| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **366188** | A. BUILDING _____ B. WING _____ | **09/21/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **LUTHERAN HOME AT TOLEDO** | **131 NORTH WHEELING STREET TOLEDO, OH 43605** |

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) |
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| F 0580<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, staff interviews, and review of the facility charting and documentation policy, the facility failed to ensure the physician was notified timely of the resident refusals of treatment. This deficient practice affected one (#5) of three residents reviewed for the provision of timely care and treatment in a facility census of 76. Findings include; Review of Resident #5's record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Further review of the electronic medical record revealed the resident was discharged from the facility on 04/02/20 at 6:30 P.M. Review of the nurses notes on 04/01/20 at 7:30 P.M., revealed the resident arrived via stretcher, transferred to bed by ambulette staff, and medications were verified by Certified Nurse Practitioner (CNP) #1. Review of the hospital community referral form dated 04/01/20, indicated Resident #5 required [MEDICAL TREATMENT] at 9:00 A.M. every Tuesday, Thursday, and Saturday. Review of the admission physician treatment orders revealed to monitor the resident for signs and symptoms (S/S) of cough, sore throat, and shortness of breath each shift for 21 days. There was no evidence in the record to indicate this order was implemented. Further review of admission orders [REDACTED]. Review of medication administration records (MAR) from 04/01/20, revealed no medications were provided to the resident. According to the MAR from 04/02/20, the resident was noted with a blood sugar of 173 before breakfast. However, no dosage of insulin was recorded as administered. According to the sliding scale, the resident would have required the administration of two units of Humalog insulin. The MAR indicated [REDACTED].M. and [MEDICATION NAME] 1 gram tablet was administered at 6:00 A.M. However, no further medications were administered. Review of the MAR indicated [REDACTED]. Review of the nurses notes on 04/02/20 at 7:02 P.M., documented physical therapy went into the residents room to do therapy. Resident #5 refused to go to [MEDICAL TREATMENT] and did not specify a reason. The resident refused all morning medications and complained of nausea. The nurse offered the medication [MEDICATION NAME] 5 mg, and the resident refused this morning and the resident refused this administration also. The resident asked for something for pain and the nurse offered her Tylenol, as per as needed (PRN) order. The resident rolled her eyes and said nevermind and requested to go to the hospital Review of Certified Nurse Practitioner (CNP) #1's acute visit notes dated 04/02/20 (no time indicated) assessed the resident as alert to person, place, time, and circumstance. The resident was evaluated related to abdominal pain, nausea, refusing to go to [MEDICAL TREATMENT], refusing all medications and resident care. CNP #1 noted the resident seemed frustrated and stated she was nauseated with a stomach ache and wanted to go to the hospital. CNP #1 then went to review the medical record and stated she would return in five minutes. While reviewing the chart, CNP #1 was informed 911 Emergency Medical Services (EMS) was called and on the way to the facility. On 09/16/20 at 11:25 A.M., interview with the Director of Nursing (DON) and Assistant DON, verified there was no documentation in the record including notification of the physician regarding the residents refusals and health status concerns. On 09/16/20 at 12:10 P.M., telephone interview with EMS Staff #1 revealed EMS was summonsed to the facility by an outside caller on 04/02/20 at 3:32 P.M. The squad arrived at the facility at 3:44 P.M., and transported the resident to the hospital. On 09/16/20 at 12:09 P.M., interview with CNP #1 verified on 04/01/20 at 8:00 P.M., she reviewed Resident #5's admission medications and responded with confirmed orders at 8:47 P.M. On 04/02/20 at approximately 3:00 P.M., she evaluated the resident for refusal of medications and treatments ([MEDICAL TREATMENT] T, Th, Sa). CNP #1 went to review the residents medical record and stated she would return to the resident room in five minutes. CNP #1 verified Resident #5 was alert and oriented and able to make appropriate decisions. The resident was then sent to the hospital. CNP #1 was unable to indicate what time she received a notification the resident was refusing medications or [MEDICAL TREATMENT]. Review of the facility charting and documentation policy revised 04/12, indicated all observations, medications administered, services performed, ect., must be documented in the residents medical records. Documentation of procedures and treatments shall include care specific details and shall include at a minimum: the date and time the procedure/treatment was provided, name and title of individual who provided care, the assessment data and or any unusual findings obtained during the procedure/treatment, notification of family, physician or other staff if indicated. This deficiency is an incidental finding discovered at the time of Complaint Number OH 546. |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, staff interviews, and review of the facility charting and documentation policy, the facility failed to ensure ongoing assessment and treatments were implemented timely. This deficient practice affected one (#5) of three residents reviewed for the provision of timely care and treatment in a total facility census of 76. Findings include: Review of Resident #5's record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Further review of the electronic medical record revealed the resident was discharged