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	03/28/2022

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and facility policy review, the facility failed to follow professional medication administration standards to ensure Resident #8's medication was used for another resident (Resident #14). This affected one resident (Resident #8) out of three resident's reviewed for medication administration. Findings include: Review of Resident #8's medical record revealed an admitted [DATE] and diagnoses included congestive heart failure, chronic kidney disease, stage three, and chronic atrial fibrillation. Review of Resident #8's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 was cognitively intact and required extensive assistance of one staff member for bed mobility, transfers, and toilet use. Review of Resident #8's physician orders on 03/08/22 revealed orders for Furosemide 20 milligram (mg), give one tablet by mouth one time a day for fluid retention. Review of Resident #8's care plan dated 03/09/22, revealed Resident #8 was at risk for nutritional decline related to his diagnoses. Resident #8 would maintain adequate nutritional status as evidenced by maintaining weight within five percent of current body weight. Some weight fluctuation expected in weight related to Lasix (Furosemide). Interventions included to notify the registered dietician, family and physician of significant weight changes; to observe and evaluate weight and weight changes. Review of Resident #14's Medication Administration Record (MAR) on 03/22/22 revealed Furosemide 40 mg tablet was due at 9:00 A.M. and administered by Registered Nurse (RN) #206. Observation on 03/22/22 at 9:50 A.M. of RN #206 revealed she searched the medication cart for Resident #14's Furosemide 40 mg tablets, was unable to locate the medication, and picked up Resident #8's medication card which contained Furosemide 20 mg tablets. RN #206 removed two 20 mg tablets from the card, placed them in a medication cup, and administered the two tablets to Resident #14. RN #206 stated she was unable to locate Resident #14's Furosemide in the medication cart, Resident #8 was receiving the same medication, just a different dose, so she removed two Furosemide 20 mg tablets (equaled Furosemide 40 mg) from Resident #8's card and administered it to Resident #14. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/22/22 at 9:55 A.M. with Director of Nursing (DON) verified RN #206 administered Resident #8's Furosemide to Resident #14. Review of facility policy titled, Medication Administration, revised 12/16/21, revealed medications were administered in accordance with written orders of the attending physician. Follow safe preparation practices. Never administer medications supplied for one resident to another resident.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and facility policy review, the facility failed to ensure appropriate care and services were provided for one resident's (Resident #2) right hip pressure ulcer. Actual Harm occurred when Resident #2's right hip pressure ulcer identified on 02/13/22 was not accurately documented in the medical record, care planned interventions were not implemented and Resident #2's pressure ulcer deteriorated to an unstageable pressure ulcer without a change in treatment. This affected one resident (Resident #2) out of three residents reviewed for pressure ulcers. Findings include: Review of Resident #2's medical record revealed an admitted [DATE] and diagnoses included dementia with behavioral disturbance, cerebral infarction, and unspecified sequelae of nontraumatic subarachnoid hemorrhage. Review of Resident #2's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #2 had severe cognitive impairment and required extensive assistance of two staff members for bed mobility, transfers, and toilet use. Resident #2 was always incontinent of urine and frequently incontinent of bowel. Resident #2 did not have a pressure ulcer or injury. Review of Resident #2's Braden Scale for Predicting Pressure Sore Risk dated 09/10/21 and 12/15/21, revealed Resident #2 was at a low risk for developing pressure injury or ulcers. Review of Resident #2's progress notes on 02/13/22 revealed a change of condition note was written by Registered Nurse (RN) #200 and included Resident #2 had a skin wound or ulcer, change in skin color or condition. A treatment was ordered to apply a foam dressing and there was no change in mental status or functional status. Further review of the progress notes revealed a stage two pressure ulcer was identified and had a length of 5.0 centimeters (cm), a width of 2.0 cm, the depth was not included, and Physician Assistant (PA) #201 was notified. No further description of the pressure ulcer was documented. Review of Resident #2's physician orders on 02/13/22 revealed orders for right hip pressure area, cleanse with normal