31 resided on the COVID-19 unit. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/10/21 at 1:17 P.M. with RN #609 revealed she remembered Resident #31 moaning on 10/31/21 when she came in but could not remember any details except that she had spoken to PA #602 about looking at his pain management and changing the Tramadol to something else as she felt it was ineffective. Review of the facility policy titled Pain Management, dated July 2021, revealed the facility would evaluate and identify a resident for pain, determine the type, location and severity and develop a care plan for pain management. The policy revealed staff were to observe a resident for pain indicators including moaning, crying, other vocalization, and body posture as guarding or protecting an area. The policy revealed the nursing assistant would communicate to the licensed nurse when a resident was experiencing pain. The policy revealed the licensed nurse would communicate any new onset of pain to the physician. The staff would implement the care plan and administer interventions for pain. This deficiency substantiates Complaint Number OH00127169.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39973 Based on record review, interviews, review of staffing policies, job description of the Director of Nursing (DON) and facility assessment, the facility failed to ensure a licensed nurse was assigned to care for six residents (Resident's #8, #15, #18, #31, #37 and #43) residing on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. resulting in no licensed care being completed including the administration of medication, administration of skin treatments, respiratory assessments, blood glucose checks, and vital signs as ordered. The facility had one agency nurse, Registered Nurse (RN) #611, on duty for the resident population of 43 residents and she did not include the care of the residents on the COVID-19 unit. This resulted in Immediate Jeopardy on 10/31/21 when the COVID-19 unit did not have a licensed nurse assigned to care for the residents on 10/31/21 from 7:00 A.M. to 7:00 P.M. The lack of adequate staffing resulted in actual harm or the potential for serious harm when Residents #8 and #31 experienced intolerable pain when they were not assessed or provided pain medications as ordered, Residents #8 and #18 experienced elevated blood sugars when they did not have their blood glucose levels checked or their ordered insulin administered, Resident #8 did not receive wound care treatments, and Resident's #8, #15, #18, #31, #37 and #43 did not have medication administration, respiratory assessments and vital signs completed as ordered. This affected all six residents residing on the COVID-19 unit. The facility census was 43. On 10/31/21 at 5:08 P.M., the Administrator and RN Corporate Clinical Coordinator #600 were notified Immediate Jeopardy began on 10/31/21 when the facility failed to ensure a licensed nurse was assigned to care for six residents (Resident's #8, #15, #18, #31, #37 and #43) residing on the COVID-19 unit from 7:00 A.M. to 7:00 P.M. resulting in no licensed care being completed as ordered including the administration of medication, blood glucose checks, administration of skin treatments, COVID-19 respiratory assessments, and vital signs. The Immediate Jeopardy was removed on 11/09/21 when the facility implemented the following corrective actions: The staffing levels were reviewed by the Administrator and Regional Director of Operation (RDO) #627 on 11/09/21 at 10:55 A.M. and deemed appropriate. The facility is actively recruiting for new licensed and certified staff. All residents (Resident's #8, #15, #18, #31, #37 and #43) on the COVID-19 unit had the potential to be affected by the staffing levels in the facility and have been reviewed and any identified issues addressed. RDO #627 reviewed staffing requirements per regulations, appropriate mitigating staffing strategies on 11/09/21 at 10:55 A.M. with the Administrator. The staffing sheets will be reviewed by the Administrator five times weekly for one month, then weekly for one month, then monthly for three months and signed off by the Administrator/designee as appropriate to meet the needs of the residents. Any identified issues will be immediately relayed to the Director of Nursing (DON) (upon hire)/RDO #627 and RN/ Corporate Clinical Coordinator #600. All staffing concerns will be submitted to and reviewed by the Quality Assurance Performance Improvement (QAPI) committee monthly for review and recommendations. The Administrator is responsible for sustained compliance. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In the event there is no scheduled licensed nurse coverage in the facility (minimum needed is one per census), the Administrator will offer incentives to employee nurses to pick up the shift(s) and attempt to secure agency contract nurses. The DON (upon hire) is responsible for clinical support inside the facility. Until a DON is hired, RN Corporate Clinical Coordinator #600 (Acting DON) is responsible for clinical support inside the facility. The Administrator will notify RDO #627 of all call offs and unsuccessful attempts. In that event, a plan will be made to utilize other sister facility licensed staff and/or corporate nurse staff. Although the Immediate Jeopardy was removed on 11/09/21, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings include: 1. Review of physician orders for 10/31/21 revealed Resident #15 was to receive Dexamethasone tablet 6 milligram (mg) by mouth one time a day for inflammation ordered for 9:00 A.M., Digoxin 125 microgram (mcg) tablet by mouth for heart failure ordered for 5:00 P.M. and to take a pulse rate prior to administering, Metoprolol Tartrate tablet 50 mg one tablet by mouth ordered for 9:00 A.M. for hypertension and to take a blood pressure and pulse prior to administering the medication and hold if the pulse rate was below 60 and systolic blood pressure less than 100, and Gabapentin (anticonvulsant) 300 mg one capsule by mouth ordered for 9:00 A.M., 1:00 P.M. and 5:00 P.M. Also, Resident #15 had orders for a respiratory screener to assess his respiratory status and vital signs including blood pressure, pulse, temperature, and oxygen saturation level to be completed on day shift. Review of the October 2021 Medication Administration Record (MAR) revealed Resident #15 did not receive any of his ordered medications on 10/31/21 from 7:00 A.M. to 7:00 P.M as well as Resident #15 did not have an assessment of his respiratory status due to confirmed COVID-19 and vital signs completed on day shift as ordered. 2. Review of the physician orders for 10/31/21 revealed Resident #18 was to receive Dexamethasone 6 mg by mouth ordered for 9:00 A.M. for inflammation, Lisinopril 5 mg one tablet by mouth for hypertension ordered for 9:00 A.M., Lovenox solution (anticoagulant) 40 mg per 0.4 milliliter (ml) inject subcutaneously ordered for 10:00 A.M., Tradjenta 5 mg tablet by mouth ordered for 9:00 A.M. for diabetes, Metformin 1000 mg one tablet by mouth ordered for 9:00 A.M. and 5:00 P.M. for diabetes, Benzonatate capsule 100 mg give one capsule by mouth for cough at 9:00 A.M., 1:00 P.M., and 5:00 P.M., obtain a glucose level at 8:00 A.M., 12:00 P.M. and 5:00 P.M. and inject Humalog-solution 100 units per ml subcutaneously per sliding scale. Resident #18 also had orders for a respiratory screener to assess respiratory status due to confirmed COVID-19, and vital signs including blood pressure, pulse, respirations, temperature, and oxygen saturation level ordered for lunch time. Review of the October 2021 MAR revealed Resident #18 did not receive any of his medications, respiratory screen, blood glucose checks, or vital signs as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the nursing note dated 10/31/21 at 7:23 P.M. and authored by RN #609 revealed a random blood sugar was obtained, and Resident #18's blood sugar was 397 mg dL. The nursing noted revealed RN #609 notified Physician's Assistant (PA) #602 and received a new order to administer one dose of 8 units of regular insulin immediately to cover the elevated blood sugar. 3. Review of the admission physician orders for October 2021 revealed Resident #8 had an order for Furosemide (Lasix) 40 mg by mouth ordered for 9:00 A.M. for fluid retention and to have his blood pressure checked and hold the Lasix if systolic blood pressure was below 110, Gabapentin 100 mg give one capsule my mouth ordered for 5:00 P.M. for nerve pain, Guaifenesin extended release 600 mg by mouth for cough ordered for 9:00 A.M., NPH insulin suspension 100 units per ml give 10 ml subcutaneously one time a day before breakfast for diabetes ordered for 7:30 A.M., NPH insulin suspension 100 units per ml give 11 units subcutaneously in the evening before dinner for diabetes ordered for 5:00 P.M., Carvedilol 25 mg tablet by mouth two times a day for hypertension and check blood pressure and hold the medication if the systolic blood pressure was less than 110 or if the heart rate was less than 50 ordered for 9:00 A.M., check blood glucose level and administer Lispro insulin 100 units per ml by injecting subcutaneously per sliding scale before meals for diabetes ordered for 11:00 A.M. and 4:00 P.M., Oxycodone-Acetaminophen 10-325 mg tablet by mouth every four hours as needed for pain, Acetaminophen 325 mg tablet administer two tablets every four hours as needed for mild pain. Resident #8 also had an order for a respiratory screener to check respiratory status due to confirmed COVID-19, and vital signs including blood pressure, pulse, temperature, respirations, and oxygen saturation level was to be completed at lunch time. Resident #8 had treatments orders including: