STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWARK CARE AND REHABILITATION	75 MCMILLEN DRIVE NEWARK, OH 43055

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review and resident and staff interview the facility failed to maintain sufficient levels of nursing staff to ensure medications were administered timely and to ensure all residents received timely and adequate care to maintain their highest level of well-being. This affected six residents (#24, #28, #78, #84, #85 and #91) and had the potential to affect all 95 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #24 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) 3.0 assessment, dated 09/04/20 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 03 indicating severe cognitive impairment and the resident required extensive two staff assistance for bed mobility, transfers, and toilet use. A review of the physician's orders [REDACTED].M.) and Insulin [MEDICATION NAME] Solution Pen-injector 100 U/ml with instructions to inject 12 U subcutaneous before meals for diabetes (due at 8:00 A.M.). An observation on 09/22/20 at 9:36 A.M. with Licensed Practical Nurse (LPN) #278 revealed Resident #24's 8:00 A.M. medications (Tresiba and Insulin [MEDICATION NAME]) were being given at this time. The resident received 50 U of Tresiba FlexTouch Solution Pen-injector and 12 U of Insulin [MEDICATION NAME] Solution Pen-injector late. Interview on 09/22/20 at 9:36 A.M. with LPN #278 revealed it was a struggle to get all of her medications passed on time everyday due to the facility being short staffed State tested nursing assistants (STNAs) and nurses. She stated she often has to help the STNAs since they're overwhelmed because the unit (Unit 3) has a lot of residents, a lot of medications to administer, a lot of residents with behaviors and a lot of residents who require two staff to assist. She was aware the medications were late and she further stated the resident had already had his breakfast. Interview on 09/22/20 at 12:35 P.M. with Resident #24 revealed his medications were always given to him late and he had even had his night time medications given to him in the morning. Resident #24 further stated he felt the late medications would be solved if there were more staff. In addition, review of the physician's orders [REDACTED].M.), [MEDICATION NAME] 500 mg twice daily (antipsychotic) (dose due at 9:00 P.M.), [MEDICATION NAME] 150 mg twice daily for pain (dose due at 9:00 P.M.), and [MEDICATION NAME] 25 mg twice daily [MEDICAL CONDITION](dose due at 9:00 P.M.). The resident also had orders to receive once a day medications at bedtime, including Atorvastatin 80 milligrams (mg) at bedtime for hypercholestemia (due at 10:00 P.M.), multivitamin tablet one tablet daily for supplement (due at 9:00 P.M.) and [MEDICATION NAME] 1 mg at bedtime for [MEDICAL CONDITION] (due at 9:00 P.M.). An observation on 09/22/20 at 11:34 P.M. with LPN #301 revealed the LPN administered the resident's [MEDICATION NAME] and [MEDICATION NAME] at this time. In addition, The LPN administered the once daily Atorvastatin, multivitamin and [MEDICATION NAME]. The medications were observed administered late as they were scheduled to be administered at 9:00 P.M. and 10:00 P.M. LPN #301 verified the medications she administered at the time of the administration. 2. Review of the medical record for Resident #28 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. The MDS 3.0 assessment, dated 08/28/20 revealed the resident had a BIMS score of 15 indicating the resident was cognitively intact. The resident required limited one staff assistance for transfers, and she was independent for bed mobility, walking and toilet use. A review of the physician's orders [REDACTED].). In addition, the resident also had orders for the once daily medications, Atorvastatin 20 milligrams (mg) at bed time for [MEDICAL CONDITION] (due at 9:00 P.M.), [MEDICATION NAME] 600 mg at bedtime for pain (due at 10:00 P.M.) and [MEDICATION NAME] 15 mg at bed time for depression (due at 10:00 P.M.). An observation on 09/22/20 at 11:23 P.M. with LPN #301 revealed the LPN was observed administering the resident's [MEDICATION NAME] at this time. In addition, the LPN administered the resident's