| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366274 | A. Building<br>B. Wing | 02/17/2023 |

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

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|---|---|
| F 0660<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Plan the resident's discharge to meet the resident's goals and needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706<br><br>Based on closed record review, hospital record review, Total Parenteral Nutrition (TPN) Team documentation and interview, the facility failed to develop and implement an effective discharge plan for Resident #30 to ensure total parental nutrition (TPN), a specialized formula given through the vein which provides most of the nutrients the body needs was ordered/provided and a home health infusion nurse was arranged for home care following the resident's discharge home from the facility on 01/19/23.<br><br>Actual Harm occurred on 01/22/23 when Resident #30 presented to the emergency room with signs of hypovolemic shock (volume depletion) after the facility failed to arrange for home going TPN including the coordination of pharmacy services and a home health infusion nurse at the time of discharge from the facility. Upon discharge, the facility provided enough TPN to administer through 01/21/23 in the A.M. Resident #30 was hospitalized from 01/22/23 through 02/01/23. This affected one (Resident #30) of three residents reviewed for discharge/transfer. The facility census was 29.<br><br>Findings include:<br><br>Review of the closed medical record for Resident #30 revealed an admitted [DATE] post hospitalization for malnutrition. Diagnoses included severe protein malnutrition, disorder of protein plasma metabolism, nutritional anemia, Crohn's disease (chronic inflammatory bowel disease), gastroesophageal reflux disease without esophagitis, generalized anxiety, major depressive disorder, ileostomy (small intestine is diverted through an opening in the abdomen) and fistula of the intestines. The resident was admitted with TPN orders and treatment.<br><br>The current TPN order details dated 12/24/22 revealed TPN was to be on (infuse) for 12 hours and be off 12 hours. On Monday, Wednesday and Friday Resident #30 received lipid TPN (provides essential fatty acids) at the same rate.<br><br>Review of the Admission Minimum Data Set (MDS) 3.0 assessment for Resident #30, dated 12/30/22, revealed intact cognition. Resident #30 required extensive assist of two for bed mobility, transfer, and extensive assist of one for walking in room. Resident #30 weighed 117 pounds with an unknown weight loss or gain. Resident #30 received parental intravenous (IV) therapy with 51 percent or more of daily calories being received through IV.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0660<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of a service note dated 01/12/23 timed 4:26 P.M. revealed Resident #30 plans regarding home health care were to include transportation and home delivery of TPN and other supplies necessary for returning home safely. Date proposed by Resident #30 was 01/18/23. The note indicated the discharge plan of care evaluation was initiated.<br><br>Review of a nurse note dated 01/17/23 and timed 1:58 P.M. revealed TPN and ostomy self-care at home was reviewed. Resident #30 verbalized step by step the process of each without any errors in steps. Resident #30 verbalized that she would be returning home with home health services. The note indicated pharmacy was called for written TPN orders and extra TPN. Pharmacy representative stated there would be extra TPN in the tote delivered that night. The note indicated no other concerns at that time.<br><br>Review of notes provided by the nutritional support team of Cleveland Clinic revealed on 01/17/23 at 3:03 PM., Dietitian #43 was notified by Registered Nurse (RN) #44 the patient (Resident #30) completed teaching and signed a patient agreement. Patient wanted to discharge 01/18/23 from the skilled facility. The noted indicated no information received regarding plans for home infusion pharmacy and home care and no records received from facility. Call made to the facility where patient resided and spoke with case manager (Social Services [SS] #42). The notes further indicated SS #42 had never completed a TPN discharge and was unsure of process. Patient had not been set up with a home infusion pharmacy, but SS #42 was working on setting up home care. Discussed patient first needed to be accepted by a home infusion pharmacy, benefits run, and out-of-pocket cost determined. Examples of home infusion pharmacies in town with contact information were provided. The notes indicated once the patient had been accepted by home infusion pharmacy they should be updated. A request for clinical notes, most recent TPN formula and most recent labs be sent to the clinic to review. Once those were reviewed and patient accepted by a home health care agency and home infusion pharmacy, the nutritional support team would send an order to start home parental nutrition at discharge. Recommendation indicated awaiting documentation from skilled facility including clinic notes labs and TPN formula. Awaiting confirmation, patient accepted by home infusion pharmacy and home care nursing.