STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366183	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEASONS NURSING AND REHAB	456 SEASONS RD STOW, OH 44224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0684 **Level of harm** - Minimal harm or potential for 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** Based on record review and interview the facility failed to provide dressing changes for Resident #6's right knee abscess according to physician orders. This affected one of resident reviewed for skin conditions. Findings include: Resident #6 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #6's annual Minimum Data Set (MDS) assessment dated [DATE] revealed he was alert, oriented and had intact cognition. This assessment indicated he also had an open lesion. Resident #6's non-pressure ulcer skin report dated 03/06/20 revealed he had an abscess to his right knee. Review of Resident #6's physician orders [REDACTED]. Staff were to use moisturizer to the surrounding skin for dryness and leave scabbed area open to air. Review of Resident #6's March 2020 Treatment Administration Record (TAR) revealed his treatment was signed as completed on 03/07/20 (Saturday) and 03/08/20 (Sunday). Interview on 03/09/20 at 10:54 A.M. with Resident #6 revealed the resident's dressing to his right knee was not completed over the weekend, 03/07/20 and 03/08/20. Interview on 03/09/20 at 12:46 P.M. with Licensed Practical Nurse (LPN) #330 confirmed when she changed Resident #6's dressing to his right knee on 03/09/20, the old dressing was dated Friday 03/06/20.
F 0761 **Level of harm** - Minimal harm or potential for actual 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review revealed the facility failed to ensure [MEDICATION NAME] solution, solution used to test for [MEDICAL CONDITION] (TB), was properly dated, used and disposed of according to manufacture guidelines. This affected nine residents, Residents #3, #11, #14, #19, #28, #33, #37, #39 and #47 and 26 new employees, State tested Nurse Assistants (STNAs) #303, #304, #305, #307, #310, #311, #315, #316, #317, #319, #320, #321, #322, #324, #325, #326, #327, #328 and #329, Dietary Aides (DAs) #306, #308, #314, #318, Registered Nurse (RN) #309, Licensed Practical Nurse (LPN) #313, and the Administrator and had the potential to affect all 48 residents residing in the facility. Findings included: On 03/11/20 at 8:40 A.M. an observation of medication storage revealed the medication storage refrigerators had [MEDICATION NAME], Purified Protein Derivative (TB) solution, multi-vials received by pharmacy on 06/07/19. There were three open vials. One vial was not labeled with the open date, one vial was labeled with an open dated of 01/22/20 and one vial was labeled with an open date of 01/23/20. Review of the pharmacy delivery records revealed the [MEDICATION NAME] vials were delivered to the faciliy on 06/07/19. On 03/11/20 at 8:44 A.M., interview with Registered Nurse (RN) #302 verified when opening a [MEDICATION NAME] vial, it should be dated with the date opened and then discarded after 30 days. RN #302 verified one vial was not dated and two vials were outdated. On 03/11/20 at 9:00 A.M., interview with the Director of Nursing (DON) verified all opened [MEDICATION NAME] vials were to be dated when opened and discarded after 30 days. The DON was unable to say which employees or residents received a TB test from which vial, as all the vials had the same lot number. Review of the list of employees hired from 06/07/19 through 03/12/20 revealed there were 26 new employees, State tested Nurse Assistants (STNAs) #303, #304, #305, #307, #310, #311, #315, #316, #317, #319, #320, #321, #322, #324, #325, #326, #327, #328 and #329, Dietary Aides (DAs) #306, #308, #314, #318, Registered Nurse (RN) #309, Licensed Practical Nurse (LPN) #313 and the Administrator were all hired and received TB testing using these vials during this time frame. Review of the list of residents admitted /readmitted that received a TB test from these vials from, 06/07/19 through 03/12/20 revealed there were nine residents, Residents #3, #11, #14, #19, #28, #33, #37, #39 and #47. Review of the manufacture recommendations for TB solution revealed vials in use more than 30 days should be discarded due to deterioration. Review of the facility policy, Storage of Medications, dated April 2007, revealed the facility shall not use discontinued, outdated or deteriorated drugs and they should be disposed of appropriately.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation, interview, and infection control guidelines, the facility failed to ensure bodily fluids were cleaned properly. This had the potential to affect all 48 of 48 residents that resided at the facility. Findings include: Observation 03/09/20 at 8:20 A.M. revealed Maintenance Director #331 was cleaning feces off the social services door with a towel, without wearing gloves. Interview with Maintenance Director #331 at that time confirmed the observation and concern. Review of the Centers for Disease Control and Prevention for Environmental Infection Control Guidelines, reviewed 05/14/19, revealed recommended cleaning strategies for spills of body fluids included for the worker assigned to clean up bodily fluids to wear gloves. Interview on 03/12/20 at 9:12 A.M. with the Director of Nursing confirmed staff should wear gloves while cleaning feces.