cleanse the right heel with normal saline, apply betadine (antiseptic) and calcium alginate (dressing for heavily draining wounds) and cover with foam dressing ordered to be completed at 5:00 P.M., and cleanse the right heel with normal saline, pat dry, apply betadine, cover with abdominal (ABD) pad, and wrap with Kerlix gauze ordered to be completed at 5:00 P.M. Review of the October 2021 MAR and Treatment Administration Record (TAR) revealed Resident #8 received Oxycodone-Acetaminophen 10-325 mg tablet by mouth on 10/31/21 at 5:54 A.M. as Resident #8's pain level was a seven on a pain scale from zero to ten. Resident #8 did not receive any further Oxycodone-Acetaminophen until 10/31/21 at 7:15 P.M. when his pain level was documented as a ten on a pain scale from zero to ten. The MAR and TAR revealed Resident #8 did not receive any of his medications, blood glucose level checks, respiratory assessment, vital signs, and treatments completed as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Review of the nursing note dated 10/31/21 at 8:29 P.M. and authored by RN #609 revealed she completed a random blood sugar check, and Resident #8's blood sugar was 374 mg dL. RN #609 notified PA #602 and received an order to give NPH insulin 11 units now. Interview on 11/03/21 at 2:09 P.M. with Resident #8, who is cognitively intact with a Brief interview for Mental Status (BIMS) score of 15, revealed he did not receive any of his pain medications all day one day when he was on the COVID-19 unit and was in severe pain to the point he thought he was dying from the pain. Resident #8 revealed the nurses do not change his dressings daily. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/4/21 at 9:57 A.M. with RN #609 revealed Resident #8 was in severe pain when she arrived on the COVID-19 unit on 10/31/21 at 7:00 P.M. Resident #8 was crying, and RN #609 assessed his pain level as a 10 as well as Resident #8 verbalized his pain level was a 10 on a pain scale from zero to ten. RN #609 revealed she reviewed the MAR and was aware Resident #8 had not received any Oxycodone-Acetaminophen since early that morning at approximately 5:00 A.M. RN #609 revealed she medicated Resident #8 with Oxycodone-Acetaminophen 10-325 mg tablet per the as needed order and notified PA #602. 4. Review of the physician orders revealed on 10/31/21 Resident #31 had the following orders: Amiodarone 200 mg by mouth scheduled at 9:00 A.M. for atrial fibrillation, Finasteride 5 mg tablet by mouth for prostate hyperplasia ordered for 9:00 A.M., Fluticasone Furoate aerosol 100- 25 micrograms (mcg) administer one inhalation ordered for 9:00 A.M. for COPD, Lidocaine patch 4 percent apply to affected area due to left femur fracture to be applied at 9:00 A.M., Zoloft 25 mg by mouth for depression ordered for 9:00 A.M., Spiriva hand held inhaler 18 mcg one capsule inhale orally for COPD ordered for 9:00 A.M. Budesonide-Formoterol Fumarate aerosol 160-4.5 mcg two puffs for COPD ordered for 9:00 A.M Resident #31 also had an order for Tramadol 50 mg give 0.5 (half) tablet by mouth every 12 hours as needed for pain for up to five days, an order dated 11/02/21 for Tylenol 325 mg give two tablets by mouth every six hours as needed for pain and Oxycodone HCL 5 mg by mouth four times a day for pain from the left hip fracture. In addition, Resident #31 had physician orders to have a respiratory screen completed at lunch time every day, and vital signs including blood pressure, temperature, pulse, respirations, and oxygen saturation rate completed at 2:00 P. M. every day. Review of the October 2021 MAR revealed Resident #31 had not received any of his medications, respiratory screen, or vital signs completed as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Resident #31 had a physician order for Tramadol 50 mg give 0.5 tablet by mouth every 12 hours as needed for pain. Review of the nursing notes dated 10/31/21 at 8:07 P.M. and authored by RN #609 revealed she assessed the effectiveness of the Tramadol that was provided to Resident #31 on 10/31/21 at 6:32 A.M. at 10/31/21 8:07 P.M. and revealed the Tramadol was ineffective as Resident #31's pain level was a seven on a pain scale from zero to ten. 5. Review of the physician orders for 10/31/21 revealed Resident #43 had orders including: Aldactone (diuretic) 50 mg tablet by mouth ordered for 9:00 A.M., Celexa 20 mg by mouth for depression ordered for 9:00 A.M., Coreg 3.125 mg tablet for hypertension ordered for 8:00 A.M., Keppra 500 mg tablet for epilepsy ordered for 9:00 A.M., Gabapentin 300 mg capsule by mouth for epilepsy ordered for 9:00 A.M., 1:00 P.M. and 5:00 P.M. Resident #43 also had physician orders to have a respiratory screen and vital signs including blood pressure, temperature, pulse, respirations, and oxygen saturation rate completed at also at lunch time every day. Review of the October 2021 MAR revealed Resident #43 did not receive any of his medications, respiratory screen, and vital signs as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Review of the physician orders for 10/31/21 revealed Resident #37 had orders including: Arava 20 mg by mouth for rheumatoid arthritis ordered for 9:00 A.M., Hydroxychloroquine Sulfate 200 mg by mouth for COVID-19 ordered for 9:00 A.M., Lidocaine patch 4 percent topically to affected area for arthritis ordered to be applied at 9:00 A.M., Lisinopril 2.5 mg by mouth for hypertension ordered for 9:00 A.M., Prednisone (steroid) 2.5 mg tablet by mouth to be given with Prednisone 3 mg tablet by mouth ordered for 9:00 A.M., and Glyburide 2.5 mg by mouth for diabetes ordered for 9:00 A.M. and 5:00 P.M. Resident #37 also had treatment orders that included mupirocin ointment two percent to apply to healing wounds (there was no location of wound noted on the order) ordered at 2:00 P.M., respiratory screen for Covid-19 was to be completed at lunch time, and vital signs including blood pressure, pulse, temperature, and oxygen saturation rate due to COVID-19 were to be completed at 1:00 P.M. Review of the October 2021 MAR and TAR for Resident #37 revealed Resident #37 did not receive any of the ordered medications, mupirocin treatment, respiratory screen, or vital signs completed as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Interview on 11/03/21 at 10:37 A.M. and 11/08/21 at 8:27 A.M. with RN Corporate Clinical Coordinator #600 verified all six residents (Resident's #8, #15, #18, #31, #37 and #43) residing on the COVID-19 unit did not receive any of their ordered medications, treatments, COVID-19 respiratory assessments, blood glucose checks, and vital signs on 10/31/21 from 7:00 A.M. to 7:00 P.M. as there was not a nurse on the COVID-19 unit. RN Corporate Clinical Coordinator #600 revealed she was not aware there was not a nurse on the COVID-19 unit and that no medication or treatments were completed on 10/31/21 from 7:00 A.M. to 7:00 P. M. until 11/01/21. RN Corporate Clinical Coordinator #600 revealed the DON walked out on 10/31/21 and resigned. Interview on 11/04/21 at 10:42 A.M. with RN #611 revealed she was scheduled to work at the facility on 10/31/21 from 7:00 A.M. to 11:00 A.M. but when she arrived, she was the only nurse on the non- COVID-19 unit when there were usually two nurses, and there was not a nurse on the COVID-19 unit. She revealed she was not able to get everything done on the non-COVID-19 unit so she would not have had time to go to the COVID-19 unit. RN #611 revealed she was never instructed by the Administrator or anyone else to go on the COVID-19 unit as that would have been an infection control issue going back and forth as well as she was not able to get everything done on the non-COVID-19 unit including administering medications and treatments. RN #611 revealed she refused to take the medication cart keys from the previous shift nurse that had worked on the COVID-19 unit as she made it known she was not taking responsibility for the COVID-19 unit as it was unsafe. RN #611 revealed she was unsure the previous shift nurse's name or what that nurse did with the medication cart keys. She revealed the Administrator was aware she was not going onto the COVID-19 unit. Interview on 11/04/21 at 11:05 A.M. with STNA #612 revealed on 10/31/21 from 7:00 A.M. to 7:00 P.M. he was the only staff member that worked on the COVID-19 unit, and there was no nurse. STNA #612 revealed Resident #8 stated he had severe pain to his back and requested his pain medication. STNA #612 revealed Resident #8 moaned out continuously which began mid-morning on 10/31/21. STNA #612 revealed Resident #8 continued to be in severe pain, moaning out continuously and holding his back until 10/31/21 at 7:00 P.M. when RN #609 came on duty. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	STNA #612 revealed Resident #31 was recently admitted to the facility with a fractured hip. STNA #612 revealed Resident #31 was in pain as he was moaning out and showing signs of discomfort. STNA #612 revealed he knew that Resident #31 could receive Tramadol for his pain but because there was no nurse on the COVID-19 unit. STNA #612 indicated Resident #31 could not be assessed or receive pain medication as he should have. STNA #612 revealed he contacted the Administrator multiple times regarding no nurse and Residents #8 and #31 being in pain, and each time the Administrator stated he was working on getting a nurse. STNA #612 revealed Resident #15 continued to state that he could not breath throughout the shift. STNA #612 revealed he attempted to provide comfort but was concerned as he had no idea how his vital signs were especially his oxygen saturation level. STNA #612 revealed he notified the Administrator and RN #611 of Resident #15's complaint of difficulty breathing, and STNA #612 stated, again, they did nothing. STNA #612 revealed he felt he was stuck on the COVID-19 unit in an unsafe situation with residents in pain and having respiratory issues, and he felt helpless as he could do nothing as he was not a nurse. Interview on 11/08/21 at 4:07 P.M. with the Administrator revealed on 10/29/21 the DON resigned but had given a 30-day notice. The Administrator revealed he knew on 10/29/21 and 10/30/21 the facility still did not have a nurse for the COVID-19 unit for 10/31/21 from 7:00 A.M. to 7:00 P.M. The Administrator revealed on 10/30/21 at approximately 6:00 P.M. he had assigned the DON to cover the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. and she acknowledged that she would. The Administrator revealed he notified RN Corporate Clinical Coordinator #600 on 10/29/21 that the DON had resigned on 10/29/21, and she had indicated she would be at the facility on 11/01/21 but the administrator did not recall if he informed RN Corporate Clinical Coordinator #600 that they did not have nursing coverage for the COVID-19 unit for 10/31/21 as he had assumed the DON would cover. The Administrator indicated he received a call from STNA #612, who was working on the COVID-19 unit, at approximately 8:00 A.M. that there was not a nurse on the unit as the DON had not arrived. The Administrator revealed he had attempted to contact the DON multiple times but received no return call. The Administrator stated he attempted to contact agencies for a nurse. The Administrator revealed he notified the one nurse in the facility, RN #611, that she would have to administer medication on the non- COVID-19 unit and the COVID-19 unit. The Administrator revealed he was aware the census of the facility was 43 but assumed maybe at the end of the day she would have been able to get to the COVID-19 unit. The Administrator verified he was not aware RN #611 was unable to go to the COVID-19 unit, and he was not aware medications, treatments, or assessments were not completed on 10/31/21 from 7:00 A.M. to 7:00 P.M. The Administrator indicated he was not aware Resident #8 and Resident #31 had not had their pain addressed as he indicated he thought RN #611 was addressing the needs on the COVID-19 unit. The Administrator verified he did not check with RN #611 on 10/31/21 after he had assigned her to go onto the COVID-19 unit as he assumed she was. The Administrator indicated he did not contact RN Corporate Clinical Coordinator #600 as he did not feel she would be able to assist as she lived over three hours away. The Administrator also verified he did not contact RN Corporate Clinical Coordinator #600 regarding guidance regarding nursing services on 10/31/21. The Administrator also verified he did not contact the resident's primary care physicians to notify them there was not a nurse on the unit as he indicated he felt RN #611 was going onto the COVID-19 unit. The Administrator revealed he did contact Regional Director of Operations (RDO) #627 on 10/31/21 at approximately 11:32 A.M. regarding the situation of additional mitigating staffing steps including having RN #611 service the six residents on the COVID-19 unit. The Administrator indicated on 10/31/21 at 5:00 P.M. the DON entered the facility and resigned effective immediately. (continued on next page)

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The Laurels of Chagrin Falls	150 Cleveland Street Chagrin Falls, OH 44022

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility job description titled Director of Nursing Services, dated April 2004, revealed the primary purpose of the DON was to plan, organize, develop, and direct the overall operation of the nursing services in accordance with federal, state, and local standards, guidelines, and regulation that govern our facility and as may be directed by the Administrator to ensure quality care was always maintained. The job description revealed the DON was to coordinate the staffing needs of the nursing services necessary to meet the total nursing needs of the residents including assigning enough licensed nurses. The job description revealed the DON was to perform on call responsibilities as necessary or required and provide direct nursing care as necessary. Review of the staffing procedure titled Mitigate Staffing Shortages, dated 07/28/20 revealed when staffing shortages were occurring, healthcare and employers may need to implement crisis capacity strategies to continue to provide patient care. The procedure revealed the facility was to develop regional plans to identify designated healthcare facilities or alternative care sites with adequate staffing to care for patients with COVID-19. Interventions under the crisis capacity strategies included implement regional plans to transfer patients with COVID-19 to designated healthcare facilities or alternative care sites with adequate staffing. The Administrator had placed a N/A (not applicable) next to this intervention. Review of facility form titled Facility Assessment- V2, dated 01/07/21, revealed the facility average census over the past 12 months was 33. The facility assessment revealed under staffing plan the average number of licensed nurses providing direct care in a 24-hour period was four. The facility assessment did not identify plans to service residents on the COVID-19 unit including a staffing plan. Review of the facility form titled Mitigating Staffing Steps Taken For 10/31/21, completed by the Administrator revealed on 10/30/21 at 5:04 P.M. the Administrator discussed staffing for 10/31/21 with the DON at 6:01 P. M. The Administrator assigned the DON to cover the COVID-19 unit if no staff picked up, and the DON acknowledged she would cover, and at 7:31 P.M. the Administrator had received approval from RDO #627 to offer incentives. The form revealed on 10/31/21 at 8:12 A.M. the Administrator attempted other agencies; at 8:13 A.M. the Administrator informed RN #611 she would have to provide nursing services including medications to residents on the COVID-19 unit in the event another nurse did not pick up; at 8:16 A.M. the Administrator notified the DON to see if she was aware there was only one nurse in the building, and she needed to come into the facility but received no response; at 11:32 A.M. the Administrator notified RDO #627 of the situation and discussed additional mitigation staffing steps including having the agency nurse who was in the building service the six residents on the COVID-19 unit; at 12:00 P.M. the Administrator arrived at the facility, and at 5:00 P.M. the DON entered the kitchen at the facility and informed the Administrator she was quitting effective immediately with no notice. This deficiency substantiates Complaint Number OH00127169.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, observation, record review, review of facility policy and procedure regarding diabetic management, medication administration, and pain management the facility failed to ensure medications were administered on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. resulting in significant medications errors affecting four residents (Resident's #8, #18, #31 and #43) residing on the COVID-19 unit. This resulted in Immediate Jeopardy that caused actual harm for four residents, (Residents #8, #18, #31 and #43) due to the failure to administer significant medication. On 10/31/21 at 7:30 A.M. Resident #8, who had a diagnosis of diabetes, was not given his NPH insulin 10 units subcutaneously (SQ) before breakfast at 7:30 A.M., his NPH insulin 11 units SQ before dinner at 5:00 P.M., and an omitted blood glucose level check with coverage with Lispro insulin 100 units per ml administered per sliding scale at 11:00 A.M. and 4:00 P.M. The failure to administer the medications as ordered resulted in Resident #8's blood sugar on 10/31/21 at approximately 7:30 P.M. registering high when checked at a level of 374 milligrams (mg) per deciliter (dL) requiring administration of 11 units of NPH insulin ordered to be given immediately by Physician Assistant (PA) #602. On 10/31/21 at 10:00 A.M. Resident #18, who had a history of pulmonary embolism, did not receive physician ordered anticoagulant medication (Lovenox injection) in addition he did not have his blood sugar checked per physician order at 8:00 A.M., 12:00 P.M. and 5:00 P.M. Medications including Humalog insulin 100 units per milliliter (ml) injected subcutaneously per sliding insulin were not given. On 10/31/21 at 7:23 P.M. Resident #18's blood sugar was 397 mg dL requiring eight units of regular insulin given immediately per order of PA #602. On 10/31/21 between 7:00A.M. and 7:00 P.M. Resident #8 and Resident #31 were not assessed for pain or provided their ordered pain medications resulting in intolerable pain evidenced by the residents crying and moaning out for an extended time period. Registered Nurse (RN) #609 arrived on duty on 10/31/21 at 7:00 P.M. and observed Resident #8 crying out in severe pain with a pain level of ten on a pain scale of zero to ten. RN #609 indicated Resident #31's pain on 10/31/21 at 8:07 P. M. was a seven on a pain scale of zero to ten. On 10/31/21 Resident #43, who had a diagnosis of epilepsy, did not receive his anti-seizure medication Keppra at 9:00 A.M. and gabapentin at 9:00 A.M., 1:00 P.M. and 5:00 P.M. as ordered resulting in the potential for seizure activity. This affected four of six residents residing on the COVID-19 unit. The facility census was 43. On 11/08/21 at 5:08 P.M., the Administrator and RN Corporate Clinical Coordinator #600 were notified Immediate Jeopardy began on 10/31/21 when the facility only had one nurse, RN #611, who was assigned to the entire resident