Atorvastatin, [MEDICATION NAME] and [MEDICATION NAME] at that time. The medications were administered late. The LPN verified the medication was administered at 11:23 P.M. 3. Review of the medical record for Resident #84 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. The MDS 3.0 assessment, dated 07/25/20 revealed the resident had severe cognitive impairment and required extensive two staff assistance for bed mobility, transfers and toilet use. A review of the physician's orders [REDACTED].) and Sodium Chloride 1 gram (G) four times a day [MEDICAL CONDITION](dose due at 10:00 P.M.). An observation on 09/22/20 at 11:07 P.M. with LPN #301 revealed the LPN administered the [MEDICATION NAME] and Sodium Chloride at this time. The medications were observed being administered late. 4. Review of the medical record for Resident #78 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. The MDS 3.0 assessment, dated 07/28/20, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact and required extensive two staff assistance for bed mobility, transfers and toilet use. A review of the physician's orders [REDACTED].M.), [MEDICATION NAME]-[MEDICATION NAME] Aerosol 9-4.8 mcg/act with instructions to inhale two puffs twice daily for [MEDICAL CONDITION] (dose due at 9:00 P.M.) and [MEDICATION NAME] 600 milligrams (mg) twice daily (dose due at 9:00 P.M.). An observation on 09/22/20 at 11:16 P.M. with LPN #301 revealed the LPN administered the resident's [MEDICATION NAME] and [MEDICATION NAME] at this time. The medications were observed being administered late. Interview on 09/22/20 from 10:25 P.M. through 11:34 P.M. with LPN #301 revealed it was difficult for her to complete her medication pass on time which was a nightly concern. She stated some of the residents on the unit should be on a different unit (memory care) and she couldn't complete her work because of the amount of interruptions from the residents. During this interview she also confirmed the medications that were administered late for Resident #24, Resident #28, Resident #78 and Resident #84. Review of the undated facility policy titled Administering Medications revealed medications must be administered in accordance with the orders, including any required time frame and administered within one hour of their prescribed time, unless otherwise specified. 5. Interview on 09/17/20 at 6:35 A.M. with LPN #227 revealed the evening/bedtime medications passed on Unit 3 were always late, sometimes not administered until 12:00 A.M. or 1:00 A.M. He stated the reason for the late medications was because of low staffing, high resident needs and a high number of residents on the workload. Interview on 09/17/20 at 6:55 A.M. with State tested Nurse Assistant (STNA) #275 revealed she didn't feel there was enough staff for the residents in the facility to get adequate attention. She felt Unit 3 and Unit 4 had residents who required a lot of attention and required multiple staff assistance to help with care. Interview on 09/22/20 at 10:22 P.M. with STNA #258 revealed the facility was always short staffed and Unit 3 was a very heavy unit (indicating a high work load). She stated it was typically just her and the nurse on that unit so the nurse had to help her with residents who required two staff to assist which deters the nurses from their duties. Interview on 09/22/20 at 12:20 P.M. with Resident #85 revealed her medications were always late and she has even had night time medications given to her in the morning. She further stated she felt the staff were over worked because the STNAs call off too much. Interview on 09/22/20 at 12:25 P.M. with Resident #91 revealed her mediations were always late and she had even had her night time medications given to her in the morning (once at 3:00 A.M.). She further stated the staff were over worked and short staffed. Review of the undated facility policy titled Staffing, revealed the facility would maintain adequate staffing on each shift to ensure the residents needs and services were met. This deficiency substantiates Complaint Number OH 832, Complaint Number OH 790,

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

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) Complaint Number OH 247 and Complaint Number OH 079.