from the facility on 04/02/20 at 6:30 P.M. Review of the nurses notes on 04/01/20 at 7:30 P.M., revealed the resident arrived via stretcher, transferred to bed by ambulette staff, and medications were verified by Certified Nurse Practitioner (CNP) #1. Review of the hospital community referral form dated 04/01/20, indicated Resident #5 required [MEDICAL TREATMENT] at 9:00 A.M. every Tuesday, Thursday, and Saturday. Review of the admission physician treatment orders revealed to monitor the resident for signs and symptoms (S/S) of cough, sore throat, and shortness of breath each shift for 21 days. There was no evidence in the record to indicate this order was implemented. Further review of admission orders [REDACTED]. Review of medication administration records (MAR) from 04/01/20, revealed no medications were provided to the resident. According to the MAR from 04/02/20, the resident was noted with a blood sugar of 173 before breakfast. However, no dosage of insulin was recorded as administered. According to the sliding scale, the resident would have required the administration of two units of Humalog insulin. The MAR indicated [REDACTED].M. and [MEDICATION NAME] 1 gram tablet was administered at 6:00 A.M. However, no further medications were administered. Review of the MAR indicated [REDACTED]. Further review of the record revealed there was no documentation regarding a physical assessment, monitoring of medication, [MEDICAL TREATMENT], treatment refusals, or communication with the physician or Certified Nurse Practitioner CNP #1. According to the electronic medical record the resident was discharged from the facility on 04/02/20 at 6:30 P.M. Review of the nurses notes on 04/02/20 at 7:02 P.M., documented physical therapy went into the residents room to do therapy. Resident #5 refused to go to [MEDICAL TREATMENT] and did not specify a reason. The resident refused all morning medications and complained of nausea. The nurse offered the medication [MEDICATION NAME] 5 mg, and the resident refused this morning and the resident refused this administration also. The resident asked for something for pain and the nurse offered her Tylenol, as per as needed (PRN) order. The resident rolled |

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

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.

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| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>her eyes and said nevermind and requested to go to the hospital Review of Certified Nurse Practitioner (CNP) #1's acute visit notes dated 04/02/20 (no time indicated) assessed the resident as alert to person, place, time, and circumstance. The resident was evaluated related to abdominal pain, nausea, refusing to go to [MEDICAL TREATMENT], refusing all medications and resident care. CNP #1 noted the resident seemed frustrated and stated she was nauseated with a stomach ache and wanted to go to the hospital. CNP #1 then went to review the medical record and stated she would return in five minutes. While reviewing the chart, CNP #1 was informed 911 Emergency Medical Services (EMS) was called and on the way to the facility. On 09/16/20 at 11:25 A.M., interview with the Director of Nursing (DON) and Assistant DON, verified there was no documentation in the record including notification of the physician regarding the residents refusals and health status concerns. On 09/16/20 at 12:10 P.M., telephone interview with EMS Staff #1 revealed EMS was summonsed to the facility by an outside caller on 04/02/20 at 3:32 P.M. The squad arrived at the facility at 3:44 P.M., and transported the resident to the hospital. On 09/16/20 at 12:09 P.M., interview with CNP #1 verified on 04/01/20 at 8:00 P.M., she reviewed Resident #5's admission medications and responded with confirmed orders at 8:47 P.M. On 04/02/20 at approximately 3:00 P.M., she evaluated the resident for refusal of medications and treatments ([MEDICAL TREATMENT] T, Th, Sa). CNP #1 went to review the residents medical record and stated she would return to the resident room in five minutes. CNP #1 verified Resident #5 was alert and oriented and able to make appropriate decisions. The resident was then sent to the hospital. CNP #1 was unable to indicate what time she received a notification the resident was refusing medications or [MEDICAL TREATMENT]. Review of the facility charting and documentation policy revised 04/12, indicated all observations, medications administered, services performed, ect., must be documented in the residents medical records. Documentation of procedures and treatments shall include care specific details and shall include at a minimum: the date and time the procedure/treatment was provided, name and title of individual who provided care, the assessment data and or any unusual findings obtained during the procedure/treatment, notification of family, physician or other staff if indicated. This deficiency substantiates Complaint Number OH 546. |
| F 0760<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that residents are free from significant medication errors.