STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365305	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Willoughby	37603 Euclid Ave Willoughby, OH 44094

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 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** 42011 Based on closed record review and interview, the facility failed to collect a urinalysis for one resident, Resident #136 per the physicians orders. This affected one resident (Resident #136) of three residents reviewed for physician orders/labs. The facility census was 132. Findings include: Closed record review for Resident #136 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included type two diabetes mellitus, hydronephrosis, weakness, and retention of urine. Record review of the Medicare five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #136 was cognitively intact. Resident #136 was dependent for toileting and was frequently incontinent of urine. Record review of the Certified Nurse Practitioner (CNP) #369 progress note for Resident #136 dated 09/27/24 at 10:19 A.M. revealed worsening confusion and anxiety, ordered to send urine stat. Record review of the physician orders for Resident #136 revealed an order dated 09/27/24 to collect urine for urinalysis. Record review of the urinalysis lab result for Resident #136 revealed the urine specimen was collected on 09/30/24 and reported to the facility on [DATE]. The results of the urinalysis revealed an abnormal result of three plus leukocytes, six to 20 white blood cells, bacteria and mucous. The urine had mixed flora, so sensitivity was not able to be completed. On 10/02/24 a new physician order was received for Resident #136 to straight cath for urine specimen and send for a urinalysis and culture and sensitivity. Record review for Resident #136 revealed no documentation of the straight cath for the urinalysis with a culture and sensitivity was completed on 10/02/24 or after. Record reviews revealed there was no documentation either to why the urinalysis was not collected for Resident #136. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/19/24 with Director of Nursing (DON) revealed the CNP ordered the urinalysis stat for Resident #136 on 09/27/24. DON revealed urinalysis could not be done stat, the lab would not come to the facility to collect a stat urinalysis so she explained that to the CNP. DON confirmed the urinalysis was not collected until 09/30/24 and the results received on 10/01/24 had mixed flora. DON confirmed the physician ordered the straight cath for the urinalysis with a culture and sensitivity on 10/02/24. DON revealed she reviewed the labs collected by the lab company and confirmed the urinalysis was not collected for Resident #136 on or after 10/02/24 per the physicians orders. DON also confirmed there was no documentation in the medical record to why the urinalysis was not completed and confirmed there should have been documentation. DON revealed she did not know why the nurses did not collect the urinalysis per the physicians orders. This deficiency represents non-compliance investigated under Complaint Number OH00158759.

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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 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** 42011 Based on review of the Payroll-Based Journal (PBJ) Staffing Data Report, interview with residents and staff and review of the facility assessment, the facility failed to assure sufficient staff to care for residents needs. This had the potential to affect all residents residing at the facility. The facility census was 132. Findings include: Record review of the PBJ Staffing Data Report 1705D Fiscal Year Quarter 3 2024 (April 1 - June 30) revealed Facility ID: OH00603 triggered a one star staffing rating and excessively low weekend staffing. Record review of the Facility assessment dated [DATE] revealed a Certified Bed Capacity of 157. The average daily census the last assessment revealed short stay average census of 19.4 and long stay average census was 105.4; This assessment will inform the facility's staffing decision to ensure that there are a sufficient number of staff with appropriate competencies and skill sets necessary to care for residents needs as identified through resident assessments and plans of care. The facility will consider staffing needs for each resident unit in the facility for each shift and adjust as necessary based on the resident population. Licensed nurses 1.0 -1.3, nurse aids 1.5 - 1.66 and nursing personnel with administrative duties .20 - .26. Review of the daily schedule revealed on 09/21/24 Licensed nurses were 1.05 and nurse aids were 1.4; On 09/22/24 Licensed Nurses were 1.05 and nurse aids were 1.29. Interview on 11/19/24 between 9:02 A.M. and 11:18 A.M. with Certified Nursing Assistant (CNA) #207 and #368 revealed at times when there are call offs, residents are not checked and changed every two hours and some residents don't receive their scheduled showers. Interview on 11/19/24 between 12:55 P.M. and 3:25 P.M. with Resident #118 and Resident Council President Resident #111 revealed at times it takes up to an hour for staff to answer call lights, showers/bathing are not consistently being done, residents are not being changed timely, especially on the weekends. The interview on 11/19/4 at 3:31 P.M. with Administrator revealed the corporate staff review the actual staff punches used to submit the PBJ. This deficiency represents non-compliance investigated under Complaint Number OH00158759.