STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365847	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bath Manor Special Care Centre	2330 Smith Road Akron, OH 44333

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 0580 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review, interview, review of the Emergency Medical Services (EMS) Prehospital Care Report and review of the facility policy, the facility failed to timely notify the Guardian of Resident #18 when a significant change in condition occurred. This affected one resident (#18) of three residents reviewed for notification of changes. The facility census was 109. Findings include: Record review for Resident #18 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease with early onset, schizophrenia, mood disorder, impulse disorder, restlessness and agitation, and need for assistance with personal care. Record review revealed Resident #18 had a Legal Guardian. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18 was severely cognitively impaired, dependent upon staff for transfers, used a wheelchair, and was dependent for mobility. Review of the progress note for Resident #18 dated 12/27/24 at 2:29 A.M. completed by Licensed Practical Nurse (LPN) #499 included during the P.M. medication pass, Resident #18 became unresponsive. The TeleMedicine (TeleMed) (use of technology to remotely deliver medical services) Certified Nurse Practitioner (CNP) wanted Resident #18 sent out to the hospital. The paramedics arrived, and Resident #18 needed Narcan (medication to treat narcotic overdose). Resident #18 became responsive. TeleMed was notified and ordered neuro checks per facility protocol. Resident #18 became unresponsive again and was aroused in five minutes. Contacted TeleMed again, and they ordered every 15 min checks and to hold any narcotics until seen by the doctor. Will notify the Director of Nursing (DON) and family in the A.M. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated written statement created by LPN #499 included she (LPN #499) started the shift on 12/26/24 at 7:00 P.M. During the medication pass for residents she went to Resident #18's room to give him his medications. Resident #18 seemed like he was asleep. LPN #499 began to say Resident 18's name multiple times and put the head of the bed up. Resident #18 opened his eyes and closed them again. LPN #499 started to say his name again and rubbed his chest, doing a sternal rub. LPN #499 sat Resident #18 up more and told him she had his medications. Resident #18 said, Huh and opened his mouth and took his medication. LPN #499 revealed Resident #18 still did not seem right, and she contacted TeleMed and was instructed to send Resident #18 to the emergency room . EMS arrived and assessed Resident #18's pupils and said, They are pinpointed; he needs Narcan. Resident #18 came to in five to ten seconds after receiving the Narcan and started to be himself again. LPN #499 revealed she never told EMS not to take Resident #18 to the hospital. They said since he was back to himself, there was no reason to take him to the hospital. LPN #499 revealed EMS instructed to keep an eye out or if it happened again to administer Narcan because of the half-life of Narcan. Documentation included EMS left, Resident #18 was checked every 30 minutes. Around 12:00 A.M. the Certified Nurse Aide (CNA) reported Resident #18 was not himself again. Both staff were saying his name, and he ended up waking up. TeleMed was contacted, gave an order for the Narcan but because the resident was awake was told not to give it and monitor resident every 15 minutes. LPN #499 revealed she did not notify the family that late at night, she informed them in the morning. Review of the Fire Department #606's Prehospital Care Report with the call dated 12/26/24 at 8:48 P.M. completed by Emergency Medical Technician (EMT) #605 revealed the unit was on scene on 12/26/24 at 9:02 P.M. related to an emergent response. The resident's name was (Resident #18). Primary Impression: Poisoning by drug/meds/biol substance, accidental. Narrative included, the unit was dispatched for an unknown problem. Upon arrival, Resident #18 was lying in bed with a pulse and breathing. Staff stated they were unable to wake him. They gave him pain medication around 8:00 P.M. and when they went to check on him, he was unresponsive. Resident #18 had pinpoint pupils. Staff grabbed Narcan and wanted to administer. Staff administered two milligrams (mg) Narcan. Resident #18 woke up one minute later. Staff stated he was now acting normal, they did not want him to go to the hospital, and they would monitor him. Staff refused transport. Resident #18 was nonverbal. Review of the Refusal form included: Resident #18 refusal of service; Resident #18 advised of medical treatment and evaluation needed and further harm may result without medical treatment. Depart 12/26/24 at 9:24 P.M. The phone interview on 01/22/24 at 4:42 P.M. with the Guardian of Resident #18 revealed she was upset that the facility did not notify her on 12/26/24 when Resident #18 was found to be unresponsive, was administered Narcan and the decision was made by someone not to send him to the hospital. The Guardian revealed the signature on the refusal form was Resident#18's signature. The Guardian revealed the paramedics did not know Resident #18 had a guardian. The facility did though, and they should have called her. The Guardian revealed the nurse called her on 12/27/24 at 6:00 A.M. and revealed she was upset because she would have sent Resident #18 to the hospital after receiving the Narcan to see what was in his system. An interview on 01/23/25 at 2:52 P.M. with the Director of Nursing (DON) revealed the Guardian for Resident #18 should have been notified of the change in condition as soon as possible. Review of the policy titled, Resident Change in Condition Policy revised 11/10/20 revealed the provider/family/responsible party will be notified as soon as practicably possible. This deficiency represents non-compliance investigated under Complaint Number OH00161054.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review and review of the facility policy, the facility failed to provide A. M. care to include washing face and hands and oral care for Residents #76 and #106. This affected two residents (#76 and #106) of three residents reviewed for activities of daily living (ADL). The facility census was 109. Findings include: 1. Record review for Resident #76 revealed an admitted [DATE]. Diagnoses included spastic hemiplegic cerebral palsy, multiple sclerosis, cervical disc disorder, blindness in the left eye, muscle weakness and need for assistance with personal care. Review of the care plan dated 10/28/24 revealed Resident #76 had an ADL self-care and mobility deficit related to multiple sclerosis, weakness, debility, cerebral palsy, and impaired mobility. Interventions included assistance with hygiene/bathing hygiene, dressing, grooming, toileting, feeding, and oral care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #76 was cognitively intact. Resident #76 required substantial/maximal assistance from staff with oral hygiene, bathing, and personal hygiene. Resident #76 used a wheelchair and was dependent upon staff for chair/bed transfers. Observation on 01/22/25 at 10:04 A.M. of Certified Nursing Assistant (CNA) #457 providing A.M. care for Resident #76 revealed CNA #457 did not wash or offer to wash Resident #76's face or hands and did not provide or offer to provide Resident #76 with oral care. CNA #457 confirmed she completed all A.M. care for Resident #76 and exited the room. Observation revealed Resident #76 had visible residual food particles left in his mouth, and his face was oily. Resident #76 revealed the staff never provided him with oral care. Resident #76 revealed he would like his mouth cleansed and rinsed and it would be nice to get his face washed in the morning. CNA #457 returned to Resident #76's room per the surveyor's request and confirmed mouth care was not completed, food residual was left in Resident #76's mouth, and Resident #76 did not have his face or hands washed at all this A.M. 2. Record review for Resident #106 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), muscle weakness, muscle wasting and atrophy, malignant neoplasm of cervix uteri, and the need for assistance with personal care. Review of the care plan dated 05/13/24 revealed Resident #106 had a self-care deficit related to weakness, impaired mobility, COPD, depression, and cancer. Interventions included bathing/hygiene with assistance from one to two staff. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #106 was moderately cognitively impaired. Resident #106 required partial/moderate assistance with oral hygiene and was dependent upon staff for personal hygiene. (continued on next page)

