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	12/12/2022

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on interview and record review the facility failed to ensure Resident #184's baseline care plan addressed the resident's chronic pain. This affected one resident (#184) of three residents reviewed for baseline care plans. The facility census was 32. Findings include: Review of Resident #184's medical records revealed an admitted [DATE], with no listed diagnosis. Review of current physician orders for December 2022 revealed #184 was ordered Percocet (narcotic pain medication) 10-325 milligrams (mg) every eight hours for chronic pain. Review of Resident #184's baseline care plan dated 12/02/22 revealed the care plan did not address Resident #184's chronic pain. Interview on 12/04/22 at 2:20 P.M. with Resident #184's husband revealed Resident #184 was taking narcotic pain medication prior to her admission for chronic pain in her arm and shoulder and was unable to state the exact dosage, however he stated it was a lot. Observation on 12/05/22 at 8:48 A.M. revealed Resident #184 was lying in bed and was yelling out for a nurse. Upon entering Resident #184's room, Resident #184 stated she was having pain in her shoulder. Registered Nurse (RN) #441 was informed at 8:50 A.M. Review of the Medication Administration Record on 12/05/22 revealed no documentation that pain medication had been administered to Resident #184. Interview on 12/05/22 at 12:34 P.M. with RN #441 revealed she had administered pain medication to Resident #184, however she had been unable to sign off the medication in the computer system. RN #441 indicated she had signed out the medication in the narcotic book at 9:54 A.M. RN #441 stated Resident #184 had reported a pain level of eight out of 10 at that time (0= no pain and 10=worst pain imaginable). Interview on 12/12/22 at 10:10 A.M. with Director of Nursing (DON) confirmed Resident #184's baseline care plan did not address Resident #184's chronic pain. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Care Planning revised 06/24/21 revealed a baseline care plan would be developed within 48 hours and was to include interventions to provide effective person-centered care.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on interview and record review the facility failed to ensure care plans accurately reflected the needs and care to be provided. This affected two residents (#8 and #1) of five reviewed for care planning. The facility census was 34. Findings include: 1. Review of Resident #8's medical records revealed an admitted [DATE]. Diagnoses included muscle spasms and diabetes. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had intact cognition, required extensive assistance with bed mobility, toileting and personal hygiene and total assistance with transfers. Review of Resident #8's care plan dated 10/27/22 revealed no care plan in place for the use of a hand splint. Review of the current physician orders for December 2022 revealed no orders related to the use of hand splint. Observation on 12/04/22 at 11:18 A.M. revealed Resident #8 had a splint to his left hand and the left hand appeared to be contracted. Interview with Resident #8 at time of observation revealed he wore the splint most of the time and staff did not always take it off prior to bed. Observation on 12/05/22 at 6:55 A.M. revealed Resident #8's hand splint was on his bedside table. Interview on 12/05/22 at 6:58 A.M. with State tested Nursing Assistant (STNA) #428 revealed she assisted Resident #8 was removing his splint in the evening and if the resident was awake she would assist him with applying the splint. Observation on 12/05/22 at 8:42 A.M. with Registered Nurse (RN) #407 revealed Resident #8 had a hand splint for his left hand contracture. RN #407 stated the splint was supposed to be on during the day and off at night. At time of interview the hand splint was observed to be on the resident's bedside table. Interview on 12/12/22 at 10:10 A.M. with the Director of Nursing (DON) confirmed Resident #8's care plan did not include the use of a hand splint. 45442 2. Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, schizophrenia, schizoaffective disorder depressive type, acute kidney failure, moderate protein-calorie malnutrition, major depressive disorder, anxiety disorder, psychotic disorder with delusion, epilepsy, and neuroleptic induced parkinsonism. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment dated [DATE] revealed Resident #1 had severe cognitive impairment and required supervision with set up for eating and limited assistance of one staff for walking in his room and on the unit. Review of the care plan dated 11/01/22 for Resident #1 revealed the care plan did include a plan for meeting Resident #1's nutritional needs. Interview on 12/12/22 at 9:30 A.M. with Registered Dietitian (RD) #444 revealed she was unaware Resident #1 did not have a care plan to address nutritional needs. Interview on 12/12/22 at 10:15 A.M. with the Director of Nursing (DON) confirmed Resident #1 did not have a nutrition care plan. Review of the facility policy titled Care Planning revised 06/24/21, revealed every resident would have a person-centered Plan of Care developed and implemented that was consistent with the resident's comprehensive assessment. The care plan should be specific, and unique to each 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 37095 Based on observation, interview, and record review, the facility failed to ensure residents received scheduled and appropriate activities on the weekend. This affected Residents #7, #21, #22 and #84 and had the potential to affect all 34 residents in the facility. Findings include: Record review of the facility activity calendar revealed on Sunday 12/04/22 the following activities were scheduled: Trivia and coffee at 1:00 P.M., floats and tunes at 2:00 P.M., and word puzzles at 3:00 P.M. This exact schedule was also in place for Sunday 12/11/22 and Sunday 