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review ,interview, and policy review, the facility failed to administer the correct medication to the resident. This affected one resident (Resident #136) of one resident reviewed for medication errors. The facility census was 132. Findings include: Record review for Resident #136 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included endocarditis, heart failure, hypertension, vascular dementia, and weakness. Record review of the Medicare five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #136 was cognitively intact. Review of the medical record for September 2024 for Resident #136 revealed there was no documentation of a medication error that occurred or the physician being notified of a medication error. Review of the form titled, Investigative Data Sheet Medication/Treatment Error and Omission Form dated 09/24/24, untimed revealed Resident #136 received an incorrect blood pressure medication. The administration error was the wrong drug. The physician was notified, the responsible party was notified and the order received was to monitor blood pressure. The name of the medication nor the amount of time to monitor the blood pressure was documented on the form. Record review of the Medication Administration Record (MAR) for Resident #136 revealed on 09/24/24 at 9:00 A.M. Resident #136 received medications that included metoprolol succinate ER 12.5 milligrams (mg) for hypertension, spironolactone 25 mg for hypertension, torsemide 20 mg for hypertension, and Entresto 24-26 mg for hypertension (given at 9:00 A.M. and 5:00 P.M.). Interview on 11/19/24 at 3:55 P.M. with Director of Nursing (DON) revealed on 09/24/24 (unsure of the time) Registered Nurse (RN) #201 administered a blood pressure pill and a multivitamin to Resident #136 that was another residents medication. DON confirmed there was no documentation in Resident #136's medical record regarding the medication error, physician notification or if there were any new orders regarding the error. DON revealed RN #201 must have forgotten to document the information. DON confirmed the medication error, resident assessment, MD notification and any new orders should be documented in the resident medical records. DON revealed she discussed the medication error with RN #201 but neither her nor RN #201 wrote down the names of the medication administered in error to Resident #136. DON revealed she did not remember the names of the medications, but remembered it was a blood pressure medication and a multivitamin. Review of a notebook paper provided by DON with handwritten times and dated 09/24/24 - 09/25/24 with Resident #136's name next to the date revealed blood pressures were documented starting on 09/24/24 at 3:45 P.M. and monitored approximately every hour through 09/25/24 at 2:30 P.M.; No abnormal blood pressures were observed in the documentation. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 11/20/24 at 6:17 P.M. with Resident #136's daughter revealed she was visiting Resident #136 on 09/24/24 in the evening when the medication error was made. Resident #136's daughter revealed, The nurse gave my mom the pills, they did not look right so I went to get the nurse, I turned around and my mom already took them, there was four of them, at first the nurse denied giving her the wrong pills then she admitted after looking at the records they were supposed to be for another resident, not her, she said don't worry about it, she will be fine. Resident #136's daughter revealed she wrote the name of the pills down that was given to Resident #136 in error. Resident #136's daughter revealed the pills were sodium bicarbonate (used to relieve heartburn), colace (used for constipation), norvasc five mg (used for high blood pressure) and simethicone (used to treat the symptoms of gas). Review of the facility policy titled, Preparation and General Guidelines, Medication Administration dated November 2021 revealed preparation of medication included Five Rights. Right resident, right drug, right dose, right route and right time are applied for each medication being administered. A triple check of these five rights are recommended. Residents are identified before medication is administered using two methods of identification. Medications supplied to one resident are never administered to another resident. This deficiency represents non-compliance investigated under Complaint Number OH00158759.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review and interview, the facility failed to document a medication error, the name of the medication, and follow up in one resident, Resident #136's medical record. This affected one resident (Resident #136) of one resident reviewed for medication errors. The facility census was 132. Findings include: Record review for Resident #136 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included endocarditis, heart failure, hypertension, vascular dementia, and weakness. Record review of the Medicare five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #136 was cognitively intact. Review of the medical record for September 2024 for Resident #136 revealed there was no documentation of a medication error that occurred or the physician being notified of a medication error. Review of the form titled, Investigative Data Sheet Medication/Treatment Error and Omission Form dated 09/24/24, untimed revealed Resident #136 received an incorrect blood pressure medication. The administration error was the wrong drug. The physician was notified, the responsible party was notified and the order received was to monitor blood pressure. The name of the medication nor the amount of time to monitor the blood pressure was documented on the form. Record review of the Medication Administration Record (MAR) for Resident #136 revealed on 09/24/24 at 9:00 A.M. Resident #136 received medications that included metoprolol succinate ER 12.5 milligrams (mg) for hypertension, spironolactone 25 mg for hypertension, torsemide 20 mg for hypertension, and Entresto 24-26 mg for hypertension (given at 9:00 A.M. and 5:00 P.M.). Interview on 11/19/24 at 3:55 P.M. with Director of Nursing (DON) revealed on 09/24/24 (unsure of the time) Registered Nurse (RN) #201 administered a blood pressure pill and a multivitamin