STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365591	A. Building B. Wing	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Lawn Nursing Home	15028 Old Lincolnway East Dalton, OH 44618

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to ensure comprehensive assessments were complete and accurate. This finding affected three residents (Resident's #6, #12 and #15) of 21 residents reviewed for comprehensive assessments. The facility census was 65. Findings include: 1. Review of Resident #6's medical record revealed he was admitted on [DATE] with diagnoses including anxiety disorder, essential hypertension, and major depressive disorder. Review of Resident #6's Minimum Data Set (MDS) 3.0 comprehensive assessment dated [DATE] revealed, during the seven-day look back period from 07/02/22 to 07/08/22, he did not receive hypnotics or diuretics. Review of Resident #6's physician orders revealed an order dated 05/12/22 for Restoril (hypnotic) 7.5 mg (milligrams) give one tablet by mouth at bedtime for insomnia and an order dated 05/04/22 for Lasix (diuretic) give 60 mg by mouth two times a day related to essential hypertension. Review of Resident #6's medication administration records (MAR) from 07/02/22 to 07/08/22 revealed he received seven days of a diuretic medication and seven days of a hypnotic medication. Interview on 08/02/22 at 7:51 A.M. with Licensed Practical Nurse (LPN) MDS #107 confirmed Resident #6's MDS 3.0 comprehensive assessment did not accurately reflect the hypnotic or diuretic medications administered during the seven-day look back period from 07/02/22 to 07/08/22. 2 Review of Resident #12's medical record revealed he was admitted to the facility on [DATE] with diagnoses including diabetes, anxiety disorder, and major depressive disorder. Review of Resident #12's MDS 3.0 assessment dated [DATE] revealed, during the seven-day look back period from 07/09/22 to 07/15/22, he did not receive antibiotic medications. Review of Resident #12's physician orders revealed an order dated 07/07/22 for Doxycycline (antibiotic) 100 mg give one tablet by mouth two times a day for seven days and an order dated 07/13/22 for Bactrim DS (antibiotic) 800-160 mg give one tablet by mouth two times a day for seven days. Review of Resident #12's MAR from 07/09/22 to 07/15/22 revealed he received three days of Bactrim DS and four days of Doxycycline for a total of seven days of antibiotic medications. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/02/22 at 7:55 A.M. with LPN MDS #107 confirmed Resident #12's MDS 3.0 comprehensive assessment did not accurately reflect the antibiotic medications administered during the seven-day look back period from 07/09/22 to 07/15/22. 3. Review of Resident #15's medical record revealed she was admitted on [DATE] with diagnoses including anxiety disorder, schizophrenia, and insomnia. Review of Resident #15's MDS 3.0 assessment dated [DATE] revealed, during the seven-day look back period from 04/16/22 to 04/22/22, she received seven doses of a hypnotic, and she did not receive antibiotic medications. Review of Resident #15's physician orders revealed an order dated 04/13/22 for Amoxicillin capsule (antibiotic) 500 mg by mouth three times a day for seven days. Review of Resident #15's MAR from 04/16/22 to 04/22/22 revealed no evidence a hypnotic medication was administered, and an antibiotic medication was administered four of the seven days. Interview on 08/01/22 at 4:21 P.M. with LPN MDS #107 confirmed Resident #15's MDS 3.0 comprehensive assessment did not accurately reflect the antibiotic or hypnotic medications administered during the seven-day look back period from 04/16/22 to 04/22/22.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review, interview, review of the manufacturer's directions, and facility policy review the facility failed to ensure a medication error rate of 5% (percent) or less. This finding affected two residents (Resident's #49 and #39) of six residents observed for medication administration. A total of 27 medications were administered with three errors for a medication error rate of 11.1%. The facility census was 65. Findings include: 1. Review of Resident #49's medical record revealed he was admitted to the facility on [DATE] with diagnoses including diabetes and hypoglycemia. Review of Resident #49's physician orders revealed an order dated 11/18/21 for Lantus (long-acting insulin) KwikPen inject 34 units subcutaneously (SQ) one time a day for diabetes and an order dated 07/05/22 for Humalog (short-acting insulin) KwikPen inject 15 units SQ with meals related to diabetes. Observation on 08/01/22 at 8:16 A.M. with Licensed Practical Nurse (LPN) # 92 of Resident #49's medication administration revealed she administered seven medications with two errors. She administered the Lantus long-acting insulin and the Humalog short acting insulin via KwikPens and she did not prime the pens with a two unit air shot per the manufacturer's directions prior to dialing up the required dose of insulin and administering the insulin medications to Resident #49. Interview on 08/01/22 at 8:26 A.M. with LPN #92 indicated she was unaware she was required to prime Resident #49's Lantus and Humalog KwikPens prior to dialing up the correct dosage and administering the insulin medications to the resident. Review of the Lantus Manufacturer directions, revised 12/20, indicated to check the label on the insulin, check the appearance of the insulin, wipe the rubber seal with alcohol, remove the protective seal from the new needle, line up the needle with the pen and always perform the safety test before each injection. Performing the safety test ensures that an accurate dose was received and the pen and needle work properly while removing air bubbles. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. Hold the pen with the needle pointing upwards, dial the pen to two units and press the injection button all the way in. Check if insulin comes out of the needle tip. Select the dose and administer the insulin. Review of the Humalog Manufacturer directions, dated 11/19, indicated to pull the pen cap straight off, wipe the rubber seal with an alcohol swab, check the liquid in the pen for color, select a new needle, pull off the paper tab from the outer needle shield, push the capped needle straight onto the pen and twist the needle on until it is tight pull off the outer needle shield, prime before each injection by selecting two units, hold your pen with the needle point up, tap the cartridge holder gently to collect air bubbles at the top, push the dose knob in until it stops and the 0 can be seen. You should see insulin at the tip of the needle. Select the dosage of the insulin to be administered and administer it to the resident. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #39's medical record revealed he was admitted on [DATE] with diagnoses including traumatic brain injury and gastrostomy status. Review of Resident #39's physician orders revealed an order dated 07/06/22 for acetaminophen liquid (Tylenol) give 650 mg via a percutaneous endoscopic gastrostomy tube or PEG tube (a soft, plastic feeding tube that goes into your stomach) every six hours for pain. Observation on 08/02/22 at 5:23 A.M. with Registered Nurse (RN) #90 revealed she administered three medications with one error. She administered 15 ml (milliliters) of Tylenol liquid via Resident #39's PEG tube. The label on the Tylenol bottle indicated the dosage was 160 mg/5 ml and she administered 480 mg of acetaminophen to Resident #39. Interview on 08/02/22 at 5:51 A.M. with RN #90 confirmed she administered 480 mg of Tylenol to Resident #39 via his PEG tube and the order was for 650 mg of Tylenol. Review of the undated Medication Administration and Documentation policy indicated medications were administered to the resident for whom they were prescribed. A total of 27 medications were administered with three errors for a medication error rate of 11.1%.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 38091 Based on record review and staff interview the facility failed to ensure its medical director or designee attended all required quality assurance (QA) meetings (at least quarterly) as required. This had the potential to affect all 65 residents residing in the facility. Findings include: Review of the facility sign-in sheets for its QA meetings for the second quarter of the year 2022 revealed meetings were held on the following dates: 04/27/22 05/03/22 06/01/22 06/14/22 06/28/22 07/12/22 07/26/22 There was no documented evidence the medical director or designee was in attendance in any of the above meetings. The Administrator verified that the facilities medical director was not in attendance for any of the QA meetings during the second quarter of 2022 during an interview on 08/03/22 at 3:15 P.M.

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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. 34297 Based on observation and interview, the facility failed to ensure the smoking areas were maintained in a clean and sanitary manner. This finding affected three residents (Resident's #6, #10 and #64) and had the potential to affect an additional five residents (Resident's #15, #22, #47, #58 and #65) the facility identified as smokers who were identified as smokers by the facility. The facility census was 65. Findings include: Observation on 08/02/22 at 9:09 A.M. of the Beechwood smoking patio revealed Resident's #10 and #64 were in the smoking area and both were assessed to smoke independently. Approximately eleven cigarette butts were observed on the ground and grass areas, and no staff were present in the smoking area at the time of the observation. Observation on 08/02/22 at 9:18 A.M. of the Beechwood smoking patio with Maintenance Director #66 confirmed the area had multiple cigarette butts on the concrete walkway and grass areas. Observation on 08/02/22 at 9:24 A.M. with Maintenance Director #66 of the Dogwood patio revealed assorted cigarette butts were on the ground and grass areas. Resident #6 was on the patio smoking, and he was assessed to smoke independently. Resident #6 was observed flicking the ashes of his cigarette on the ground and no nursing staff were present at the time of the observation. A fireproof cigarette receptacle was near the doors with a garbage can located next to the fireproof receptacle. The front side of the garbage can opening and lid were observed to have multiple burns and ashes. The inside of the garbage can had an undetermined amount of cigarette butts along with paper trash and other debris. Interview on 08/02/22 at 9:28 A.M. with Maintenance Director #66 confirmed the Beechwood and Dogwood smoking patios had multiple cigarette butts on the ground and the garbage can on the Dogwood smoking area had ashes and cigarette burns on the lid. He lifted the lid and confirmed multiple cigarette butts as well as paper and other trash in the garbage can.