<br><br>Review of a 01/17/23 fax sent at 5:53 P.M. to Doctor #41, at the All TPN Team, reflected a 12/22/22 Parenteral Nutrition Progress Note from the Nutritional Support Team included Resident #30 planned to discharge 12/23/22 to a skilled facility. After discharge from skilled facility Doctor #41 would take over TPN management at the home.<br><br>Review of a note from the Digestive clinic authored by Dietitian #40 dated 01/18/23 and timed 10:22 A.M. revealed receipt of skilled facility information including labs, notes from inpatient stay, and partial formula. Return call to skilled facility to obtain the remaining vital information prior to resuming parenteral nutrition orders. A detailed message was left with SS #42 requesting full TPN formula that included volume and hours to be infused as well as which pharmacy and health home care would be servicing, to be faxed as soon as possible. Awaiting remaining information prior to sending orders.<br><br>Review of a nurse note dated 01/18/23 timed 12:46 P.M. revealed the author spoke with the provider regarding upcoming discharge orders. Provider approved the release of all pain medications to Resident #30 from the facility at the time of discharge. The prescription for pain medications would need to be acquired from the provider of the resident's choice upon discharge. Education was provided to the resident. Resident verbalized understanding.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of a fax dated 01/18/23 timed 6:23 P.M. to the All TPN Team revealed the fax included the current TPN formula and titration rate.<br><br>Review of a note from the Home Nutritional Support Service dated 01/19/23 timed 10:05 A.M. revealed the TPN formula received via email continuing same volume as inpatient. Updated to database for reference. The noted indicated still no update from skilled facility on accepting home health care and infusion pharmacy despite home nutritional support request times three. Call to social worker at skilled facility sent to voicemail. Again, left detailed voice message, requesting a call back to confirm pharmacy, home health care and date of discharge. Recommendation indicated awaiting information to send parental nutrition and standing orders.<br><br>Review of nurse note dated 01/19/23 timed 12:23 P.M. revealed Resident #30 was scheduled for discharge today. TPN would remain running for the scheduled time until completion and/or discharge time; which ever came first. The note indicated would be discharging with TPN and TPN supplies. Resident was tolerating TPN well.<br><br>Review of a nurse note dated 01/19/23 timed 3:40 P.M. revealed Resident #30 was discharged at 2:00 P.M. Resident #30 took TPN, pump, and medications including narcotics. Medication education was provided and resident confirmed she understood what medications were for and how to properly administer them. Resident #30 left with her sister and no assistive device was used.<br><br>Review of the Post Discharge Plan of Care/Recapitulation of Stay Plan and Summary initiated 01/17/23 revealed no home health at this time. Doctor aware and agreed for safe discharge to home as resident was with TPN, wound and ostomy care prior to this stay and felt she was safe without home health. Resident #30 supplied with information for ordering future TPN and ostomy/wound supplies from ostomy specialist appointment. The note included Resident #30 reported she would independently order her supplies. All on hand supplies for ostomy, wounds and TPN would be sent home with Resident #30. Other services post discharge to be determined with primary care provider. Pharmacy preference Cleveland Clinic. Resident would complete TPN infusions as ordered following correct steps. Resident would maintain at an acceptable level of pain. Resident #30 would maintain ostomy/fistula care without adverse effects. Nutritional needs included regular diet, regular texture and thin consistency and needed parenteral/IV feeding. TPN orders printed and given to Resident #30 at discharge. TPN formulary orders faxed to the Cleveland Clinic pharmacy.<br><br>Review of a note authored by Dietitian #40 dated 01/20/23 timed 1:05 P.M. revealed no return call from skilled facility. Called again to confirm date of discharge, pharmacy, and home health care. Social worker not in today. Administrator stated Resident #30 already discharged . Transferred call to Director of Nursing. No answer. Left detailed message requesting update and plan of care from discharge as soon as possible as their team had not yet sent orders.