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident #17 was offered Prevnar 13 pneumococcal vaccination. This affected one (Resident #17) of five residents reviewed for immunizations. Findings include: Resident #17 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #17 was [AGE] years old. Review of Resident #17's immunization history revealed she received the [MEDICATION NAME] vaccine on 03/18/18. There was no evidence Resident #17 was offered the Prevnar 13 pneumococcal vaccine, a vaccine effective against 13 different strains of pneumonia. Interview on 03/10/20 at 2:51 P.M. with the Director of Nursing revealed the facility had not been offering Prevnar 13 vaccines, and confirmed Resident #17 specifically had not been offered the Prevnar 13. Review of the facility policy titled,Pneumococcal Vaccine, undated, revealed the Centers for Disease Control and Prevention recommends vaccination with the pneumococcal conjugate vaccine (Prevnar 13) for all adults [AGE] years or older.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the environment was clean, sanitary, and in good repair. This affected Residents #4, #6 and #24 and had the potential to affect all 48 residents residing in the

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) facility. Findings include: 1. Observation on 03/09/20 at 9:13 A.M. of Resident #4's room revealed a long, thin brown area with peeling white paint extending from the top of the wall to the middle of the ceiling. The brown area had two holes, one approximately 3 inches in diameter, and one approximately 2 inches in diameter. Interview on 03/09/20 at 11:22 A.M. with Resident #4 confirmed the ceiling had a brown area with peeling white paint and holes. Resident #4 stated the ceiling leaked water when it rained or snowed, and staff placed buckets in his room to collect the dripping water. He stated the buckets had been removed that morning. Interview on 03/09/20 at 11:30 A.M. with the Administrator revealed he was aware the ceiling leaked and needed repaired in Resident #4's room. 2. Interview on 03/09/20 at 11:44 A.M. with Resident #24 revealed the shower room across from his room was filthy. He said there was a resident that goes in there and gets feces on the toilet and shower room floor all the time and housekeeping doesn't clean it up. Observation on 03/09/20 at 1:58 P.M. of this shower room revealed a dirty dry wash cloth on the shower floor and a dirty towel on a chair in the shower. The shower room floor and bathroom floor appeared to have a dried brown substance in the grout. Observation on 03/10/20 at 10:00 A.M. of this shower room revealed floor was still dirty with a brown substance on the tile and the grout in the shower and by the room door. Later that day at 2:01 P.M., observation revealed the shower room floor to still be dirty as previously noted. Interview on 03/10/20 at 2:13 P.M. with Account Manager #300 verified the shower/bathroom had a dried brown substance on the shower floor and verified the floor needed scrubbed. Interview on 03/10/20 at 2:36 P.M. with Housekeeper (HK) #301 revealed he said he had already cleaned this shower room in the morning. 3. Observation on 03/09/20 at 8:30 A.M. and on 03/09/20 at 6:36 A.M. revealed the conference room and the library had a strong urine smell. Interview on 03/10/20 at 6:36 A.M. with the Director of Nursing (DON) confirmed the strong urine smell in the conference room and indicated a resident urinates in the area. 4. During an environmental tour on 03/12/20 from 2:00 P.M. to 2:26 P.M. the following findings were observed and confirmed through interview with Maintenance Director #331: a. The door to the therapy room had significant black markings on it. b. The conference room door frame had significant chipping, black marks, and was scrapped. c. The wallpaper in the hall between the social services office and conference room was peeling off. Maintenance Director #331 revealed this was due to the ceiling leaking above the wall. d. The door frames leading to the library and lobby area were scrapped and had black markings. e. The urine smell in the lobby was still present. f. The floor in the lobby area near a couch leg had a dried substance that had been there since 03/09/20 at 8:30 A.M. g. The carpet near the nurse's station had a large bleach spot on it, with stains on the edges of the carpet. h. The living room ceiling had significant patching and a blind on the window was stained. Maintenance Director #331 revealed the ceiling leaks and he has to repair it. Maintenance Director #331 revealed the stain on the blind was due to the leaks. Maintenance Director #331 revealed the rubber on the roof was pulling away from the flashing causing the leaks. i. The living room couch had multiple stains. j. The floor was not swept under the table in the living room. k. A chair in the living room had cobwebs underneath it near the legs of the chair. l. The common shower room did not have a threshold in the door frame. m. The railing near room [ROOM NUMBER] was chipped. n. Resident #6 did not have a threshold in his door frame. o. There were significant amount of cigarette butts all throughout the courtyard. p. While outside, the roof was visibly caving in above the dining room, with multiple shingles displaced across the roof. q. The sidewalks in the courtyard were not in good repair, as evidence by uneven ground. Interview on 03/12/20 at 2:27 P.M. with the DON confirmed the ground was uneven in the courtyard.