population of 43 residents and was not able to check blood sugars, or administer any medications including pain medications, anti-seizure, anticoagulant, and insulin per physician orders on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. This resulted in a potential for Resident #43 to have seizure activity, Resident #8 and Resident #31 to have intolerable pain for an extended period and Resident #8's blood sugar to be 374 mg dL on 10/31/21 at approximately 7:30 P.M. requiring a one-time order of NPH insulin of 11 units and Resident #18's blood sugar on 10/31/21 at 7:23 P.M. to be 397 mg dL requiring 8 units of regular insulin. The Immediate Jeopardy was removed on 11/09/21 when the facility implemented the following corrective actions: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #8 was evaluated for pain by Minimum Data Set (MDS)/ RN #623 on 11/03/21 at 11:32 A.M. Care plan for pain was reviewed 11/09/21 at 11:00 A.M. by RN/ MDS Coordinator #622 for Resident #8. Resident #8 was evaluated by the PA #602 and was noted to be stable after receiving insulin late on 11/03/21. Resident #8 received scheduled insulin on 11/08/21 and 11/09/21 per sliding scale and was without signs or symptoms of hypoglycemia or hyperglycemia. Resident #8 received scheduled Neurontin for nerve pain on 11/08/21 and 11/09/21. Resident #8 received scheduled Oxycodone-Acetaminophen (pain medication) 10/325 milligrams (mg) per physician orders on 11/08/21 and 11/09/21. Resident #31 was evaluated by PA #602 on 11/02/21 at approximately 10:00 A.M. and noted to be stable after receiving medications late on 10/31/21. Resident #31 was evaluated on 11/09/21 at 10:06 A.M. by the MDS/ RN #622. Resident #31 refused the Lidocaine patch on 11/09/21 at 9:00 A.M. and PA #602 was notified 11/09/21 at 11:00 A.M. Resident #31 is receiving Oxycodone per physician order and has had no uncontrolled pain. Resident #18 was evaluated by PA #602 on 11/02/21 at approximately 10:00 A.M. due to missed insulin. Resident #18 received insulin per sliding scale on 11/03/21. Resident #18 was discharged on [DATE]. Resident #43 was reviewed and did not have any negative outcomes following missed anti-seizure medications. Review of the corrective action on 11/10/21 at 11:05 A.M. verified it was completed. Medication Administration Records (MAR's) were reviewed beginning from 11/01/21 by the RN Corporate Clinical Coordinator #600, or designee if any other residents received pain medications, insulin, anti-seizure and/or anticoagulant late and/or had medications omitted. No insulin, pain medications, anti-seizure and/or anticoagulants were missed and/or late since 11/08/21. Pain management care plans were reviewed by RN/ MDS #622 and #623 and diabetic care plans were reviewed by RN/ Corporate Float MDS #624 on 11/09/21 from 7:00 A.M. through 3:00 P.M. and updated as necessary. Review of the corrective action on 11/10/21 at 11:45 A.M. verified it was completed. The medication administration policy was reviewed during the Quality Assurance Performance Improvement (QAPI) meeting on 11/09/21 at 1:30 P.M. In attendance were the Administrator, RN Corporate Clinical Coordinator #600, Medical Director #628, and Regional Director of Operation #627. Review on 11/10/21 at 12:00 P.M. verified the QAPI meeting was conducted on 11/09/21 at 1:30 P.M. All licensed nurses on duty 11/09/21 at 7:00 A.M. were educated on the medication administration policy with a strong emphasis on medication administration times. PA #602 was notified of missed or late medications on 11/09/21 at 11:00 A.M. by RN Corporate Clinical Coordinator #600, or designee. 100 percent of facility licensed nurses (two nurses on payroll) received education on the medication administration policy by RN/ Clinical Coordinator on from 11/04/21 at 1:00 P.M. to 11/05/21 7:00 A.M. Medication management policy and procedure education was provided to the Director of the Primary Staffing Agency #629 on 11/09/21 at 3:03 P.M. by the Administrator and will be provided to agency nurses prior to being sent to the facility. Any licensed nurses sent to the facility without education validation will receive the education by the RN Corporate Clinical Coordinator #600 upon hire, the Director of Nursing (DON)/designee prior to start of their shift. All newly hired licensed nurses will receive the same education during new hire orientation by RN Corporate Clinical Coordinator #600 or the DON (when hired)/designee. Review of the in-service training verified the training occurred on 11/08/21 at 7:00 P.M., 11/09/21 at 7:00 A.M., 11/09/21 at 3:30 P.M., 11/09/21 at 5:10 P.M., and 11/10/21 at 7:15 A.M. with licensed nurses prior to their beginning of their shift as well as the two facility nurses, Licensed Practical Nurse (LPN) #630 and RN #619. Interview on 11/10/21 at 12:04 P.M. with RN #631 and RN #632 verified they received the training prior to the start of their shift, and they were knowledgeable regarding the medication administration policy and procedure. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Audits five times weekly for one month and then weekly for one month and then monthly for three months will be conducted via observation relative to pain medication administration, insulin administration, anti-seizure and/or anticoagulants, by the RN Corporate Clinical Coordinator #600, DON (when hired)/designee, of residents on a pain management program and/or insulin to ensure that pain medication, insulin administration, anti-seizure and/or anticoagulant is completed timely. Any identified issues with pain will be addressed immediately. The results will be submitted to the QAPI committee monthly for review and recommendations. The Administrator is responsible for sustained compliance. Although the Immediate Jeopardy was removed on 11/09/21, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings include: 1. Review of the medical record for Resident #18 revealed an admitted [DATE] and discharge date of [DATE]. Resident #18's diagnoses included COVID-19, dementia, diabetes, history of pulmonary embolism, and hypertension. Review of the care plan dated 10/28/21 revealed Resident #18 did not have a care plan regarding management of diabetes. Review of the physician orders for 10/31/21 revealed Resident #18 was to receive Lovenox solution (anticoagulant) 40 mg per 0.4 milliliter (ml) inject subcutaneously ordered for 10:00 A.M., obtain glucose level at 8:00 A.M., 12:00 P.M. and 5:00 P.M. and inject Humalog-solution 100 units per ml subcutaneously per sliding scale. Review of the October 2021 MAR revealed Resident #18 did not receive any of his ordered medications including his anticoagulant and insulin per sliding scale on 10/31/21 from 7:00 A.M. to 7:00 P.M. Review of the nursing note dated 10/31/21 at 7:23 P.M. and authored by RN #609 revealed a random blood sugar was obtained, and Resident #18's blood sugar was 397 mg dL. The nursing note revealed RN #609 notified PA #602 and received a new order to administer a one-time dose of eight units of regular insulin. Interview on 11/03/21 at 10:37 A.M. and 11/08/21 at 8:27 A.M. with RN Corporate Clinical Coordinator #600 verified Resident #18 did not receive any ordered medications on 10/31/21 from 7:00 A.M. to 7:00 P.M. including his blood glucose level checked at 8:00 A.M., 12:00 P.M. and 5:00 P.M. and insulin administered per sliding scale as there was not a nurse on the COVID-19 unit. RN Corporate Clinical Coordinator #600 verified Resident #18's blood sugar was taken on 10/31/21 at 7:23 P.M. and was elevated at 392 mg dL requiring a one-time dose of regular insulin. RN Corporate Clinical Coordinator #600 verified Resident #18 did not have a care plan regarding management of diabetes. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/03/21 at 11:45 A.M. with PA #602 revealed on 10/31/21 at approximately 7:30 P.M. she was notified by RN #609 that there had not been a nurse on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. The facility only had an aide on the unit, and Resident #18 did not receive any medications during this time including his insulin. PA #602 revealed RN #609 checked Resident #18's blood sugar. His blood sugar was 397 mg dL, and she ordered a one-time dose of eight units of regular insulin to be given immediately. 