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** Based on observation, record review, policy review and staff interview the facility failed to maintain a medication error rate of less than five percent. The medication error rate was calculated to be 15.58% and included 12 observed medication errors of 77 medication administration opportunities. This affected four residents (#24, #28, #78, and #84) of nine residents observed during medication administration. Findings include: 1. Review of the medical record for Resident #24 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) 3.0 assessment, dated 09/04/20 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 03 indicating severe cognitive impairment and the resident required extensive two staff assistance for bed mobility, transfers and toilet use. A review of the physician's orders [REDACTED].M.) and Insulin [MEDICATION NAME] Solution Pen-injector 100 U/ml with instructions to inject 12 U subcutaneous before meals for diabetes (due at 8:00 A.M.). An observation on 09/22/20 at 9:36 A.M. with Licensed Practical Nurse (LPN) #278 revealed Resident #24's 8:00 A.M. medications (Tresiba and Insulin [MEDICATION NAME]) were being given at this time. The resident received 50 U of Tresiba FlexTouch Solution Pen-injector and 12 U of Insulin [MEDICATION NAME] Solution Pen-injector late. Interview on 09/22/20 at 9:36 A.M. with LPN #278 revealed it was a struggle to get all of her medications passed on time everyday due to the facility being short staffed State tested nursing assistants (STNAs) and nurses. She stated she often has to help the STNAs since they're overwhelmed because the unit worked (Unit 3) has a lot of residents, a lot of medications, a lot of behaviors and a lot of residents who require two person assist. She was aware the medications were late and she further stated the resident had already had his breakfast. In addition, review of the physician's orders [REDACTED].M.), [MEDICATION NAME] 500 mg twice daily (antipsychotic) (dose due at 9:00 P.M.), [MEDICATION NAME] 150 mg twice daily for pain (dose due at 9:00 P.M.), and [MEDICATION NAME] 25 mg twice daily [MEDICAL CONDITION](dose due at 9:00 P.M.). An observation on 09/22/20 at 11:34 P.M. with LPN #301 revealed the LPN administered the resident's [MEDICATION NAME] and [MEDICATION NAME] at this time. The medications were observed administered late as they were scheduled to be administered at 9:00 P.M. LPN #301 verified the medications she administered at the time of the administration. 2. Review of the medical record for Resident #28 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. The MDS 3.0 assessment, dated 08/28/20 revealed the resident had a BIMS score of 15 indicating the resident was cognitively intact. The resident required limited one staff assistance for transfers, and she was independent for bed mobility, walking and toilet use. A review of the physician's orders [REDACTED].). An observation on 09/22/20 at 11:23 P.M. with LPN #301 revealed the LPN was observed administering the resident's [MEDICATION NAME] at this time. The medication was administered late. The LPN verified the medication was administered at 11:23 P.M. 3. Review of the medical record for Resident #84 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. The MDS 3.0 assessment, dated 07/25/20 revealed the resident had severe cognitive impairment and required extensive two staff assistance for bed mobility, transfers and toilet use. A review of the physician's orders [REDACTED].) and Sodium Chloride 1 gram (G) four times a day [MEDICAL CONDITION](dose due at 10:00 P.M.). An observation on 09/22/20 at 11:07 P.M. with LPN #301 revealed the LPN administered the [MEDICATION NAME] and Sodium Chloride at this time. The medications were observed being administered late. At the time of the observation, LPN #301 was also observed pulling the medications from the cart without viewing/checking the medications with the Medication Administration Record [REDACTED]. Review of the medical record for Resident #78 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. The MDS 3.0 assessment, dated 07/28/20, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact and required extensive two staff assistance for bed mobility, transfers, and toilet use. A review of the physician orders [REDACTED].M.), [MEDICATION NAME]-[MEDICATION NAME] Aerosol 9-4.8 mcg/act with instructions to inhale two puffs twice daily for [MEDICAL CONDITION] (dose due at 9:00 P.M.) and [MEDICATION NAME] 600 milligrams (mg) twice daily (dose due at 9:00 P.M.). An observation on 09/22/20 at 11:16 P.M. with LPN #301 revealed the LPN administered the resident's [MEDICATION NAME] and [MEDICATION NAME] at this time. The medications were observed being administered late. Interview on 09/22/20 from 10:25 P.M. through 11:34 P.M. with LPN #301 revealed it was difficult for her to complete her medication pass on time which was a nightly concern. She stated some of the residents on the unit should be on a different unit (memory care) and she couldn't complete her work because of the amount of interruptions from the residents on Unit 3. During the interview, she also confirmed the late medications for Resident #24, Resident #28, Resident #78, and Resident #84 and the absence of checking the Medication Administration Record [REDACTED]. Review of the undated facility policy titled Administering Medications revealed medications shall be administered in a safe and timely manner, and as prescribed. It further revealed medications must be administered in accordance with the orders, including any required time frame and administered within one hour of their prescribed time, unless otherwise specified. The policy also revealed the individual administering the medications must check the label to verify the right resident, right medication, right dose, right time and right route of administration before giving the medication. This deficiency substantiates Complaint Number OH 247 and Complaint Number OH 079.