12/18/22. Interview with Resident #22 on 12/04/22 at 9:22 A.M. revealed the facility occasionally had activities on Saturday, otherwise there were no activities over the weekend. Observation of the facility common and activity rooms on 12/04/22 at 1:27 P.M. revealed no evidence of any organized activities in progress. Two large whiteboards in common rooms had the day's activity schedule prominently posted. Interview with State-tested Nursing Aide #443 on 12/04/22 at 1:37 P.M. revealed she knew of no activity workers currently in the building. Group activities were usually done in the dining room. Observation of the facility common and activity rooms on 12/04/22 at 2:16 P.M. revealed six residents were in common rooms with the television on. Activity Worker #435 was rounding with an ice cream cart offering ice cream to residents at their tables and in rooms. An unidentified resident asked her if there would be activities today and she said there would be word puzzles. Observation of the facility common and activity rooms on 12/04/22 at 3:07 P.M. revealed four residents were in the dining room with the television on. Activity Worker #435 was alone in the activity room on the computer. At 3:13 P.M., Activity Worker #435 left the office with several sheets of paper and stopped in five resident rooms offering to give them a word puzzle. She walked past the four residents in the dining room without speaking to them. Interview with Activity Worker #435 on 12/04/22 at 3:20 P.M. revealed the word puzzle was for residents to work on independently. She said no resident wanted to gather for trivia or for floats and tunes, so she delivered ice cream instead. She sometimes made one-to-one visits but had not visited all dependent residents today including Resident #21 and #84. When making rounds for visits or to deliver independent activities, she said she was supposed to skip rooms when the door was closed. She worked approximately four hours every weekend day and would leave today at 3:30 P.M. Interview with Resident #7 on 12/05/22 at 9:11 A.M. revealed no one invited him to any activities Sunday, and he did not know of or attend any. Interview with the wife of Resident #21 on 12/05/22 at 2:15 P.M. revealed she did not see any activities in the facility on weekends. She said staff sometimes left the resident sitting by himself while they took others to activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #22 on 12/06/22 at 11:25 A.M. revealed no one invited him to any activities Sunday, and he did not know of or attend any. Review of the activity logs for Resident #84, and #21 revealed no activity was documented for Resident #84 on the weekends of 11/19/22, 11/26/22, or 12/03/22. One-to-one visits were documented as done for Resident #21 on 12/04/22 at 1:40 P.M. The surveyor reviewed the above findings with Activity Director #426 on 12/07/22 at 2:27 P.M., including that one-to-one activities were documented as done for Resident #21 even though interview verified Activity Worker #435 did not do any activities for Resident #21 that day. Activity Director #426 said Activity Worker #435 documented it as done because she saw another staff member talking to the resident. Activity Director #426 said one activity assistant worked on the weekends from approximately 1:00 P.M. until dinnertime. This deficiency represents non-compliance investigated under Complaint Number OH00136408.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, record review and interview the facility failed to ensure residents received adequate, necessary and timely care and treatment to meet their total care needs. The facility failed to ensure antibiotics and x-rays were completed as ordered for Resident #16, failed to ensure monthly weights were completed for Resident #1, and failed to ensure physician orders were in place for blood glucose monitoring of Resident #84. Actual Harm occurred on 12/08/22 when Resident #16, who was cognitively impaired and required staff assistance for activities of daily living was admitted to the hospital with a diagnosis of sepsis (blood infection) related to a wound to the left heel. Physician's orders for the antibiotic, Doxycycline and imaging to rule out osteomyelitis were not completed as ordered contributing to the hospitalization . This affected one resident (#16) of one resident reviewed for wounds and two residents (#1 and #84) of 14 sampled residents. The facility identified one resident as having wounds, Resident #16. The facility census was 34. Findings include: 1. Review of Resident #16's medical records revealed an admitted [DATE] with diagnoses including non pressure chronic ulcer of right foot, peripheral vascular disease (PVD) and diabetes. Record review revealed Resident #16 was admitted with two unstageable pressure ulcers (areas were not identified). Review of the Minimum Data Set (MDS) 3.0 assessment, dated 10/25/22 revealed Resident #16 had impaired cognition, required extensive assistance with bed mobility, transfers, toileting and personal hygiene, and was incontinent of bowel and bladder. Review of the care plan dated 10/25/22 revealed Resident #16 was at risk for skin impairment related to decreased mobility and muscle weakness. Interventions included weekly head to toe skin assessments and observe wound dressing frequently to ensure intact. Review of physician's orders from 09/19/22 through 10/17/22 revealed Resident #16 was ordered the antibiotic, Doxycycline 100 milligrams (mg) twice a day for 28 days for wound infection. Review of Resident #16's physician orders for November 2022 revealed an order to cleanse left heel with normal saline, pack with Dakins (antiseptic) soaked gauze, cover with absorbent dressing and wrap with Kerlix daily and as needed, and paint right heel with Betadine (antiseptic) and apply absorbent dressing every Monday, Wednesday and Friday. Review of a skin and wound assessment for Resident #16 dated 11/18/22 revealed the wound nurse practitioner suspected osteomyelitis (bone infection) and a new order to consult with the house physician to obtain imaging was given. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the wound care progress note/wound evaluation for Resident #16 dated 11/18/22 revealed an order for calcium alginate with silver (antimicrobial wound dressing to prevent infection) to the right heel, cover with an absorbent dressing and gauze daily and as needed. The left heel wound was ordered to be packed with Dakins soaked gauze, cover with an absorbent dressing and wrap with gauze daily and as needed. Review of Resident #16's progress note dated 11/18/22 authored by the Assistant Director of Nursing (ADON) revealed the wound nurse practitioner suspected osteomyelitis and to consult with house physician to obtain imaging. Review of the wound care progress note/wound evaluation authored by the wound nurse practitioner, for Resident #16, dated 11/23/22 revealed to continue with calcium alginate to right heel, cover with absorbent dressing and gauze daily and as needed. Left heel wound was to be packed with Dakins soaked gauze twice daily. The evaluation indicated the wound had an odor and thick drainage. Doxycycline (an antibiotic) 100 mg was recommended. The note indicated to notify the house physician of recommendations for antibiotic therapy. Review of the physician's orders revealed no order for Doxycycline on 11/23/22. Review of the wound care progress note/wound evaluation for Resident #16, dated 11/30/22 revealed to discontinue the calcium alginate to right heel and begin packing the wound with Dakins soaked gauze twice daily. Wound was noted to be odorous. Left heel wound continued to be packed with Dakins soaked gauze twice daily. The note stated to extend the Doxycycline 100 mg for an additional 10 days, and might require diagnostic imaging at the discretion of the house physician due to the high risk of osteomyelitis. The note indicated nursing to notify the house physician. Review of physician's orders revealed no orders for imaging on 11/30/22. However, review of Resident #16's progress note, dated 11/30/22 revealed an order was placed with an x-ray company and a confirmation number and contact person at the x-ray company were listed. Further review of Resident #16's physician orders revealed an order for Doxycycline 100 mg on 12/01/22 through 12/10/22 twice a day for infection. Interview on 12/05/22 at 2:45 P.M. with the Director of Nursing (DON) revealed Resident #16's orders did not contain an order for an imaging. The DON stated she would need to check the resident's chart to see if an x-ray had been performed. Review of Resident #16's physician's orders revealed following the interview with the DON, on 12/06/22 an order was obtained for an x-ray of bilateral feet. Review of Resident #16's progress note, dated 12/06/22 revealed the facility contacted the x-ray company and was informed the company did not have an x-ray tech available and would send one on 12/07/22. Interview on 12/06/22 at 9:33 A.M. with Licensed Practical Nurse (LPN) #446 revealed she was asked by the DON to place orders for an x-ray for Resident #16. LPN #446 stated she worked for an agency and was not aware of the situation regarding Resident #16's wounds/x-rays. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/06/22 at 9:38 A.M. with the DON revealed the DON was unable to locate an order for the x-ray and the DON asked LPN #446 to place orders for the x-ray to be completed. The DON further stated there was no physician order in place for the antibiotic until she entered the order on 12/01/22. Interview on 12/06/22 at 12:08 P.M. with the Assistant Director of Nursing (ADON) revealed the ADON received verbal orders for Resident #16 on 11/18/22 to obtain imaging and consult with the house physician. The ADON was unable to state why the orders were not completed or in the computer system. Observation of wound care on 12/07/22 at 10:55 A.M. for Resident #16 with the DON and LPN #433 revealed wounds to the resident's bilateral heels had a strong odor and thick yellowish drainage coming from the wounds. Interview on 12/07/22 at 11:22 A.M. with the DON revealed she received the wound progress notes and evaluations weekly and stated she must have missed the recommended orders for the x-ray and the antibiotics. The DON confirmed the recommended antibiotics were ordered on 12/01/22 and the x-ray would be completed on 12/07/22. Review of the progress note, dated 12/07/22 revealed the x-ray results showed Resident #16 had osteomyelitis of the left heel. The note indicated the nurse practitioner was notified and Resident #16 was to be transported to the hospital. Review of the progress note dated 12/08/22 revealed Resident #16 was admitted to the hospital with sepsis (blood infection). 2. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia, acute kidney failure and moderate protein-calorie malnutrition. Review of the MDS quarterly assessment dated [DATE] revealed Resident #1 had severe cognitive impairment and required supervision with set up for eating and limited assistance of one staff for walking in his room and on the unit. Further review of Resident #1's medical record revealed the last recorded weight was on 09/23/22 and no weight refusals were documented in the nursing progress notes or under the monthly weight task listed in the task bar. Review of Resident #1's current physician orders for December 2022 did not reveal an order for monthly weights. Review of the nutrition assessment completed by Registered Dietitian (RD) #444 on 12/05/22 revealed no new weights since 09/23/22 to review and weights were usually stable. Interview on 12/12/22 at 9:30 A.M. with Registered Dietitian (RD) #444 revealed residents should be weighed monthly and if a resident refused to be weighed it should be documented in the medical record. Interview on 12/12/22 at 10:15 A.M. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed Resident #1 had not been weighed between 09/23/22 and 12/06/22. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the 07/14/21 revised facility policy titled, Weight Management revealed weekly weights would be completed by the 10 th of each month and documented in the medical record. The Dietary Manager and/or Registered Dietitian would communicate weight changes to the interdisciplinary team, attending physician and resident responsible party and be documented in the medical record. 3. Record review of Resident #84 revealed he was admitted to the facility 11/19/22 and had diagnoses including cognitive communication deficit, hyperkalemia, and type 2 diabetes. Review of Resident #84's hospital discharge instructions dated 11/18/22 revealed Resident #84 was to receive blood glucose checks with meals and at bedtime. Review of Resident #84's physician orders revealed no current or previous orders for blood sugar monitoring. Review of the resident's vital signs records revealed no documented blood sugar checks for the resident. Review of Resident #84's progress notes and physician assessments revealed no explanation as to why the hospital instructions were not carried out. Interview with the Director of Nursing on 12/07/22 at 4:16 P.M. confirmed the above findings and lack of blood glucose monitoring for Resident #84 who had a diagnoses of type 2 diabetes.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, record review and interview the facility failed to ensure to care planning and a physician's order were in place for use of a hand splint for Resident #8. This affected one of 14 sampled residents. Facility census was 34. Findings include: Review of Resident #8's medical revealed an admitted [DATE] with a diagnosis including muscle spasms. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had intact cognition, and required extensive assistance with bed mobility, transfers, toileting and personal hygiene. Observation on 12/04/22 at 11:18 A.M. revealed Resident #8 had a splint to his left hand and the hand appeared to be contracted. Interview with Resident #8 at time of observation revealed he wore the splint most of the time and stated the staff did not always take it off prior to bed. Observation on 12/05/22 at 6:55 A.M. revealed Resident #8's hand splint was on the resident's bedside table. Interview on 12/05/22 at 6:58 A.M. with State tested Nursing Assistant (STNA) #428 revealed she assisted Resident #8 in removing his splint in the evening and if the resident was awake she would assist him with applying the splint. Observation and interview on 12/05/22 at 8:42 A.M. with Registered Nurse (RN) #407 revealed Resident #8 had a hand splint for his left hand contracture. RN #407 stated the brace was supposed to be on during the day and off at night. At time of interview the hand splint was observed on the resident's bedside table. Review of current physician orders for December 2022 revealed no orders for Resident #8 to wear a hand splint. Interview on 12/12/22 at 10:10 A.M. with the Director of Nursing confirmed Resident #8's care plan did not include the use of a hand splint.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095 Based on interview and record review, the facility failed to ensure resident physicians signed and acted on pharmacy recommendations. This affected four of five (Residents, #1, #7, #12 and #15) residents reviewed for unnecessary medications. The total census was 34. Findings include: 1. Record review of Resident #12 revealed she was admitted [DATE] and had diagnoses including hyperlipidemia, dementia with behavior disturbances, and major depressive disorder. Her medications included Atorvastatin (an anti-hyperlipidemia medication) and 2 milligrams of Aripiprazole (an antipsychotic) daily. Review of resident #12's pharmacy record reviews revealed a consultation report dated 03/08/22 which recommended a lipid panel be drawn on the next convenient lab day and yearly thereafter. The report was signed as accepted on 06/08/22, however her records revealed no evidence the lab was drawn although she had seven blood draws since the time of the order. Another consultation report dated 07/22/22 noted she had received 2 milligrams Aripiprazole daily since her admission and recommended a dose reduction be attempted. The report had no signature indicating it was read by or communicated to the physician. Interview with the Director of Nursing on 12/06/22 at 10:36 A.M. confirmed the above findings. 45442 2. Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, schizophrenia, schizoaffective disorder depressive type, acute kidney failure, moderate protein-calorie malnutrition, major depressive disorder, anxiety disorder, psychotic disorder with delusion, epilepsy, and neuroleptic induced parkinsonism. Review of the MDS quarterly assessment dated [DATE] revealed Resident #1 had severe cognitive impairment. Review of pharmacy recommendations for Resident #1 revealed on 04/14/22 as well as 05/09/22 pharmacy recommendations were not signed by the physician, there were no pharmacy reviews presented for 08/22/22 and 09/22/22 and the facility was unable to provide the pharmacy recommendations report for 11/16/22. Interview on 12/12/22 at 7:58 A.M. with the Director of Nursing (DON) confirmed recommendations were not signed for April and May 2022, pharmacy recommendations came to the DON, and she was unable to state what the process was since she had only been at the facility for one month. 3. Review of medical record for Resident #7 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, moderate protein-calorie malnutrition, major depressive disorder, and history of traumatic brain injury. Review of the MDS quarterly assessment dated [DATE] revealed Resident #7 was cognitively intact. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician orders for Resident #1 revealed a 07/24/22 order for Depakote 500 milligrams (mg), one time a day at bedtime for seizures. An order dated 08/24/22 indicated to obtain a renal/Depakote labs. Review of the pharmacy review for Resident #7 revealed on 07/26/22 pharmacy recommendations included valproic acid level to be drawn the next lab day and every six months following. The pharmacy review was not acknowledged or signed by the physician. On 08/17/22 pharmacy recommendations for pantoprazole (heartburn medication) were not acknowledged or signed by the physician, on 09/21/22 the pharmacy recommendations for pantoprazole were repeated again, not acknowledged or signed by the physician. On 10/14/22 the pharmacy recommendations for a fasting lipid panel with a complete blood count with a repeat of every 12 months was not acknowledged or signed by the physician. Review of lab results for Resident #7 revealed on 08/25/22 Resident #7 refused the lab draw and the order was discontinued. On 08/28/22 a complete blood count (CBC) was completed but the renal/Depakote was not obtained at that time. Interview on 12/12/22 at 7:58 A.M. with the DON confirmed July 2022 pharmacy recommendations for Resident #7 were not signed by a nurse or physician and the order for Depakote blood draw was not completed and the order was discontinued. The DON also confirmed the recommendations by pharmacy for pantoprazole in August and again in September 2022 were not signed by a nurse or physician and the recommendations were not followed. The recommendations in October 2022 for a lipid panel with weekly CBC were also not signed or followed. 4. Review of Resident #15's medical records revealed an admitted [DATE]. Diagnosis included depression, bipolar and dementia. Review of the care plan dated 08/15/22 revealed Resident #15 had fluctuations in mood related to bipolar and depression. Interventions included observe for effectiveness of medications and report abnormalities to physician. Review of the MDS assessment dated [DATE] revealed Resident #15 had intact cognition. Review of current physician orders for December 2022 revealed Resident #15 was ordered Vanlafaxine 150 mg once daily for depression. Review of pharmacy recommendation dated 10/14/22 revealed a recommendation was made to reduce the Vanlafaxine from 150 mg to 112.5 mg due to medication could be associated with high blood pressure. Pharmacy recommendations did not contain a physician's signature or indication the recommendation was to be accepted or declined. Interview on 12/12/22 at 7:58 A.M. with the DON confirmed the pharmacy recommendations for Resident #15 had not been acknowledge by the physician, and she confirmed the current orders were still in place for Vanlafaxine at 150 mg. Interview on 12/12/22 at 11:50 A.M. with the DON revealed she had contacted the Nurse Practitioner (NP) on 12/12/22 and stated the NP had not agreed with the pharmacy recommendation to decrease the dosage. The DON confirmed the NP had not been aware of the pharmacy recommendations made on 10/14/22.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095 Based on interview and record review, the facility failed to ensure gradual dose reductions (GDRs) were attempted or considered for psychotropic medications. This affected one of five (Resident #12) residents reviewed for unnecessary medications. The total census was 34. Findings include: Record review of Resident #12 revealed she was admitted [DATE] and had diagnoses including dementia with behavioral disturbances and major depressive disorder. Her medications included 2 milligrams of Aripiprazole (an antipsychotic) daily, ordered 09/02/21. Record review of a pharmacy consultation report dated 07/22/22 noted she had received 2 milligrams Aripiprazole daily since her admission and recommended a dose reduction be attempted. The report had no signature indicating it was read by or communicated to the physician. Review of her other records revealed no evidence any dose reduction was assessed or attempted within the past year. Interview with the Director of Nursing on 12/06/22 at 10:36 A.M. confirmed the above findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on observation, record review and interview the facility failed to maintain a medication error rate of less than five percent. The medication error rate was 10.71 percent. Three errors occurred in 28 opportunities for error. This affected two residents (#22 and #36) of five residents observed for medication administration. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including type II diabetes, hypertension, and kidney transplant. Review of the care plan dated 10/27/22 revealed Resident #22 was at risk for fluctuation of blood sugar levels related to type II diabetes and end stage renal disease. Interventions included to administer medications as ordered and to observe for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #22 had intact cognition and received insulin by injection. Review of the physician's orders dated January 2022 revealed Resident #22 had an order for Novolog flex pen (short acting insulin) to be injected subcutaneous by pen prior to meals. Observation of medication administration on 01/05/23 at 12:15 P.M. revealed Registered Nurse (RN) #100 preparing the Novolog pen by removing the cap, twisting the needle onto the pen, and dialing the pen to administer 14 units of insulin. RN #100 applied gloves, wiped Resident #22's abdomen with alcohol and administered the insulin. RN #100 did not prime the insulin pen prior to dialing the 14 units. 2. Review of the medical record for Resident #36 revealed an admitted [DATE] with diagnoses including type II diabetes, hypertension a high blood pressure, hemiplegia one sided weakness. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #36 had intact cognition and received insulin by injection. Review of the care plan dated 10/04/22 revealed Resident #36 was at risk for fluctuation of blood sugar levels related to type II diabetes. Interventions included to administer medications as ordered and to observe for signs and symptoms of hypoglycemia and hyperglycemia. Review of the physician's orders dated January 2022 revealed Resident #36 had an order for Novolog flex pen (short acting insulin) 10 units to be injected subcutaneous by pen prior to meals. In addition Resident #36 had an order for insulin based on the following sliding scale. For blood blood sugar of 0-150 give no insulin, 151-200 give two units, 201- 250 give four units, 301-350 give eight units and 352-400 give 10 units. Observation of medication administration on 01/05/22 at 12:30 P.M. revealed RN #100 checking Resident #36's blood sugar. Resident #36's blood sugar was 130. RN #100 prepared a Novolog pen to administer ten units by removing the cap for the insulin, twisting the needle onto the pen and dialing ten units of insulin. RN #100 applied gloves, wiped Resident #37's abdomen with alcohol and administered the insulin. RN #100 did not prime the insulin pen prior to dialing in the 10 units. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/05/22 at with RN #100 at 1:05 P.M. verified that she did not prime Resident #22's or Resident #36's insulin pens. RN #100 stated she did not know the insulin pens required priming prior to every injection and she primed the pens that morning. Review of the manufacturer's instructions for Novolog pen revealed to prime the pen before each injection. Priming the pen removed air from the needle and cartridge that may have collected during normal use and ensured the pen was working properly. Priming the pen ensured proper dosing. Review of the facility policy titled Medication Administration, dated 09/09/22 revealed the nurse was responsible to read and follow precautionary instructions on the prescription labels. 3. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including type II diabetes, hypertension, and kidney transplant. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #22 had intact cognition and received insulin by injection. Review of the physician's orders dated January 2022 revealed Resident #22 had an order for metoprolol succinate 50 milligram (mg) extended release tablet. Observation of medication administration on 01/09/23 at 8:10 A.M. revealed RN #100 preparing Resident #22's morning medications including metoprolol succinate. RN #100 crushed the medication tablets including the metoprolol succinate 50 mg extended release tablet and mixed all the crushed tablets with applesauce. RN#100 administered the medications to Resident #22. Interview with RN #100 immediately after the observation revealed she was unaware that metoprolol succinate was an extended-release tablet that should not be crushed. Review of the manufacturer prescribing information revealed metoprolol succinate extended-release tablets were scored and could be divided; however, the whole or half tablet should be swallowed whole and not chewed or crushed. Review of the facility policy titled Medication Administration, dated 09/09/22 revealed to follow safe preparation practices and check the do not crush list before crushing medications. If, necessary, contact the ordering physician for a change to a different route of administration when the medication cannot be crushed.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, record review and interview the facility failed to ensure antibiotics were ordered and administered to Resident #16 in a timely manner to treat suspected osteomyelitis (bone infection). Actual Harm occurred on 12/08/22 when Resident #16 was admitted to the hospital with a diagnosis of sepsis (blood infection) related to a wound to the left heel. Physician order for the antibiotic, doxycycline was not obtained as recommended to treat suspected osteomyelitis contributing to the hospitalization . This affected one resident (#16) of one resident reviewed for wounds. The facility identified one resident as having wounds, Resident #16. The facility census was 34. Findings include: 1. Review of Resident #16's medical records revealed an admitted [DATE] with diagnoses including non pressure chronic ulcer of right foot, peripheral vascular disease (PVD) and diabetes. Resident #16 was admitted with two unstageable pressure ulcers (areas were not identified). Review of the Minimum Data Set (MDS) 3.0 assessment, dated 10/25/22 revealed Resident #16 had impaired cognition, required extensive assistance with bed mobility, transfers, toileting and personal hygiene, and was incontinent of bowel and bladder. Review of physician's orders from 09/19/22 through 10/17/22 revealed Resident #16 was ordered the antibiotic, doxycycline 100 milligrams (mg) twice a day for 28 days for wound infection. Review of Resident #16's physician orders for November 2022 revealed an order to cleanse left heel with normal saline, pack with Dakins (antiseptic) soaked gauze, cover with absorbent dressing and wrap with Kerlix daily and as needed, and paint right heel with Betadine (antiseptic) and apply absorbent dressing every Monday, Wednesday and Friday. Review of a skin and wound assessment for Resident #16 dated 11/18/22 revealed the wound nurse practitioner suspected osteomyelitis and a new order to consult with the house physician to obtain imaging was given. Review of the wound care progress note/wound evaluation for Resident #16 dated 11/18/22 revealed an order for calcium alginate with silver (antimicrobial wound dressing to prevent infection) to the right heel, cover with an absorbent dressing and gauze daily and as needed. The left heel wound was ordered to be packed with Dakins soaked gauze, cover with an absorbent dressing and wrap with gauze daily and as needed. Review of Resident #16's progress note dated 11/18/22 authored by the Assistant Director of Nursing (ADON) revealed the wound nurse practitioner suspected osteomyelitis and to consult with house physician to obtain imaging. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the wound care progress note/wound evaluation authored by the wound nurse practitioner, for Resident #16, dated 11/23/22 revealed to continue with calcium alginate to right heel, cover with absorbent dressing and gauze daily and as needed. Left heel wound was to be packed with Dakins soaked gauze twice daily. The evaluation indicated the wound had an odor and thick drainage. Doxycycline 100 mg was recommended. The note indicated to notify the house physician of recommendations for antibiotic therapy. Review of the physician's orders revealed no order for doxycycline on 11/23/22. Review of the wound care progress note/wound evaluation for Resident #16, dated 11/30/22 revealed to discontinue the calcium alginate to right heel and begin packing the wound with Dakins soaked gauze twice daily. Wound was noted to be odorous. Left heel wound continued to be packed with Dakins soaked gauze twice daily. The note stated to extend the doxycycline 100 mg for an additional 10 days, and might require diagnostic imaging at the discretion of the house physician due to the high risk of osteomyelitis. The note indicated nursing to notify the house physician. Further review of Resident #16's physician orders revealed an order for Doxycycline 100 mg on 12/01/22 through 12/10/22 twice a day for infection. Interview on 12/06/22 at 9:38 A.M. with the Director of Nursing (DON) revealed although a recommendation for doxycycline was made on 11/23/22 there was no physician order in place for the antibiotic until she entered the order on 12/01/22. Observation of wound care on 12/07/22 at 10:55 A.M. for Resident #16 with the DON and LPN #433 revealed wounds to the resident's bilateral heels had a strong odor and thick yellowish drainage coming from the wounds. Interview on 12/07/22 at 11:22 A.M. with the DON revealed she received the wound progress notes and evaluations weekly and stated she must have missed the recommended order for antibiotics. The DON confirmed the antibiotics recommended on 11/23/22 were ordered on 12/01/22. Review of the progress note, dated 12/07/22 revealed x-ray results showed Resident #16 had osteomyelitis of the left heel. The note indicated the nurse practitioner was notified and Resident #16 was to be transported to the hospital. Review of the progress note dated 12/08/22 revealed Resident #16 was admitted to the hospital with sepsis (blood infection).

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42733 Based on observation, interview and record review the facility failed to ensure medications were properly stored. This had the potential to affect all 34 residents residing in the facility. Findings include: 1. Observation of a medication cart on 12/05/22 at 10:37 A.M. with Licensed Practical Nurse (LPN) #445 revealed the medication cart contained numerous loose unidentifiable pills in various compartments of the medication cart. LPN #445 stated she was agency staff and this was her first day at the facility and she did not check the cart for loose pills. 2. Observation of a medication cart on 12/05/22 at 10:40 A.M. with Registered Nurse (RN) #441 revealed numerous loose pills in several areas of the cart as well as three medication cards that contained medications behind a drawer on the bottom of the cart that had made it difficult to completely close the bottom drawer. RN #441 stated she worked for agency and it was her first day at the facility and she was unaware of the loose pills and medication cards that were making it difficult to close the bottom drawer. Interview on 12/05/22 at 10:48 A.M. with Director of Nursing (DON)confirmed the observations, and she stated medication carts should be checked regularly to ensure no loose medications were in the medication carts. Review of facility policy titled Storage and Expiration of Medications, Biological's revised 07/21/22 revealed facility personnel should inspect nursing nursing storage area on a regular basis.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095 Based on interview and record review, the facility failed to draw blood labs according to orders. This affected two of five residents (Resident #12 and #4) reviewed for unnecessary medications. The total census was 34. Findings include: 1. Record review of Resident #4 revealed she was admitted [DATE] and had diagnoses including paranoid schizophrenia, iron deficiency anemia, type 2 diabetes, hyperlipidemia, vitamin B-12 deficiency, and vitamin D deficiency. Her medications included Vitamin B-12, Vitamin D, and iron supplements, Atorvastatin (an anti-hyperlipidemia medication), and insulin injections. She had active orders for a yearly lipid panel (blood draw) dated 07/24/19, a HgB A1c (diabetic lab), CBC (complete blood count), and LFT (liver function test) blood draw every six months dated 06/14/21, and a CBC, CMP (complete metabolic panel), HgB A1C, lipid panel, Vitamin B-12, and Vitamin D lab draw ordered 08/04/22. Record review of Resident #4's laboratory documentation for the past year revealed blood draw refusals on 07/08/22, 02/18/22, and 12/14/21. A renal panel and CBC were drawn on 03/10/22 and 12/15/21. A hepatic panel with a HgB A1C and CBC were drawn 12/21/21. No other lab draws or attempts were noted. Interview with the Director of Nursing on 12/06/22 at 10:36 A.M. confirmed the above findings. 2. Record review of Resident #12 revealed she was admitted [DATE] and had diagnoses including dementia, acute embolism, failure to thrive, and hyperlipidemia. Her medications included Atorvastatin. She had an active order dated 03/17/22 for a CBC, RFP (renal function panel), and magnesium lab draw to be done weekly. A pharmacy consultation report dated 03/08/22 noted she received Atorvastatin and recommended a lipid panel be drawn on the next convenient lab day and yearly thereafter. The report was signed as accepted on 06/08/22 and a paper order for it was written and signed. Record review of Resident #12's laboratory documentation for the past year revealed multiple timeframes where she did not receive the ordered weekly lab draws, including the weeks of 08/28/22, 10/09/22, 10/30/22, 11/06/22, and 11/13/22. There was no evidence the ordered lipid panel was drawn even though seven blood labs were done since the date of the order. Interview with the Director of Nursing on 12/06/22 at 10:36 A.M. confirmed