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including COVID-19, pneumonia due to COVID-19, diabetes, chronic kidney disease, atrial fibrillation, gangrene not classified, completed traumatic amputation of left great toe, chronic osteomyelitis, pain in right foot, pain in left foot, pain in unspecified shoulder, and low back pain. Review of the admission physician orders for October 2021 revealed Resident #8 had an order for NPH insulin suspension 100 units per ml give 10 ml subcutaneously one time a day before breakfast for diabetes ordered for 7:30 A.M., NPH insulin suspension 100 units per ml give 11 units subcutaneously in the evening before dinner for diabetes ordered for 5:00 P.M., check blood glucose level and administer insulin Lispro 100 units per ml by injecting subcutaneously per sliding scale before meals for diabetes ordered for 11:00 A.M. and 4:00 P.M., Oxycodone-Acetaminophen 10-325 mg tablet by mouth every four hours as needed for pain, and Acetaminophen 325 mg tablet administer two tablets every four hours as needed for mild pain. Review of the October 2021 MAR revealed Resident #8 received Oxycodone- Acetaminophen 10-325 mg tablet by mouth on 10/31/21 at 5:54 A.M. for a pain level of seven on a pain scale of zero to ten. Resident #8 did not receive any further Oxycodone-Acetaminophen until 10/31/21 at 7:15 P.M. when his pain level was documented as a ten on a pain scale of zero to ten. The MAR revealed Resident #8 did not receive any of his ordered medication including insulin and pain medications on 10/31/21 from 7:00 A.M. to 7:00 P.M. and did not have his blood glucose level checked as ordered. Review of the admission assessment labeled Nursing Comprehensive Evaluation V1-V13 for Resident #8 dated 10/28/21 and completed by RN #618 revealed Resident #8 was currently having pain and had pain in the last five days. Resident #8 revealed his pain was in his lower back and bilateral heels. Resident #8 revealed his pain was an eight on a pain scale of zero to ten. Resident #8 revealed his pain got as bad as a 10 on a pain scale of zero to ten. Review of the care plan dated 10/28/21 revealed Resident #8 was at risk for pain. Interventions included anticipate resident's need for pain relief as needed and respond immediately to any complaint of pain, and notify physician if interventions were unsuccessful or if current complaint was a significant change from resident's experience of pain. Resident #8 did not have a care plan related to management of diabetes and interventions. Review of the admission Brief Interview for Mental Status (BIMS) dated 10/29/21 revealed Resident #8 was cognitively intact with a BIMS score of a 15. Review of the nursing note dated 10/31/21 at 8:29 P.M. and authored by RN #609 revealed she completed a random blood sugar check, and Resident #8's blood sugar was 374 mg dL. RN #609 notified PA #602 and received an order to give NPH insulin 11 units now for coverage of the elevated blood sugar. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/03/21 at 10:37 A.M. and 11/08/21 at 8:27 A.M. with RN Corporate Clinical Coordinator #600 verified there was only one aide on the COVID-19 unit, and there was not a nurse on 10/31/21 from 7:00 A. M. to 7:00 P.M. RN Corporate Clinical Coordinator #600 verified Resident #8 did not receive any medications or blood sugar checks that were scheduled between 7:00 A.M. to 7:00 P.M. including Resident #8's insulin, and pain medication. The last Oxycodone-Acetaminophen 10-325 mg as needed was given on 10/31/21 at 5:54 A.M., and he had not received any further Oxycodone-Acetaminophen until 10/31/21 at 7:15 P.M. per RN #609. RN Corporate Clinical Coordinator #600 revealed the DON walked out, and the Administrator tried to get a nurse but was unable to. Interview on 11/03/21 at 11:45 A.M. with PA #602 revealed on 10/31/21 at approximately 7:30 P.M. she was notified by RN #609 that there had not been a nurse on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. The facility only had a state tested nurse aide (STNA) on the unit, and Resident #8 did not receive any medications during this time. PA #602 revealed she was aware Resident #8 did not receive any pain medications all day and was in pain when RN #609 had arrived on duty. PA #602 revealed Resident #8 had chronic back pain and received medications as needed to control his pain. PA #602 revealed RN #609 administered his pain medication when she arrived on the unit at approximately 7:00 P.M. PA #602 also revealed she was aware Resident #8 had not had his blood glucose level checked or any ordered insulin on 10/31/21 from 7:00 A.M. to 7:00 P.M. PA #602 revealed RN #609 checked Resident #8's blood glucose level, and it was 374 mg dL. She ordered NPH insulin 11 units to be given right away and recheck Resident #8's blood glucose level. Interview on 11/03/21 at 2:09 P.M. with Resident #8, who is cognitively intact, revealed he did not receive any of his pain medications all day one day when he was on the COVID-19 unit and was in severe pain to the point he thought he was dying from the pain. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #8 revealed it was still in progress. Interview on 11/04/21 at 11:05 A.M. with STNA #612 revealed on 10/31/21 from 7:00 A.M. to 7:00 P.M. he was the only staff member that worked on the COVID-19 unit, and there was not a nurse. STNA #612 revealed Resident #8 stated he had severe pain to his back and requested his pain medication. STNA #612 revealed Resident #8 moaned continuously which began mid-morning on 10/31/21. STNA #612 revealed he contacted the Administrator multiple times regarding no nurse and Resident #8 moaning in pain, and each time STNA #612 revealed the Administrator stated he was working on getting a nurse. STNA #612 revealed Resident #8 continued to be in severe pain, moaning continuously and holding his back until 10/31/21 at 7:00 P.M. when RN #609 came on duty. STNA #612 revealed he felt terrible as there was nothing, he could do except try to make Resident #8 more comfortable. Interview on 11/04/21 at 9:57 A.M. with RN #609 revealed Resident #8 was in severe pain when she arrived on the COVID-19 unit on 10/31/21 at 7:00 P.M. as Resident #8 was crying and had a pain level assessed as a ten on a pain scale of zero to ten. RN #609 revealed she reviewed the MAR and was aware Resident #8 had not received any Oxycodone-Acetaminophen since early that morning at approximately 5:00 A.M. RN #609 revealed she medicated Resident #8 with Oxycodone-Acetaminophen 10-325 mg tablet per his as needed order and notified PA #602. 3. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including fracture of unspecified part of neck of left femur, congestive heart failure, chronic obstructive pulmonary disease (COPD), and Alzheimer's disease. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the physician orders revealed on 10/31/21 Resident #31 had the following orders: lidocaine patch 4 percent apply to affected area due to left femur fracture which was to be applied at 9:00 A.M. Resident #31 also had an order for Tramadol 50 mg give 0.5 (one half) tablet by mouth every 12 hours as needed for pain for up to five days. Review of the admission assessment labeled Nursing Comprehensive Evaluation, dated 10/30/21, completed by RN #621 revealed Resident #31 was not having pain and had not had pain in the last five days. Review of the October 2021 MAR revealed Resident #31 had not received any of his medications including pain medications ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Resident #31 had a physician order for Tramadol 50 mg give 0.5 tablet by mouth every 12 hours as needed for pain. Review of the MAR revealed Resident #31 was given Tramadol on 10/30/21 at 8:37 P.M. for a pain level of seven on a pain scale of zero to ten that was effective. The MAR revealed Resident #31 was given Tramadol on 10/31/21 at 6:32 A.M., and it was documented Resident #31's pain level was an eight on a pain scale of zero to ten, and the Tramadol was ineffective for Resident #31's pain. Review of the nursing notes dated 10/31/21 at 8:07 P.M. and authored by RN #609 revealed she assessed the effectiveness of the Tramadol that was provided to Resident #31 on 10/31/21 at 6:32 A.M. and revealed the Tramadol was ineffective as Resident #31's pain level was a seven on a pain scale of zero to ten. There was no documented evidence in the nursing notes of any intervention provided for Resident #31's pain level being assessed as a seven on a pain scale of zero to ten. There was no documented evidence he received additional pain management medication or that PA #602 was notified regarding his pain level being a seven. Review of the care plan dated 11/01/21 revealed Resident #31 did not have a care plan regarding pain management. Review of the BIMS dated 11/01/21 revealed Resident #31 had severe cognitive impairment. Review of the Admission MDS 3.0 assessment dated [DATE] revealed it was still in progress. Interview on 11/04/21 at 11:05 A.M. with STNA #612 revealed on 10/31/21 from 7:00 A.M. to 7:00 P.M. he was the only staff member that worked on the COVID-19 unit, and there was not a nurse. STNA #612 revealed Resident #31 was recently admitted to the facility with a fractured hip. STNA #612 revealed Resident #31 was in pain as he was moaning and showing signs of discomfort. STNA #612 revealed he knew Resident #31 could receive medication for his pain but because there was no nurse on theCOVID-19 unit, Resident #31 could not be assessed or receive pain medication as he should have. STNA #612 revealed he contacted the Administrator multiple times regarding no nurse and Resident #31 being in pain, and each time the Administrator stated he was working on getting a nurse. STNA #612 revealed he was frustrated as he knew Resident #31 was in pain. STNA #612 stated he was a STNA and was unable to give medications, and all he could do was try to make Resident #31 comfortable by repositioning him in bed for comfort . (continued on next page)

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The Laurels of Chagrin Falls	150 Cleveland Street Chagrin Falls, OH 44022