<br><br>Review of a note authored by Dietician #41 dated 01/20/23 timed 4:32 P.M. revealed patient return call. Resident #30 said she left the skilled nursing facility yesterday, 01/19/22. Skilled facility sent her with two TPN bags for the weekend as well as flushes. Resident #30 said she did not have a pharmacy or home health care set up and would need TPN after the weekend. Recommendation indicated would need to follow up Monday if skilled facility returned call with information, otherwise would likely need to send patient to emergency room to have TPN arrangements set up.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of a nurse note dated 01/21/23 at 4:38 P.M. revealed the nurse called the facility pharmacy regarding Resident #30's TPN. The nurse was informed the pharmacy filled Resident #30's order on the 17th and next refill would have been the 20th but Resident #30 was already discharged by that date.<br><br>Review of a nurse note dated 01/22/23 at 8:33 A.M. revealed on 01/17/23 the pharmacy sent a total of three bags of TPN: one bag of non-lipid TPN that was to be infused Thursday (01/19/23) and two bags of Lipid containing TPN for Wednesday (01/18/23) and Friday (01/20/23).<br><br>According to the nurse's note related to the pharmacy call, Resident #30 had enough TPN to last through Friday (01/20/23). If she infused the TPN at night she would have finished what she took home with her Saturday morning (01/21/23) which would be consistent with Resident #30 calling the facility Saturday asking if there were more bags of TPN there for her.<br><br>Review of note authored by Dietician #45 dated 01/23/23 timed 9:23 A.M. revealed Resident #30 was admitted to the hospital from the emergency room yesterday (01/22/23). Recommendation indicated awaiting hospital discharge and home health care agencies to be arranged for a safe discharge.<br><br>Review of the hospital discharge summary dated 02/01/23 revealed Resident #30 presented to the emergency room with signs of hypovolemic shock. Resident #30 presented with dizziness hypertension, tachycardia, acute kidney injury. History was most consistent with hypokalemia (low potassium) from not getting TPN and fluids following discharge from skilled facility. Resident #30 also had shortness of breath for several months which could be the result of weakness and deconditioning tear. Also has a history of Crohn's disease and TPN dependent, having multiple abdominal surgeries, multiple fistulas, and chronic abdominal pain. Elevated, alkaline phosphates, and liver function test, acute kidney injury pre-renal poor intake and hypotension, hyponatremia, hypovolemia due to poor oral intake and absence of TPN the last few days. The resident was also assessed to have a deep vein thrombosis (DVT) in upper extremity.<br><br>Interview 02/17/23 at 10:24 A.M. with All TPN Team Dietician #40 from the Cleveland Digestive Clinic revealed Resident #30 was discharged from the skilled facility without a plan and was re-hospitalized three days after she was discharged with lightheadedness, generalized weakness, hypovolemic shock, and tachycardia. Dietician #40 included the clinic repeatedly reached out to the facility, left voicemails and verbal directions of the clinic needing current TPN orders, laboratory test and what home health agency and pharmacy Resident #30 was going to use. Dietician #40 revealed she called SS #42 leaving a voicemail without a return call. The initial fax she received from the skilled facility had partial information. The second fax contained the TPN order. However, the clinic was not informed of what pharmacy to send the TPN to and what home health agency Resident #30 would be using for an infusion nurse. Dietician #41 included Resident #30 had been on TPN for two years but was new to the Digestive Clinic as of December of 2022 due to moving to Ohio.<br><br>Interview 02/17/23 at 1:49 P.M. with SS #42 revealed this was her first social services position and she was new to the job. SS #42 had never set up home health and stated she called every facility in the rolodex. It did not occur to SS #42 to call the Digestive clinic to inquire about providers with an infusion nurse.