saline, pat dry, cover with foam dressing every day shift and as needed. Further review of the physician orders from 02/13/22 through 03/22/22 did not reveal orders for Resident #2's right hip pressure ulcer. Review of Resident #2's Skin and Wound Evaluation dated 02/16/22 revealed Resident #2 had an in-house acquired, stage two pressure ulcer (partial-thickness skin loss with exposed dermis) to her right trochanter (hip), the wound was present two weeks and measured a length of 6.0 cm, width of 3.9 cm and the depth was documented not applicable. Review of Resident #2's MDS assessment dated [DATE] revealed Resident #2 had severe cognitive impairment and required extensive assistance of two staff members for bed mobility, transfers, and toilet use. Resident #2 was frequently incontinent of urine and bowel and had a stage two pressure ulcer on her right hip. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2's Quarterly Nutritional Re-Evaluation dated 02/21/22, revealed there were no noted skin injuries and no pressure areas. The nutritional evaluation did not include the documentation of a stage two pressure ulcer to the right hip in Resident #2's medical record from 02/13/22 and 02/16/22. Review of Resident #2's medical record did not reveal a Braden Scale for Predicting Pressure Sore Risk was completed from 02/13/22 through 03/14/22. Review of Resident #2's care plan dated 03/07/22 revealed Resident #2 had and actual impairment to skin integrity related to open area right hip abrasion and reduce likelihood of pressure injury development through next review date. Skin injury of the right hip would show signs of healing by review date. Resident #2 would have no complications related to open area to right hip through the review date. Interventions included to apply pressure relieving, reducing mattress, pillows, etcetera to protect the skin while in bed; to conduct weekly head to toe skin assessments and report new, abnormal findings to physicians as needed. The care plan included Resident #2 was at risk for skin breakdown related to impaired balance, impaired mobility and cognition, dementia with behavioral disturbances, cerebrovascular accident. Minimize risk in an effort to reduce likelihood of pressure injury development through next review date. Interventions included to turn and reposition Resident #2 every two hours and as needed. Review of Resident #2's dietary progress notes on 03/07/22 revealed documentation Resident #2 had a stage two pressure ulcer to the right hip. The resident was provided Med Pass (nutritional supplement) 120 milliliters (ml) every day to help with nutritional needs. Review of Resident #2's Wound and Skin Evaluation on 03/11/22 revealed Resident #2 had a stage two pressure ulcer of the right trochanter (hip), it was in-house acquired, and present for two weeks. The length was 3.5 cm, width of 2.8 cm, and the depth was not documented (stated not applicable). The documentation stated the wound was deteriorating. There was no documentation the physician, physician's assistant, dietician or responsible party was notified. There was no further documentation of the wound's characteristics including color, drainage, or wound bed. Review of Resident #2's Braden Scale for Predicting Pressure Sore Risk dated 03/15/22, revealed Resident #2 was at moderate risk for developing pressure injury or ulcers. Review of Resident #2's Wound and Skin Evaluation on 03/17/22 revealed Resident #2 had a stage two pressure ulcer of the right trochanter, in-house acquired, and present for two weeks. The length was 3.8 cm, width was 2.1 cm, and the depth was not documented (stated not applicable). The documentation stated the progress was stalled, and there was no documentation the physician, physician's assistant, dietician, or responsible party was notified. There was no further documentation of the wound's characteristics including color, drainage, wound bed. Review of Resident #2's progress notes from 01/28/22 through 03/22/22 did not reveal documentation Resident #2 was turned and repositioned every two hours or she refused to be turned and repositioned every two hours. Review of Resident #2's progress notes from 02/14/22 through 03/22/22 did not reveal documentation MD #202 or PA #201 were notified of Resident #2's worsening right hip pressure ulcer. There was no documentation of wound location, measurements, and characteristics. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2's Wound and Skin Evaluation on 03/23/22 revealed Resident #2 had a stage two pressure ulcer of the right trochanter (hip), it was in-house acquired, and present for two weeks. The length was 3.9 cm, width of 2.7 cm, and the depth was not documented (stated not applicable). The documentation stated the wound was deteriorating. There was documentation the physician, physician's assistant, and responsible party were notified. There was no documentation the dietician was notified of the deteriorating pressure ulcer. There was no documentation of the wound's characteristics including color, drainage, wound bed. Observation on 03/23/22 at 7:10 A.M. revealed Resident #2 was lying on her left side in bed. Interview on 03/23/22 at 9:55 A.M. with Director of Nursing (DON) revealed she was new to the facility since 01/03/22. The DON stated she was not certified to be a wound nurse and the facility did not use a wound physician or a wound nurse practitioner. DON stated she measured and documented information for Resident #2's pressure ulcer by using an application on her cell phone. DON stated she was still learning the system and trying to figure it out because she wanted to do it correctly. DON stated she received some instruction from Clinical Care Coordinator (CCC) #203 when she was first hired, but CCC #203 was called to a different facility and unable to return for further instruction. DON stated she took a picture of the wound with the cell phone and the application calculated the wound measurements, then she loaded the picture and wound measurements into the resident's electronic record and manually filled out the rest of the Skin and Wound evaluation for the description of the wound. DON stated she did not manually measure the pressure ulcer and compare her numbers to the cell phone measurements to ensure accuracy. DON stated she had problems with the system and some of the information did not carry over into the electronic record. When asked what interventions would be appropriate for a resident with a pressure ulcer the DON stated the resident should be lying on an air mattress. DON stated she did not know if Resident #2 was lying on an air mattress. Observation on 03/23/22 at 10:10 A.M. of Resident #2 with the DON revealed Resident #2 was not lying on a low air loss mattress. Resident #2 had a pressure redistribution foam mattress. DON confirmed Resident #2 did not have a low air loss mattress. Observation on 03/23/22 at 1:47 P.M. of Resident #2 with DON revealed Resident #2 was lying on her left side in bed and had a pressure ulcer on her right hip. The pressure ulcer was dark red around the edges of the wound, the wound bed was a light yellow white color, and the center of the wound bed had a dark gray color with a small maroon area. The pressure ulcer measured a length of 3.9 cm, width 2.5 cm, and the depth was unable to be determined because of slough tissue. A small dark red spot about the size of a dime was noted to the lower left of the pressure ulcer, and the DON stated the small dark red spot did not blanche. The DON stated the spot was not there on 03/17/22 when she evaluated the wound, and the wound bed on 03/17/22 was all white and did not have the dark gray or maroon color. Interview on 03/23/22 at 3:30 P.M. with PA #201 revealed she was not called by any nurse regarding Resident #2's pressure ulcer and she had not seen the pressure ulcer since the third or fourth week of February 2022. Interview on 03/23/22 at 3:22 P.M. with Medical Director (MD) #202 revealed he had not observed or evaluated Resident #2's pressure ulcer. MD #202 stated he relied on the nurse's to tell him if there was a problem with a pressure ulcer, and he had not received a phone call from any nurse regarding Resident #2's pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/23/22 at 3:45 P.M. with DON revealed she was notified of Resident #2's pressure ulcer to the right hip on 02/13/22, but did not do an evaluation until 02/16/22. The DON stated she did not evaluate the wound until 02/16/22 because she usually did her wound assessments on Thursday. DON stated Resident #2's right hip pressure ulcer on 03/23/22 was an unstageable pressure ulcer. When asked why the documentation for Resident #2's Skin and Wound Evaluation on 03/23/22 stated Resident #2 had a stage two pressure to the right hip and was present for two weeks, the DON verified the evaluation had incorrect information. DON stated the cell phone program for wound measurements was not working properly and would not let her update the information. DON stated the documentation in Resident #2's Wound and Skin Evaluations for 03/11/22 and 03/17/22 were also incorrect. The DON revealed on 03/11/22 the right hip pressure ulcer had yellow slough in the wound bed, and was a stage three pressure ulcer. The DON revealed on 03/17/22 the wound bed was a whitish color, had a dark red area, and was getting worse. The DON confirmed she did not notify PA #201 or MD #203 about Resident #2's deteriorating right hip pressure ulcer. When asked if the correct information about the right hip pressure ulcer was documented in the progress notes the DON stated she did not document measurements or characteristics of the right hip pressure ulcer in the progress notes from 02/16/22 through 03/23/22. After