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, staff interview, and review of pharmacy documentation, the facility failed to ensure medication was administered as prescribed by the physician. This deficient practice affected one (#3) of eleven residents reviewed for medication administration in a total facility census of 76. Findings include; Review of the record for Resident #3 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. According to the most current minimum data set (MDS) assessment dated [DATE], identified the resident with moderate cognitive impairment, dependent on staff for the completion of activities of daily living, frequently incontinent of bladder and always incontinent of bowel. On 02/28/20, the physician ordered the antibiotic Bactrim DS one tablet twice daily (BID) for seven days. According to facility pharmacy delivery invoice (packing slip) dated 02/28/20, the medication [MEDICATION NAME]/ [MEDICATION NAME] DS (SMZ/TMP DS) (Bactrim DS) 800 milligram (mg)/160 mg, fourteen tablets were delivered to the facility. Review of the Medication Administration Record [REDACTED]. According to the March 2020 MAR, the resident was given and consumed the medication between 03/01/20 and 03/05/20, during the day and evening. Review of the medical record and combined MAR's noted the resident to receive 11 of the 14 doses of Bactrim DS 800 mg-160 mg tablet for urinary tract infection. On 09/16/20 at 2:30 P.M., interview with the Director of Nursing (DON) during a review of the medical record and associated pharmacy documentation, verified the resident did not receive the entire 14 antibiotic tablets and the completed antibiotic therapy. This deficiency is an incidental finding discovered at the time of Complaint Number OH 026. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, staff interviews, record review, and review of the facility admissions and infection control policies, the facility failed to implement isolation interventions regarding newly admitted residents. This deficient practice had the potential to affect 16 (#9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24) of 16 residents who reside on the 100 hall in a total facility census of 76. Findings include: Review of the Resident #16's record revealed an admission to the facility on [DATE]. [DIAGNOSES REDACTED]. Further review of the record noted on 09/01/20, while hospitalized , a Coronavirus Disease 2019 (COVID-19) laboratory test result was negative. Review of Resident #19's record revealed an admission the facility on 09/09/20. [DIAGNOSES REDACTED]. According to laboratory test results dated 09/11/20, the resident was determined to be negative for COVID-19. Observations on 09/15/20 at 10:15 A.M., revealed isolation carts outside resident rooms on the 100 hall. The isolation carts were equipped with disposable isolation gowns and gloves. No protective goggles, or face shields were available on the carts. Each room had a sign near the entry reading, Contact Isolation. The signs indicated isolation gowns, masks and gloves were required for entry to the rooms. The isolated rooms were identified as Rooms #11, #13, #15, #16, #18, #19, and #20. On 09/15/20 at 10:55 A.M., interview with State tested Nurse Aide (STNA) #102, revealed contact precaution signs on resident room doors of residents requiring quarantine isolation due to being newly admitted to the facility. STNA #102 stated required personal protective equipment (PPE) to enter the rooms included donning a mask, a protective gown, and gloves. STNA#102 during observations verified no goggles or faceshields were available at the entry to the isolated resident rooms and were not required. On 09/15/20 at 11:00 A.M., interview and observation with Licensed Practical Nurse (LPN) #203, revealed contact precaution signs on resident room doors and PPE required to enter the rooms included a mask, a protective gown, and gloves. LPN #203 was observed to be preparing for entrance to Resident #19's room. The room was equipped with an isolation cart and sign on the door indicating contact isolation. LPN #203 verified no goggles or faceshields were available at the entrance to the room and were not required due to contact precautions only required a mask, protective gown, and gloves to enter the room. LPN #203 indicated Resident #19 was in isolation due to being newly admitted and required to quarantine as a COVID-19 precaution. Observation on 09/15/20 at 11:15 A.M., noted Physical Therapy Assistant (PTA) #301 with a protective gown, gloves and mask applied. PTA #301 entered Resident #16's room with therapy equipment. The entry door to the room was marked with a sign indicating contact precaution and did not indicate droplet or that a face shield was required. On 09/15/20 at 11:32 A.M., interview with STNA #103 identified herself as working at the facility as an agency staff. She indicated contact precaution signs were on resident room doors of residents recently admitted to the facility and required quarantine. STNA #103 stated PPE required to enter these rooms included a mask, a protective gown and gloves. STNA #103 verified no goggles or faceshields were required for entry to the quarantined rooms. On 09/15/20 at 11:15 A.M., interview with the Director of Nursing (DON) and corporate Registered Nurse (RN) #1, verified 16 residents reside on the 100 hall. Of the 16 residents, seven (#11, #13, #15, #16, #18, #19, #20) residents were in isolation; and the remaining nine (#9, #10, #12, #14, #17, #21, #22, #23, #24) residents were not on isolation precautions. The DON further verified donning a faceshield or goggles and droplet precautions in accordance with the policy, were required to enter newly admitted resident rooms. The DON was aware why contact precaution signs were not in place and face shields or goggles were not available at the quarantined resident room access doors. Review of the facility Coronavirus Disease 2019 Infection Prevention and Control Recommendations, reviewed 08/2020, under Precautions Overview Standard Transmission Based Precautions/Droplet Based, were precautions where it was assumed that every person was potentially infected with a pathogen that could be transmitted. Employees will make common sense practices and utilize PPE to help protect from infection and prevent spread of infection. Examples may include donning PPE to include a mask, faceshield/goggles, gown, and gloves as appropriate. Review of the facility Admissions and Infections Policy revised 09/2020, revealed all new admissions will be tested and placed under Transmission Based Precautions (Standard/Droplet Precautions) and monitored for signs and symptoms of COVID-19 for 14 days. This deficiency substantiates Complaint Number OH 820. |