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Follow up interview 02/17/23 at 2:38 P.M. with SS #42 revealed Resident #30 had a goal to go home before her birthday. The facility staff did not feel she was ready to go home. SS #42 attempted to find home health for Resident #30 but was unable to find a home health nurse for TPN and she told Resident #30 this. The Cleveland Clinic SS #42 and she had several discussions. On 01/18/23 SS #42 spoke to Dietician #40 from the TPN team at the Cleveland Clinic about setting up the pharmacy for the resident's TPN. They decided on a provider. Dietician #40 asked for TPN formulary, recent labs, and clinical notes. SS #42 faxed the TPN formula, labs, and progress notes. SS #42 did not hear back from them that night and was off sick the next two days. SS #42 sent a fax earlier and Dietician #40 called indicating it was not complete and SS #42 sent a second fax on 01/18/23 at 6:18 P.M. When SS #42 returned to work on Monday (01/23/23) she had a message from someone else from the TPN team indicating they thought Resident #30 was discharged and they needed to know what pharmacy she chose. SS #42 called them Monday (01/23/23) and left multiple messages. Someone called back and said Resident #30 had gone back to the Cleveland Clinic (hospital). SS #42 explained to them she thought they were connected to the pharmacy and that they would call and make the needed arrangements with the pharmacy. SS #42 said she was not told she needed to find a home infusion nurse; Resident #30 told SS #42 she had a home infusion nurse. When SS #42 told Resident #30 she could not find a home infusion nurse she was very upset and wanted to go home. SS #42 did not speak to a doctor regarding the TPN and discharge. SS #42 did not call the TPN team to tell them she could not find a home health infusionist or a pharmacy to provide the TPN.<br><br>Interview 02/17/23 at 5:20 P.M. with the administrator revealed he did not know if he received a call regarding Resident #30.<br><br>Interview 02/17/23 at 5:26 P.M. with the Director of Nursing (DON) revealed she did not have a message on her phone from the Digestive Clinic. The DON said the day Resident #30 went home her TPN was started at the facility at 9:00 A.M. and ran until she left at 2:00 P.M. The DON indicated Resident #30 infused the TPN 12 hours at night when home. Resident #30 called the facility on 01/21/23 asking if there were any more bags of TPN at the facility for her. The DON referred to the 01/22/23 nurse note timed 8:33 A.M. indicating on 01/17/23 the pharmacy sent a total of three bags of TPN. One bag of non-lipid TPN that was to be infused that Thursday (01/19/23) and two bags of Lipid containing TPN for that Wednesday (01/18/23) and Friday (01/20/23). The DON verified Resident #30 was readmitted to the hospital when she did not have any TPN to infuse at home.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00139912. |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.<br><br>26706<br><br>Based on record review, policy review and staff interview, the facility failed to develop a comprehensive discharge summary. This affected one (Resident #31) of three residents reviewed for a safe discharge. The census was 29.<br><br>Findings include:<br><br>Review of Resident #31's record revealed a 08/23/22 admission. Diagnoses included acute respiratory failure with hypoxia, hypertension, type two diabetes, malignant neoplasm of prostrate, malignant neoplasm of intra abdominal lymph nodes, severe protein malnutrition, neuromuscular dysfunction of bladder, age related osteoporosis, hemiplegia and hemiparesis following cerebral infarction, acute kidney failure, and vitamin D deficiency.<br><br>Review of the Quarterly Minimum Data Set 3.0 assessment for Resident #31, dated 01/03/23, revealed Resident #31 had intact cognition. Resident #31 required extensive assist of two for bed mobility and transfer and did not walk. Resident #31 required extensive assistance of one for dressing and eating, extensive assistance of two for toilet use and personal hygiene and was totally dependent of two for bathing. Resident #31 was always incontinent of bowel and bladder. Resident #31 received physical therapy.<br><br>Review of the nurse notes dated 01/10/23 Revealed Resident #31 was discharged to another long term care facility utilizing the receiving facility's transportation. All possessions were taken with him at discharge. A face sheet and medication list were sent to the receiving facility.<br><br>Further review of the medical record revealed no evidence of a Post Discharge Plan of Care/Recapitulation of Stay Plan and Summary.<br><br>Interview 02/17/23 at 5:58 P.M. the Director of Nursing (DON) verified a comprehensive discharge recapitulation was not completed.<br><br>Review of the facility's Transfer and Discharge policy revised 09/09/23 included the when the facility anticipated discharge, a resident must have a discharge summary that included, but not limited to a recapitulation of the resident stay that included but was not limited to diagnosis, course of illness, treatment or therapy, and pertinent lab, radiology, and consultation results. A final summary of the resident status at the time of the discharge was to be available for release to authorized persons and agencies with consent of the resident or resident representative.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00139912. |