surveyor intervention documentation in the progress notes was noted on 03/23/22 regarding Resident #2's unstageable right hip pressure ulcer. Observations on 03/23/22 at 2:00 P.M., 3:00 P.M., and 4:20 P.M. of Resident #2 revealed she was lying on her left side. There was no observation of staff attempting or encouraging Resident #2 to turn and reposition. Observation on 03/23/22 at 4:20 P.M. of Resident #2 with Licensed Practical Nurse (LPN) #205 revealed Resident #2 was lying on her left side. LPN #205 stated Resident #2 liked to lay on her left hip or her right hip, and would go right back to lying on her side if she was turned. There was no observation of positioning aides in the bed or the room, and this was confirmed by LPN #205. Interview on 03/23/22 at 4:33 P.M. with Consultant Dietician (CD) #204 revealed she usually was at the facility every other week, but tested positive for COVID-19 and was out of the facility the month of February and returned on 03/07/22. CD #204 stated she remotely completed Resident #2's Quarterly Nutritional Re-Evaluation on 02/21/22 and although there were nursing progress notes on 02/13/22 regarding Resident #2's right hip pressure ulcer, CD #204 wrote Resident #2's skin was intact per notes from nursing. CD #204 stated she was first aware of Resident #2's pressure ulcer on 03/07/22, documented Resident #2 had a stage two pressure ulcer to the right hip, and Resident #2 had been on a nutritional supplement (Med Pass) for weight loss. CD #204 stated the nutritional supplement was appropriate for a stage two pressure ulcer, but additional interventions would be needed if Resident #2 had a stage three pressure ulcer. Observation on 03/24/22 at 8:20 A.M. of Resident #2's right hip pressure ulcer with PA #201 revealed Resident #2 was lying on her left side and a moderate amount of red tinged yellow drainage was observed on the dressing. The wound edges were red and sluggishly blanched around the edges. The wound bed had yellowish white tissue and the center of the wound had dark gray tissue. PA #201 stated when she saw the wound on 02/2022 it was not an open wound but now the right hip wound had deteriorated and was an unstageable pressure ulcer. When asked what information she needed about the wound to make a decision for proper treatment PA #201 stated she was not great with wounds and would ask MD #202 if she had a question. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/24/22 at 2:01 P.M. with CCC #203 revealed there were technical issues with the application used through the cell phone for measurements of wounds. CCC #203 revealed some portions of the assessments including pictures and measurements were not crossing over into the electronic medical record, and the facility was working with the cell phone application company to fix the issues. CCC #203 stated the not applicable statement under the depth area in wound measurements had to be manually changed, the depth of a wound had to be manually measured and recorded in the Skin and Wound Evaluation. CCC #203 stated once information was loaded into the program and recorded in the resident's electronic medical record, portions of it could not be modified. Interview on 03/24/22 at 3:34 P.M. with State tested Nursing Assistant (STNA) #205 revealed she worked second and third shifts. STNA #205 stated Resident #2 would allow herself to be positioned but she didn't need to worry about turning and repositioning her because she got up to her chair for meals. STNA #205 stated she did not encourage Resident #2 to turn and reposition when she was in bed. Interview on 03/25/22 at 11:53 A.M. with RN #200 revealed she documented Resident #2 had a stage two pressure ulcer on 02/13/22, and she remembered for sure it was not open at the time. RN #200 stated Resident #2's functional status had not changed since she was admitted on [DATE], she would allow staff to position her, and she did not know why Resident #2's Braden Score for Pressure Ulcer Risk was a low risk when she was admitted and changed to a moderate risk on 03/15/22. RN #200 stated Resident #2 required total care of the staff to meet her needs. Review of the facility policy titled, Skin Management, revised 07/14/21, revealed residents with wounds, pressure injury and those at risk for skin compromise were identified, evaluated, and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation were provided to ensure optimal resident outcomes. The Braden Scale would be completed upon admission, re-admission, weekly for four weeks, quarterly, and with a significant change of status by a licensed nurse to determine the risk of pressure injury development. Appropriate preventative interventions would be implemented on residents identified at risk and the interventions were documented on the care plan. A nutritional evaluation by a Registered Dietician would evaluate all residents