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation and interview on 11/09/21 at 11:24 A.M. revealed Resident #31 was up in the recliner visiting with his daughter and displayed no signs of pain or discomfort. Resident #31 revealed his pain level was about a four on a pain scale of zero to ten. Resident #31 could not provide any information regarding concerns of pain while on the COVID-19 unit. Resident #31's daughter revealed she was not able to visit when he was on the COVID-19 unit and was not able to communicate with him on the phone, so she had no information regarding his pain management while residing on the COVID-19 unit. Interview on 11/09/21 at 1:17 P.M. with RN #609 verified Resident #31 had not received any medication on 10/31/21 from 7:00 A.M. to 7:00 P.M. as there was no nurse. She verified she remembered Resident #31 moaning when she came in to work, but she could not provide any further details as she could not remember. 4. Review of the closed medical record for Resident #43 revealed an admitted [DATE] and a discharge date on 11/02/21. Resident #43's diagnoses included esophageal varices, severe alcohol use, epilepsy, upper gastrointestinal bleed, and COVID-19. Review of the care plan dated 10/28/21 revealed Resident #43 was at risk for seizure disorder. Interventions included labs as ordered and seizure precautions. Review of the physician orders for 10/31/21 revealed Resident #43 had orders including: Keppra (anti-seizure) 500 mg tablet for epilepsy ordered for 9:00 A.M., and Gabapentin (anti-seizure) 300 mg capsule by mouth for epilepsy ordered for 9:00 A.M., 1:00 P.M., and 5:00 P.M. Review of the October 2021 MAR revealed Resident #43 did not receive any of the medications including anti-seizure epilepsy medications ordered to be administered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Interview on 11/03/21 at 10:37 A.M. and 11/08/21 at 8:27 A.M. with RN Corporate Clinical Coordinator #600 verified Resident #43 did not receive any of the medications ordered to be administered on 10/31/21 from 7:00 A.M. to 7:00 P.M. as there was not a nurse on the COVID-19 unit. Review of the facility policy titled Pain Management, dated July 2021, revealed the facility would evaluate and identify a resident for pain, determine the type, location and severity and develop a care plan for pain management. The policy revealed staff were to observe a resident for pain indicators including moaning, crying, other vocalization, and body posture as guarding or protecting an area. The policy revealed the nursing assistant would communicate to the licensed nurse when a resident was experiencing pain. The policy revealed the licensed nurse would communicate a new onset of pain to the physician. The staff would implement the care plan and administer interventions for pain. Review of the facility policy labeled Medication Administration, dated November 2021, revealed the facility failed to implement their policy as the resident medications were to be administered in an accurate, safe, timely, and sanitary manner. The policy revealed do not administer medications until the discrepancy was resolved. The policy revealed medications were to be administered within 60 minutes of the scheduled time. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy labeled Diabetic Management, dated November 2021, revealed diabetic management involves both preventative measures and treatment of complications. The facility failed to implement their policy as blood glucose measurements were to be taken per physician order and results outside of ordered parameter were to be communicated to the physician immediately. The policy also revealed anti-diabetic agents including insulin were to be administered per physician order. This deficiency substantiates Complaint Number OH00127169.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 39973 Based on observation, record review, interview, review of staffing and medication administration policies, job description of the Director of Nursing (DON) and facility assessment, the facility administration, having knowledge of resident care not being delivered, failed to implement its resources to ensure all residents received appropriate care to attain and maintain the highest practicable level of physical, mental, and psychosocial well-being. The facility failed to ensure a licensed nurse was assessing, monitoring, and treating residents on 10/31/21 from 7:00 A.M. to 7:00 P.M. on the COVID-19 unit that housed six residents (Resident's #8, #15, #18, #31, #37 and #43). This resulted in Immediate Jeopardy and the likelihood of actual harm when Resident #15 was not assessed due to complaints of shortness of breath, two residents (Resident's #8 and #18) did not receive scheduled insulin resulting in elevated blood glucose levels, two residents (Resident's #8 and #31) did not receive needed pain medication resulting in intolerable pain, Resident #8 did not receive ordered treatments for skin impairment, Resident #18 did not receive anti-coagulant therapy, Resident #43 did not receive anti-convulsant medication, Resident #37 did not receive her cardiac, diabetic, or arthritic pain medications as well as her topical medication to her skin impairment, and all six residents did not receive assessment of respiratory status and vital signs. On 10/31/21 at 5:08 P.M., the Administrator and RN Corporate Clinical Coordinator #600 were notified Immediate Jeopardy began on 10/31/21 when the facility failed to ensure a licensed nurse was assigned to care for residents residing on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. resulting in no licensed care being provided as ordered including the administration of medication, blood glucose checks, administration of wound treatments, COVID-19 respiratory assessments, and vital signs for six residents (Resident's #8, #15, #18, #31, #37 and #43) housed on the COVID-19 unit. The Immediate Jeopardy was removed on 11/09/21 when the facility implemented the following corrective actions: The staffing levels were reviewed by the Administrator and Regional Director of Operation (RDO) #627 on 11/09/21 at 11:05 A.M. and deemed appropriate. The facility is actively recruiting for new licensed and certified staff. On 10/31/21 the facility census was 43. All residents (Resident's #8, #15, #18, #31, #37 and #43) on the COVID-19 unit had the potential to be affected by the staffing levels in the facility and have been reviewed and any identified issues addressed. The Administrator will be responsible to notify RDO #627 of all call offs that cannot be covered by agency staff. (RDO) #627 had reviewed staffing requirements per regulations, appropriate mitigating staffing strategies on 11/09/21 at 11:05 A.M. with the Administrator. The staffing sheets will be reviewed by the Administrator five times weekly for one month, then weekly for one month, then monthly for three months and signed off by the Administrator/designee as appropriate to meet the needs of the residents. Any identified issues will be immediately relayed to the Director of Nursing (DON) (upon hire)/RDO #627 and RN/Corporate Clinical Coordinator #600. All staffing concerns will be submitted to and reviewed by the Quality Assurance Performance Improvement (QAPI) committee monthly for review and recommendations. The Administrator is responsible for sustained compliance. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In the event there is no scheduled licensed nurse coverage in the facility (minimum needed is one per census), the Administrator will offer incentives to employee nurses to pick up the shift(s) and attempt to secure agency contract nurses. The DON (upon hire) is responsible for clinical support inside the facility. The Administrator will notify RDO #627 of all call offs and unsuccessful attempts. In that event, a plan will be made to utilize other sister facility licensed staff and/or corporate nurse staff. Although the Immediate Jeopardy was removed on 11/09/21, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings include: 1. Review of the October 2021 Medication Administration Record (MAR) revealed Resident #15 did not receive any medications including cardiac, have his blood pressure and pulse monitored prior to medication administration, a respiratory screen, or vital signs including oxygen saturation level as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. 2. Review of the October 2021 MAR revealed Resident #18 did not receive medications including an anticoagulant, and insulin, as well as blood glucose levels checked, respiratory screen or vital signs completed as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Review of the nursing note dated 10/31/21 at 7:23 P.M. and authored by RN #609 revealed a random blood sugar was obtained, and Resident #18's blood sugar was 397 milligrams (mg) per deciliter (dL). The nursing note revealed RN #609 notified Physician's Assistant (PA) #602 and received a new order to administer a one-time dose of insulin immediately to cover the elevated blood sugar. 3. Review of the October 2021 MAR and Treatment Administration Record (TAR) revealed Resident #8 received narcotic pain medication on 10/31/21 at 5:54 A.M. for a pain level of seven on a pain scale from zero to ten. Resident #8 did not receive any further pain medication until 10/31/21 at 7:15 P.M. when his pain level was documented as a ten on a pain scale from zero to ten. The MAR and TAR also revealed Resident #8 did not receive his insulin, blood glucose level, respiratory assessment, vital signs, and wound care treatments as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Review of the nursing note dated 10/31/21 at 8:29 P.M. and authored by RN #609 revealed she completed a random blood sugar check, and Resident #8's blood sugar was 374 mg dL. RN #609 notified PA #602 and received an order for a one-time dose of insulin to cover the elevated blood sugar. Interview and observation on 11/03/21 at 2:09 P.M. with Resident #8, who is cognitively intact, revealed he did not receive any of his pain medications all day one day when he was on the COVID-19 unit and was in severe pain to the point he thought he was dying from the pain. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 11/04/21 at 9:57 A.M. with RN #609 revealed Resident #8 was in severe pain when she arrived on the COVID-19 unit on 10/31/21 at 7:00 P.M. as Resident #8 was crying. RN #609 assessed Resident #8's pain level as a ten on a pain scale from zero to ten as well as Resident #8 verbalized his pain level was a ten on a pain scale from zero to ten. RN #609 revealed she reviewed the MAR and was aware Resident #8 had not received narcotic pain medication since early that morning at approximately 5:00 A.M. RN #609 revealed she administered Resident #8 his pain medication and notified PA #602. 