F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of guidance from the Centers of Disease Control (CDC) for nursing homes, policy review and interview the facility failed to maintain proper infection control practices to prevent the spread of COVID 19 within the facility. Physical Therapist (PT) #315 and State tested Nursing Assistant (STNA) #290 were observed to remove isolation gowns outside of resident rooms, no stocked personal protective equipment (PPE) carts were observed being utilized on the facility quarantine unit, Licensed Practical Nurse (LPN) #301, STNA #258 and STNA #300 were observed not wearing appropriate PPE, and LPN #301 was observed to handle Resident #84's medications with her bare hands without proper hand hygiene. This had the potential to affect all 21 residents (#10, #12, #19, #24, #25, #28, #34, #42, #58, #61, #67, #70, #78, #81, #83, #84, #85, #91, #92, #95 and #97) who resided on the 300 unit, eight residents (#15, #22, #48, #50, #63, #1, #74, and #82) who resided on the 400 unit and 12 residents (#4, #17, #27, #37, #39, #40, #45, #46, #56, #65, #93, and #98) who resided on the facility quarantine unit. The facility census was 95. Findings include: 1. On 09/22/20 at 12:05 P.M. PT #315 was observed exiting Resident #56's room. Resident #56 was observed to reside in a room on the facility COVID 19 quarantine unit and was on droplet isolation. The therapist had a gown, mask and face shield on when he exited the resident's room. The therapist proceeded to walk down the hallway and entered a clean room wearing the same gown, mask and face shield that had been worn in Resident #56's room. The physical therapist then took off the used gown in the clean room, obtained a new gown that was still in a plastic bag and removed the gown from the bag. He then placed the used gown in the plastic bag and set it on the floor. The therapist put on the clean gown, picked up the used gown in the bag, walked through doors to get back onto the unit again and threw the used gown into a large trash can that was covered with a lid. The facility clean room was an area in the facility designated for staff to apply clean PPE before they entered onto the quarantine unit. It looked like a sun room converted into this specific area for applying PPE. Staff would enter into this room, put on PPE, and then enter through another set of doors to go onto the actual unit. Therapy staff were set up to chart in this room. A big trash can with a lid was observed right inside the doors. Interview with PT #315 on 09/22/20 at 12:10 P.M. confirmed the therapist had exited Resident #56's room with his gown still on and took off the gown in the clean room. The therapist stated he didn't know he should take off his PPE inside the resident's room before he left the room. On 09/22/20 at 10:55 P.M. STNA #290 was observed to exit Resident #46's room wearing a gown, mask and face shield. In the hallway outside of the resident's room, the STNA obtained a clean gown from an end table that was stocked with PPE. STNA took off the used gown and threw it in a large trash can that was covered with a lid by the entrance to the clean room. The STNA then put on the new, clean gown and used hand sanitizer to clean her hands. Interview with STNA #290 on 09/22/20 at 11:00 P.M. confirmed the STNA exited the resident's room with her gown still on. The STNA stated, I didn't know I should have taken it off inside the room. I just knew I needed to change it in between rooms. Review of the undated facility policy titled Types of Isolation revealed for residents under droplet isolation, staff providing care must put on PPE upon room entry and discard PPE before exiting resident's room. 2. From 09/08/20 through 09/21/20 intermittent random observations of the facility quarantine unit revealed no stocked PPE carts were being used on the unit for staff to readily and easily obtain PPE for resident care use. Interviews and observations randomly made during this time period revealed the nurses were placing extra gowns on the medication carts to make sure clean PPE was available. The STNA and nursing staff were also noted to keep PPE at the nurse's station and in the clean room. Interview with LPN #305 on 09/09/20 at 6:20 P.M. confirmed clean PPE was kept in the clean room. On 09/22/20 from 10:34 P.M. to 11:40 P.M. end tables were observed to have