identified with skin impairment for nutritional status in a timely manner. Recommend labs to be drawn to evaluate protein status in all residents with existing wounds as needed. Resident's with pressure injury and lower extremity ulcers would be evaluated, measured and staged weekly in accordance with the practice guidelines until resolved. A photo could be initiated unless the resident refused. A licensed nurse would notify the attending physician with any changes as needed. A Guest/Resident at Risk meeting would be conducted at least monthly by the Interdisciplinary Team (IDT). During the meeting the IDT would evaluated resident skin changes, review treatment modalities, interventions and would make recommendations as needed. Residents reviewed for skin alterations included newly developed pressure injuries, any pressure injury that had shown no signs of healing within a two week time frame.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42013 Based on observation, interview, record review, and facility policy review, the facility failed to maintain a medication error rate of less than five percent (%). The medication error rate was calculated to be 9.09 % and included three medication errors of 33 medication administration opportunities. This affected one resident (Resident #14) out of three residents observed during medication administration observation. Findings include: Review of Resident #14's physician orders revealed an order on 12/05/21 for Humalog Solution (Insulin Lispro) 100 units per ml, inject per sliding scale for blood sugar (for a blood sugar from 201 to 250 inject 2 units) subcutaneously before meals for diabetes mellitus management, and notify physician if blood sugar is over 400. Review of Resident #14's physician orders revealed an order written on 12/30/21 for Furosemide 40 mg tablet, give one tablet by mouth one time a day for chronic kidney disease. Review of Resident #14's physician orders revealed an order written on 02/16/22 for insulin glargine solution 100 units per ml, inject 28 units subcutaneously one time a day for diabetes. Review of Resident #14's Medication Administration Record (MAR) on 03/22/22 revealed Humalog Solution (Insulin Lispro), inject per sliding scale for blood sugar subcutaneously before meals was due at 8:00 A.M. before breakfast, but was not administered until 9:50 A.M., almost two hours after breakfast. Review of Resident #14's MAR on 03/22/22 revealed Furosemide 40 mg tablet and insulin glargine 28 units was due at 9:00 A.M On 03/22/22 at 9:25 A.M. Registered Nurse (RN) #206 was observed obtaining Resident #14's blood sugar. The blood sugar was 215. On 03/22/22 at 9:50 A.M. RN #206 was observed administering medications to Resident #14. RN #206 obtained and prepared medications including Humalog Solution Insulin (Insulin Lispro) 100 units per milliliter (ml), 2 units, Furosemide 20 mg (two tablets) tablet, and insulin glargine 100 units per ml, 28 units. After preparing the medications RN #206 was observed administering the medications to Resident #14. This resulted in one medication error for Resident #14. Observation on 03/22/22 at 9:50 A.M. of RN #206 revealed she searched the medication cart for Resident #14's Furosemide 40 mg tablets, was unable to locate the medication, and picked up Resident #8's medication card which contained Furosemide 20 mg tablets. RN #206 removed two 20 mg tablets from the card, placed them in a medication cup, and administered the two tablets to Resident #14. RN #206 stated she was unable to locate Resident #14's Furosemide in the medication cart, Resident #8 was receiving the same medication, just a different dose, so she removed two Furosemide 20 mg tablets (equaled Furosemide 40 mg) from Resident #8's and administered it to Resident #14. This resulted in a second medication error for Resident #14. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/22/22 at 9:50 A.M. revealed RN #206 reached into the medication cart and picked up an insulin glargine pen injector 100 unit per ml and placed it on the top of the cart. RN #206 picked up an insulin syringe, picked up the insulin glargine pen injector, proceeded to place the insulin syringe inside the tip of the pen injector and draw up 28 units of insulin glargine. When asked what she was doing RN #206 stated the insulin glargine pen injector did not have any needles and she had to use a syringe to draw the required amount out of the pen injector to give Resident #14 the insulin glargine which was due now. RN #206 administered insulin glargine 28 units subcutaneously to Resident #14. This resulted in a third medication error for Resident #14. Interview on 03/22/22 at 9:55 A.M. with Director of Nursing (DON) revealed she was informed RN #206 put an insulin syringe in the tip of the insulin glargine pen injector and drew insulin out to administer to Resident #14. DON stated she should not have done that because it ruined the pen injector. Review of the manufacturer's recommendations dated 11/2018, revealed do not use a syringe to remove Lantus (insulin glargine) from your disposable pre-filled pen. Review of facility policy titled Medication Administration, revised 12/16/21, revealed medications were administered in accordance with written orders of the attending physician. Follow safe preparation practices. Never administer medications supplied for one resident to another resident. Administer medications within 60 minutes of the scheduled time.