4. Review of the October 2021 MAR revealed Resident #31 had not received any medications including his pain medications, as well as a respiratory screen or vital signs completed as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Review of the nursing notes dated 10/31/21 at 8:07 P.M. and authored by RN #609 revealed she assessed the effectiveness of the Tramadol that was last provided to Resident #31 on 10/31/21 at 6:32 A.M. on 10/31/21 at 8:07 P.M. and revealed the Tramadol was ineffective as Resident #31's pain level was a seven on a pain scale from zero to ten. 5. Review of the October 2021 MAR for Resident #43 revealed Resident #43 did not receive any medications including anti-seizure medications, respiratory screen or vital signs as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. 6. Review of the October 2021 MAR and TAR revealed Resident #37 did not receive any ordered medications including cardiac, diabetic, arthritic pain medication, mupirocin treatment (anti-bacterial ointment), respiratory screen or vital signs as ordered on 10/31/21 from 7:00 A.M. to 7:00 P.M. Interview on 11/03/21 at 10:37 A.M. and 11/08/21 at 8:27 A.M. with RN Corporate Clinical Coordinator #600 verified all six residents (Resident's #8, #15, #18, #31, #37 and #43) residing on the COVID-19 unit did not receive any of their ordered medications, blood glucose checks, treatments, COVID-19 respiratory assessments, and vital signs on 10/31/21 from 7:00 A.M. to 7:00 P.M. as there was no nurse providing care to the residents on the COVID-19 unit. RN Corporate Clinical Coordinator #600 revealed the Director of Nursing (DON) walked out 10/31/21 and resigned but she was not notified that there was not a nurse on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. until 11/01/21. Interview on 11/04/21 at 10:42 A.M. with RN #611 revealed she was scheduled to work at the facility on 10/31/21 from 7:00 A.M. to 11:00 A.M. but when she arrived, she was the only nurse on the non-COVID-19 unit when there were usually two nurses, and there was not a nurse on the COVID-19 unit. She revealed she was not able to get everything done on the non-COVID-19 unit so she would not have had time to go to the COVID-19 unit. RN #611 revealed she was never instructed by the Administrator or anyone else to go on the COVID-19 unit as that would have been an infection control issue going back and forth as well as she was not able to get everything done on the non-COVID-19 unit including administering medications and treatments. RN #611 revealed she refused to take the medication cart keys from the previous shift nurse that had worked on the COVID-19 unit as she made it known she was not taking responsibility for the COVID-19 unit as it was unsafe. RN #611 revealed she was unsure the previous shift nurse's name or what that nurse did with the medication cart keys. She revealed the Administrator was aware she was not going onto the COVID-19 unit. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with PA #602 revealed she had concerns with the health and safety of the residents especially after the facility was unable to provide nursing services on the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M. PA #602 revealed she was concerned that during that prolonged period all the residents on the COVID-19 unit were not assessed including respiratory assessments and vital signs even though they had confirmed diagnoses of COVID-19. PA #602 revealed she was notified by RN #609 regarding Resident's #8 and #18's blood glucose levels being elevated as they did not receive their insulin all day as well as Resident #8 was in severe pain as he had not received pain medication as needed. PA #602 revealed it was unacceptable that the facility did not provide the care and services to the residents on the COVID-19 unit for that long of time as it jeopardized their safety. PA #602 revealed the DON walked out and abandoned the residents even though the DON knew the residents were not receiving the care and services required. PA #602 revealed she felt this was neglect. PA #602 revealed she brought her concerns to the Administrator on 11/01/21. Interview on 11/04/21 at 11:05 A.M. with State tested Nursing Assistant (STNA) #612 revealed on 10/31/21 from 7:00 A.M. to 7:00 P.M. he was the only staff member that worked on the COVID-19 unit, and there was not a nurse. STNA #612 revealed Resident #8 stated he had severe pain to his back and requested pain medication. STNA #612 revealed Resident #8 moaned continuously beginning mid-morning on 10/31/21. STNA #612 revealed Resident #8 continued to be in severe pain, moaning continuously and holding his back until 10/31/21 at 7:00 P.M. when RN #609 came on duty. STNA #612 revealed Resident #31 was recently admitted to the facility with a fractured left hip. STNA #612 revealed Resident #31 was in pain as he was moaning and showed signs of discomfort. STNA #612 revealed he knew Resident #31 could receive Tramadol for his pain but because there was no nurse on the COVID-19 unit, Resident #31 could not be assessed or receive pain medication as he should have. STNA #612 revealed he contacted the Administrator multiple times regarding no nurse and regarding Resident's #8 and #31 being in pain, and each time the Administrator stated he was working on getting a nurse. STNA #612 revealed Resident #15 continued to state that he could not breath throughout the shift. STNA #612 revealed he attempted to provide comfort but was concerned as he had no idea what his vital signs were especially his oxygen saturation level. STNA #612 revealed he notified the Administrator and RN #611 of Resident #15's complaint of difficulty breathing, and STNA #612 stated, again, they did nothing. STNA #612 revealed he felt he was stuck on the COVID-19 unit in an unsafe situation with residents in pain and having respiratory distress, and he felt helpless as he could do nothing because he was not a nurse. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 11/08/21 at 4:07 P.M. with the Administrator revealed on 10/29/21 the DON resigned but gave a 30-day notice. The Administrator revealed he knew on 10/29/21 and 10/30/21 the facility still did not have a nurse for the COVID-19 unit for 10/31/21 from 7:00 A.M. to 7:00 P.M. The Administrator revealed on 10/30/21 at approximately 6:00 P.M. he assigned the DON to cover the COVID-19 unit on 10/31/21 from 7:00 A.M. to 7:00 P.M., and she had acknowledged that she was assigned. The Administrator revealed he notified RN Corporate Clinical Coordinator #600 on 10/29/21 that the DON had resigned on 10/29/21, and RN Corporate Clinical Coordinator #600 revealed she would be at the facility on 11/01/21, but he did not recall if he informed RN Corporate Clinical Coordinator #600 that they did not have nursing coverage for the Covid unit for 10/31/21 as he had assumed the DON would cover. The Administrator revealed he received a call from STNA #612 at approximately 8:00 A.M. who was working on the COVID-19 unit that there was not a nurse on the COVID-19 unit as the DON had not arrived. The Administrator revealed he attempted to contact the DON multiple times but received no return call. The Administrator attempted to contact agencies for a nurse. The Administrator revealed he notified the one nurse in the facility, RN #611, she would have to administer medication on the non-COVID-19 unit and the COVID-19 unit. The Administrator revealed he was aware the census of the facility was 43 but assumed maybe at the end of the day she would have been able to get to the COVID-19 unit. The Administrator verified he was not aware RN #611 was unable to go to the COVID-19 unit and he was not aware medications, treatments, and assessments were not completed on 10/31/21 from 7:00 A.M. to 7:00 P.M. The Administrator revealed he was not aware Resident #8 or Resident #31's pain was not being addressed as he revealed he had thought RN #611 was addressing the needs on the COVID-19 unit. The Administrator verified he did not check with RN #611 on 10/31/21 after he had assigned her to go onto the COVID-19 unit as he assumed, she was. The Administrator revealed he did not contact RN Corporate Clinical Coordinator #600 as he did not feel she would be able to assist as she lived several hours away. The Administrator also verified he did not contact RN Corporate Clinical Coordinator #600 regarding guidance regarding nursing services on 10/31/21. The Administrator also verified he did not contact the resident's primary care physicians on the COVID-19 unit or the Medical Director to notify them there was not a nurse on the unit or that there was a delay in residents receiving their medications and treatment as he revealed he felt RN #611 was going to go on the COVID-19 unit. The Administrator revealed he did contact Regional Director of Operations (RDO) #627 on 10/31/21 at approximately 11:32 A.M. regarding the situation of additional mitigating staffing steps including having RN #611 service the six residents on the COVID-19 unit. The Administrator revealed on 10/31/21 at 5:00 P.M. the DON entered the facility and resigned effective immediately and refused to assist with servicing the residents and their needs especially those residents on the COVID-19 unit. Review of the facility job description titled Director of Nursing Services, dated April 2004, revealed the primary purpose of the DON was to plan, organize, develop, and direct the overall operation of the nursing services in accordance with federal, state, and local standards, guidelines, and regulation