to Resident #136 that was another residents medication. DON confirmed there was no documentation in Resident #136's medical record regarding the medication error, physician notification or if there were any new orders regarding the error. DON revealed RN #201 must have forgotten to document the information. DON confirmed the medication error, resident assessment, MD notification and any new orders should be documented in the resident medical records. DON revealed she discussed the medication error with RN #201 but neither her nor RN #201 wrote down the names of the medication administered in error to Resident #136. DON revealed she did not remember the names of the medications, but remembered it was a blood pressure medication and a multivitamin. Review of a notebook paper provided by DON with handwritten times and dated 09/24/24 - 09/25/24 with Resident #136's name next to the date revealed blood pressures were documented starting on 09/24/24 at 3:45 P.M. and monitored approximately every hour through 09/25/24 at 2:30 P.M.; No abnormal blood pressures were observed in the documentation. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 11/20/24 at 6:17 P.M. with Resident #136's daughter revealed she was visiting Resident #136 on 09/24/24 in the evening when the medication error was made. Resident #136's daughter revealed, The nurse gave my mom the pills, they did not look right so I went to get the nurse, I turned around and my mom already took them, there was four of them, at first the nurse denied giving her the wrong pills then she admitted after looking at the records they were supposed to be for another resident, not her, she said don't worry about it, she will be fine. Resident #136's daughter revealed she wrote the name of the pills down that was given to Resident #136 in error. Resident #136's daughter revealed the pills were sodium bicarbonate (used to relieve heartburn), colace (used for constipation), norvasc five mg (used for high blood pressure) and simethicone (used to treat the symptoms of gas). Review of the facility policy titled, Preparation and General Guidelines, Medication Administration dated November 2021 revealed preparation of medication included Five Rights. Right resident, right drug, right dose, right route and right time are applied for each medication being administered. A triple check of these five rights are recommended. Residents are identified before medication is administered using two methods of identification. Medications supplied to one resident are never administered to another resident. This deficiency represents non-compliance investigated under Complaint Number OH00158759.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42011 Based on observation, interview, and review of the facility policy, the facility failed to assure rooms were appropriately cleaned and sanitized prior to admitting a new resident to the room. This had the potential to affect all new admissions. The facility census was 132. Findings include: Interview on 11/19/24 at 12:59 P.M. with Housekeeping Supervisor #221 revealed when a resident is discharged , the room the resident resided in is deep cleaned within 24 hours of the discharge. The deep cleaning included all trash would be pulled, all the contents in the room that belonged to the former resident would be removed and packed, all the drawers and closets would be emptied and cleaned and all surfaces would be cleaned. Observation and interview on 11/19/24 at 1:03 P.M. with Housekeeping Supervisor #221 of room [ROOM NUMBER] bed two revealed the portion of the room was unoccupied. Housekeeping Supervisor #221 confirmed the room had been deep cleaned and ready for a new admission. Observation with Housekeeping Supervisor #221 confirmed the nightstand in the cleaned room had a white brief in the top drawer, oxygen tubing, a used urinal with dried urine in the bottom and on the sides, and a collection canister with dried urine in the bottom. Housekeeping Supervisor #221 revealed those should have been removed when the room was deep cleaned. Observation and interview on 11/19/24 at 1:03 P.M. with Housekeeping Supervisor #221 of room [ROOM NUMBER] bed two revealed the portion of the room was unoccupied. Housekeeping Supervisor #221 confirmed the room had been deep cleaned and ready for a new admission. Observation revealed in the top drawer of the nightstand was several potato chips and crumbs. There were large visible dust piles behind the stand. The bedside stand had dry drips of a fluid on the front of the stand and thick dust on the entire lower rim of the stand. Housekeeping Supervisor #221 revealed the stand should have been moved out to clean the dust behind it, the drawers should have been cleaned out and the stand should have been washed down. Housekeeping Supervisor #221 revealed she had concerns brought to her in the past regarding the room not being deep cleaned before a new resident was admitted to the room. Housekeeping Supervisor #221 revealed that's when she started rotating housekeepers, but it only worked for a while. Interview on 11/20/24 with Resident #136's daughter revealed she was with Resident #136 when she was admitted to the facility. Resident #136's daughter revealed when she was admitted to the room, the room was still dirty, the floors were dirty, and it looked like the room hadn't been cleaned. There was another resident's personal items in the drawers and closet. Record review of the facility Admissions revealed for the months of October and November 2024 there were a total of 45 admissions to the facility. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Routine Cleaning dated 11/30/23 revealed surfaces in residents rooms/areas will be cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard to reduce the risk of infections and transmission of diseases. This deficiency represents non-compliance investigated under Complaint Number OH00158759.