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) been placed on the unit that were now stocked with PPE throughout the unit. Interview with Registered Nurse (RN) #286 on 09/22/20 at 11:10 P.M. confirmed the end tables stocked with PPE were just brought onto the unit at some point earlier on this date. The nurse stated she worked last night and they were not in place at that time. The nurse stated prior to tonight, the staff had been removing gowns outside of resident rooms and using the single large covered trash can by the entrance to the clean room to throw it away. 3. On 09/22/20 at 10:20 P.M. an observation and interview with LPN #301 revealed the LPN was wearing a cloth face mask and not the required N95 mask. The LPN was also not wearing any type of face shield. LPN #301 confirmed she was not wearing the appropriate personal protective equipment (PPE) at the time of the observation. LPN #301 stated, I walk in every day with it (the cloth mask) on. They check my temperature every day. No one has said anything to me about it. When asked about the face shield, she stated there weren't any face shields at the front entrance and she didn't know were any extras were. LPN #301 then retrieved two face shields out of a nurse's station cabinet (one for herself and one for STNA #258). On 09/22/20 at 10:22 P.M. observation and interview with STNA #258 revealed the STNA was not wearing her N95 mask (it was in her hand) and she didn't have a face shield on. STNA #258 confirmed she was not wearing the appropriate PPE and verbalized the appropriate PPE to wear in the facility would be an N95 mask and a face shield. On 09/22/20 at 10:25 P.M. STNA #300 was observed not wearing a face shield. STNA #300 stated the face shield she had didn't fit and confirmed she was not wearing the appropriate PPE at that time. Interview with the STNA at the time of the observation revealed an N95 mask and face shield should be worn while working in the facility. Review of the Centers for Disease Control (CDC) Guidance titled, Preparing for COVID-19 in Nursing Homes, dated 06/25/20, revealed cloth face coverings were not considered PPE for healthcare personnel and face coverings should be worn at all times when in the facility. 4. Review of the medical record for Resident #84 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) 3.0 assessment, dated 07/25/20 revealed the resident had severe cognitive impairment and required extensive two staff assistance for bed mobility, transfers and toilet use. A review of the physician's orders [REDACTED]. An observation on 09/22/20 at 11:07 P.M. during the medication pass, revealed LPN #301 used her bare hands and touched the resident's [MEDICATION NAME] and Trazadone medications. There was no evidence the LPN had just washed or used hand sanitizer immediately before having contact with the medications with her bare hands. At the time of the observation, the LPN verified she had handled the medications with her bare hands which she had not just washed or sanitized. The LPN indicated she planned to administer the medications to the resident until the surveyor stopped her. LPN #301 proceeded to dispose of the medications and retrieved new medications following proper infection control practices. Review of the undated facility policy titled Administering Medications revealed staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications. This deficiency substantiates Complaint Number OH 832 and Complaint OH 565. This deficiency is also an example of continued non-compliance from the survey dated 08/10/20.