that govern our facility and as may be directed by the Administrator to ensure quality care was always maintained. The job description revealed the DON was to coordinate the staffing needs of the nursing services necessary to meet the total nursing needs of the residents including assigning enough licensed nurses. The job description revealed the DON was to perform on call responsibilities as necessary or required and provide direct nursing care as necessary. (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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility policy titled Medication Administration, dated October 2019, revealed the facility failed to implement their policy as medications were to be administered in an accurate, safe, timely and sanitary manner. The policy revealed medications were to be administered within 60 minutes of the scheduled time. The policy revealed the nurse was to record the dose, route, and time of the medication on the medication or treatment record. The policy did not include ensuring the facility provided proper equipment such as PCC access, PCC badges and/or scanners were provided to the nurses in a timely manner. Review of the staffing procedure titled Mitigate Staffing Shortages, dated 07/28/20 and completed by the Administrator on 10/31/21. The procedure revealed when staffing shortages were occurring, healthcare and employers may need to implement crisis capacity strategies to continue to provide patient care. The procedure revealed the facility was to develop regional plans to identify designated healthcare facilities or alternative care sites with adequate staffing to care for patients with COVID-19. Interventions revealed under the crisis capacity strategies included implement regional plans to transfer patients with COVID-19 to designated healthcare facilities or alternative care sites with adequate staffing. The Administrator had placed a N/A (not applicable) next to this intervention. Review of the facility form titled Facility Assessment- V2, dated 01/07/21, revealed the facility average census over the past 12 months was 33. The facility assessment revealed under staffing plan, the average number of licensed nurses providing direct care in a 24- hour period was four. The facility assessment did not identify plans to service residents on the COVID-19 unit including a staffing plan. Review of facility form titled Mitigating Staffing Steps Taken For 10/31/21, completed by the Administrator revealed on 10/30/21 at 5:04 P.M. the Administrator discussed staffing for 10/31/21 with the DON, 10/30/21 at 6:01 P.M. the Administrator assigned the DON to cover the COVID-19 unit if no staff picked up, and the DON acknowledged she would cover. On 10/30/21 at 7:31 P.M. the Administrator received approval from RDO #627 to offer incentives. The form revealed on 10/31/21 at 8:12 A.M. the Administrator attempted other agencies, 10/31/21 at 8:13 A.M. the Administrator informed RN #611 that she would have to provide nursing services including medications to residents on the COVID-19 unit in the event another nurse did not pick up, 10/31/21 at 8:16 A.M. the Administrator notified the DON to see if she was aware only one nurse in the building and that she needed to come into the facility but received no response, 10/31/21 at 11:32 A.M. the Administrator notified RDO #627 of the situation and discussed additional mitigation staffing steps including having the agency nurse who was in the building service the COVID-19 residents, 10/31/21 at 12:00 P.M. the Administrator arrived at the facility, and 10/31/21 at 5:00 P.M. the DON entered the kitchen at the facility and informed the Administrator she was quitting effective immediately with no notice. This deficiency substantiates Complaint Number OH00127169.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366274	A. Building B. Wing	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Chagrin Falls	150 Cleveland Street Chagrin Falls, OH 44022

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39973 Based on record review and interview, the facility failed to ensure administered medications were documented in the medical records as appropriate. This affected five (Resident's #9, #13, #17, #32 and #42) of five residents reviewed for medication administration. Findings include: 1. Review of Resident #9's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including unspecified convulsions, psychotic disorder with delusions and major depressive disorder. Review of Resident #9's medication administration record (MAR) dated 10/30/21 did not reveal evidence the resident was administered his buspirone 5 mg (milligram) for anxiety due at 9:00 A.M., lamotrigine 300 mg for epilepsy due at 9:00 A.M., polyethylene powder for constipation due at 9:00 A.M., Vitamin D-3 2000 international units (IU) for a supplement due at 9:00 A.M., bromocriptine 2.5 mg for neuroleptic induced parkinsonism due at 9:00 A.M., chloropromazine 10 mg for schizophrenia due at 9:00 A.M., clobazam 10 mg for convulsions due at 9:00 A.M., colace 100 mg for constipation due at 9:00 A.M. and namenda 5 mg for dementia due at 9:00 A.M. 2. Review of Resident #13's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including unspecified dementia without behavioral disturbance, hyperlipidemia and dysarthria following a cerebral infarction. Review of Resident #13's MAR dated 10/30/21 did not reveal evidence the resident was administered his aspirin 81 mg for cerebellar stroke syndrome due at 9:00 A.M., coumadin 6 mg for cerebellar stroke syndrome due at 5:00 P.M., folic acid 1 mg for a low folic level due at 9:00 A.M., trintellix 15 mg for depression due at 9:00 A.M. and vitamin d3 2000 IU as a supplement due at 9:00 A.M 3. Review of Resident #17's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease with late onset, major depressive disorder and muscle weakness. Review of Resident #17's MAR dated 10/30/21 did not reveal evidence the resident was administered his escitalopram 20 mg for depression due at 9:00 A.M., finasteride 5 mg for urinary retention due at 9:00 A.M., senna tablet 8.6 mg for constipation due at 9:00 A.M., vitamin d3 2000 IU for a supplement due at 9:00 A.M., aspirin 81 mg to prevent heart attack due at 9:00 A.M., docusate sodium 100 mg for constipation due at 9:00 A.M. and methocarbamol 500 mg for muscle spasms due at 9:00 A.M., 1:00 P.M. and 5:00 P.M. 4. Review of Resident #32's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including major depressive disorder, cerebral infarction and unspecified atrial fibrillation. (continued on next page)

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	366274	A. Building B. Wing	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Chagrin Falls	150 Cleveland Street Chagrin Falls, OH 44022

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #32's MAR dated 10/30/21 did not reveal evidence the resident was administered her cholecalciferol 2000 IU for repeated falls due at 9:00 A.M., cyanocobalamin 1000 mcg (micrograms) for a supplement due at 9:00 A.M., aggrenox 25-200 mg for a blood thinner due at 9:00 A.M., lactobacillus one capsule for a probiotic due at 9:00 A.M. and oyster shell calcium and vitamin D 500-200 mg (2 tablets) as a supplement due at 9:00 A.M. 5. Review of Resident #42's medical record revealed the resident was admitted to the facility on [DATE] and discharged to the hospital on 11/01/21 with diagnoses including multiple sclerosis, hypothyroidism and essential hypertension. Review of Resident #42's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #42's MAR dated 10/30/21 did not reveal evidence the resident was administered her fluoxetine 20 mg for depression due at 9:00 A.M., lisinopril 10 mg for hypertension due at 9:00 A.M., meloxicam 15 mg for osteoarthritis pain due at 9:00 A.M., oxybutynin extended release 10 mg for overactive bladder due at 9:00 A.M., dalfampridine extended release 10 mg for multiple sclerosis due at 9:00 A.M., baclofen 20 mg for a muscle relaxant due at 2:00 P.M., tizanidine 2 mg for a muscle relaxant due at 9:00 A.M. , 1:00 P.M. and 5:00 P.M. and atorvastatin 20 mg for high cholesterol due at 5:00 P.M. Interview on 11/14/21 at 12:15 P.M. with the Administrator confirmed Resident #44's MAR had multiple medications not documented as administered for 10/30/21. He stated sometimes agency staff documented on paper MARS and he would look for these records. An additional telephone interview on 11/14/21 at 1:48 P.M. with the Administrator indicated Licensed Practical Nurse (LPN) #635 (agency staff) worked the dayshift from 7:00 A.M. to 7:00 P.M. on 10/30/21 and she did not have a login to document the medications she had administered. The Administrator indicated she was unaware of where the paper MARS were to document the medications on paper. A telephone interview on 11/14/21 at 1:54 P.M. with LPN #635 indicated she was the only nurse working on 10/30/21 on the main part of the facility and she could not get in touch with the Director of Nursing (DON) for a login to document her medication administration. She indicated the nightshift agency nurse gave her a login to use so she could see the medications in the electronic health records. The nurse indicated she had administered all the resident medications on her shift from 7:00 A.M. to 7:00 P.M. but did not document any medications as administered in the resident records because she did not have the ability to do so. She stated that no staff informed her of the paper MARS in which she could document resident medications and the only documentation of medications she could complete on that date was to document in the narcotic flow records when the residents received narcotics.