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42013 Based on observation, interview, record review, and facility policy review, the facility failed to ensure appropriate infection control practices were followed. This affected four residents (Resident's #14, #18, #22, #23) reviewed for appropriate infection control practices and had the potential to affect all 24 residents residing in the facility. Findings include: Observation on 03/22/22 at 8:46 A.M. of Registered Nurse (RN) #206 revealed she prepared medications for Resident #23, picked up a reusable blood pressure cuff and a reusable pulse oximeter (measures oxygen saturation in the blood) used on the finger, and walked into Resident #23's room. RN #206 administered Resident #23's medications, took her blood pressure and obtained her oxygen saturation. RN #206 gathered the blood pressure cuff and the pulse oximeter and walked out of the room. RN #206 did not wash her hands, use hand sanitizer, or disinfect the reusable blood pressure cuff and pulse oximeter after administering Resident #23's medications, taking the blood pressure, and obtaining the oxygen saturation. Observation on 03/22/22 at 9:14 A.M. of RN #206 revealed she prepared medications for Resident #18, picked up the same reusable blood pressure cuff and pulse oximeter she used for Resident #23, did not disinfect them, and walked into Resident #18's room. RN #206 administered Resident #18's medications, took her blood pressure and obtained her oxygen saturation. RN #206 gathered the blood pressure cuff and pulse oximeter and walked out of the room. RN #206 did not wash her hands, use hand sanitizer, or disinfect the reusable blood pressure cuff and pulse oximeter after administering Resident #18's medications, taking her blood pressure and obtaining her oxygen saturation. Observation on 03/22/22 at 9:25 A.M. of RN #206 revealed RN #206 picked up a glucometer from a drawer in the medication cart and walked into Resident #14's room. RN #206 used the glucometer and checked Resident #14's blood sugar. RN #206 finished the blood sugar check, picked up the glucometer and walked out of Resident #14's room and did not wash her hands or use hand sanitizer. RN #206 did not disinfect the glucometer, opened the medication cart drawer, and placed the glucometer in the drawer. Observation on 03/22/22 at 9:50 A.M. of RN #206 revealed RN #206 prepared Resident #14's medications including insulin, walked into Resident #14's room and administered the medications including a subcutaneous injection of insulin into Resident #14's abdomen. RN #206 walked out of the room when she finished administering Resident #14's medications and did not wash her hands or use hand sanitizer. Observation on 03/22/22 at 10:30 A.M. of RN #206 revealed RN #206 prepared Resident #22's medications, walked into Resident #22's room without using hand sanitizer or washing her hands and administered Resident #22's medications including a pain patch to Resident #22's right shoulder and lower back. Observation on 03/22/22 from 8:46 A.M. through 10:30 A.M. of RN #206 did not reveal she washed her hands or used hand sanitizer. (continued on next page)

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	03/28/2022

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/22/22 at 10:35 A.M. of RN #206 confirmed she did not wash her hands or use hand sanitizer before or after administering medications for Resident's #14, #18, #22, and #23. RN #206 confirmed she did not disinfect the glucometer after obtaining Resident #14's blood sugar and placing the glucometer in the medication cart. RN #206 confirmed she did not disinfect the reusable blood pressure cuff and pulse oximeter after obtaining Resident's #18 and #23's blood pressure and oxygen saturation. Review of facility policy titled, Medication Administration, revised 12/16/21, revealed medications were administered in accordance with written orders of the attending physician. Follow safe preparation practices. Never administer medications supplied for one resident to another resident. Wash hands prior to medication preparation for each medication pass. Wash hands after direct resident contact. Alternatives to hand washing, such as alcohol based hand rubs may be used between residents where direct contact has not occurred.