the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview, and facility policy review, the facility failed to maintain a clean, sanitary kitchen area, ensure foods were stored in a clean and sanitary manner to prevent contamination and food borne illness, and ensure expired products were discarded. This affected all 34 residents residing at the facility receiving meals. Findings included: 1. Observation on [DATE] at 8:10 A.M. during tour of the kitchen with Dietary Manager #410 revealed heavily soiled floors throughout the kitchen. The cold air return vent on the opposite wall of the dish machine revealed a heavily soiled vent on the wall with thickened black dust on the grates with peeling paint. Mold that was black in color was visible on the ceiling above the dish machine, and the exhaust pipe from the dish machine to the outside wall had mold and peeling paint over the area where clean dishes were discharged from the dish machine. A light switch with metal tubing covering the electrical wires going from the wall switch towards the ceiling had peeling paint above the clean dish lane where clean trays of dishes were located. Observation of the reach in refrigerators on [DATE] at 8:17 AM with Dietary Manager #410 revealed an eight pound container of macaroni salad opened on [DATE] with a use by date of [DATE], an eight pound container of potato salad with a opened date of [DATE] and a use by date of [DATE], a two pound package of honey ham slices with an opened date of [DATE] and a use by date of [DATE], a five pound package of shredded mozzarella cheese with an opened date of [DATE] and a use by date of [DATE], a two pound package of roast beef slices with an opened date of [DATE] and use by date of [DATE], a five pound bag of shredded cheddar cheese with an open date of [DATE] and a use by date of [DATE], a two pound package of sliced Swiss cheese with an opened date of [DATE] and a use by date of [DATE], a five pound open container of cottage cheese with an opened date of [DATE] and a use by date of [DATE], an open undated package of pound cake with no date of opening or use by date listed. Observation in the dry storage area revealed an opened five-pound package of cornmeal mix with an opened date of [DATE] and a use by date of [DATE], a 12 pack of hamburger buns with a date of [DATE] stamped on them. Dietary Manager #410 stated the hamburger buns came frozen and were thawed recently but was unsure of exact date and confirmed there was not a use by date listed on the package. Dietary Manager #410 confirmed all the above items listed. Dietary Manager #410 stated the floors were cleaned as often as they were able to with the current staffing, and stated she was unsure the last date the floor was swept or mopped. On [DATE] at 9:35 A.M. Dietary Manager #410 provided a copy of a paper hanging in the kitchen that stated, Clean, Clean and Clean! Please and thank you! and confirmed she did not have any written proof of cleaning schedules having been completed since she started in [DATE]. Review of the undated Dietary Aide A.M. Duties per shift form hanging in the kitchen provided by Dietary Manager #410 revealed each shift refrigerators and freezers were to be wiped down for cleanliness, expired or outdated items were to be thrown out and the entire kitchen was to be swept and mopped. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility form titled Use by Date Storage Chart dated [DATE] revealed leftover foods were to be discarded after three days including the preparation day. Deli meats were to be disposed of after being opened for seven days. Interview on [DATE] at 3:25 P.M. with the Administrator revealed he was aware of the peeling paint in the kitchen. The Administrator stated he had gotten a quote from a painting company a couple of months ago, had submitted the quote to the corporate office for approval and had not received any further correspondence from the corporate office. Review of the kitchen repair quote submitted by the Administrator revealed a quote for repairs was completed on [DATE]. Review of corporate correspondence related to the kitchen repairs quote revealed request for repairs were submitted by the Administrator to corporate on [DATE]. Scheduling of repairs was authorized by corporate on [DATE] after the interview with the Administrator regarding the kitchen concerns. 2. Observation on [DATE] at 8:21 A.M. during medication administration with Licensed Practical Nurse (LPN) #445 for Resident #21 revealed LPN #445 pouring a cup of thickened cranberry juice that was on top of her medication cart. Observation revealed the cranberry juice had an opened date of [DATE]. The label on the back of the juice bottle indicated to discard the product after 10 days of opening. Interview with LPN #445 at the time of the observation verified the findings.

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	12/12/2022

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37095 Based on interview and record review, the facility failed to ensure baths or showers were documented appropriately. This affected one of four residents reviewed for choices and activities of daily living (Resident #84). The total census was 34. Findings include: Interview with a family member of Resident #84 on 12/04/22 at 12:10 P.M. revealed they felt the resident was not bathed regularly. Observation of Resident #84 at this time revealed he was not interviewable; Resident #84 did not appear unkempt or unclean, and no odor was noted. Record review of Resident #84 revealed he was admitted to the facility 11/19/22 and had diagnoses including cognitive communication deficit, hyperkalemia and type 2 diabetes. Review of Resident #84's nurse aide tasks log revealed the resident was supposed to have a bath or shower every Wednesday and Saturday. Review the bathing sign-off section revealed no documentation Resident #84 received any bathing while at the facility. Interview with the Director of Nursing on 12/07/22 at 4:16 P.M. confirmed the above findings