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	365847	A. Building B. Wing	01/27/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/22/25 at 10:39 A.M. revealed Resident #106 was sitting up in bed. Resident #106's hair had a big knot and was disheveled in the back. Resident #106 revealed she was not assisted with or provided oral care this A.M. and did not have her hair combed. Resident #106 revealed it would be nice to have those things done every morning. Interview on 01/22/25 at 10:43 A.M. with CNA #457 confirmed she had already completed A.M. care with Resident #106. CNA #457 verified she did not brush or offer to brush Resident #106's hair and did not provide or offer to provide oral care for Resident #106 before, during, or after A.M. care. Interview on 01/22/25 at 11:27 A.M. with the Director of Nursing (DON) revealed during A.M. care, CNAs were expected to do head-to-to-tee care, which included washing residents' face, cleaning the resident's body and providing oral care. Review of the facility policy titled, Morning Care/AM Care revised 06/15/20 revealed morning care will be offered each day to promote resident comfort, cleanliness, grooming and general wellbeing. The procedure included assisting with/provide oral hygiene, provide nail care, and brush/comb hair. This deficiency represents non-compliance investigated under Complaint Number OH00161110.

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	365847	A. Building B. Wing	01/27/2025

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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 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 observation, interview, record review and review of the Emergency Medical Service (EMS) Prehospital Care Report, the facility failed to provide appropriate care and services to Resident #18, who had a significant change in condition with an altered mental status, difficult to arouse, and periods of unconsciousness. Resident #18 was administered by mouth routine medications to include psychotropic medications while being difficult to arouse and prior to notifying the physician of the change in condition. Once contacted, the physician requested Resident #18 to be transported to the emergency room . Resident #18 was not transported to the hospital emergency room per direction of the physician, Resident #18 was administered Narcan for a potential drug overdose then resided at the facility. There were no labs obtained to determine the cause for the potential drug overdose nor was the pharmacy utilized to review medications related to the potential drug overdose. This affected one resident (#18) of one resident reviewed for a potential drug overdose. The facility census was 109. Findings include: Record review for Resident #18 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease with early onset, schizophrenia, mood disorder, impulse disorder, restlessness and agitation, and need for assistance with personal care. Record review revealed Resident #18 had a Legal Guardian. Resident #18 had no known allergies. Review of the care plan dated 07/15/24 revealed Resident #18 had behavioral symptoms not directed to others verbal/vocal symptoms like screaming, disruptive sounds, and refused to be shaved. Interventions included when the resident yells out, ask the resident if he needs anything. Provide encouragement and calmness. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18 was severely cognitively impaired, had no hallucinations or delusions, no verbal or physical behaviors exhibited no rejection of care and no wandering in the seven-day assessment reference period. Resident #18 required set up or clean up assist with eating, dependent upon staff for toileting hygiene, bathing, dressing, and personal hygiene. Resident #18 required substantial/maximal assistance for bed mobility, dependent for transfers, used a wheelchair and was dependent upon staff for mobility. Review of the physician orders for Resident #18 revealed changes in medications for December 2024 included on 12/09/24 Risperidone (antipsychotic) was increased from 0.5 milligrams (mg) two times a day to one mg two times a day (7:00 A.M. to 11:00 A.M. and 7:00 P.M. to 11:00 P.M.) and on 12/19/24 Ativan 0.5 mg (antianxiety) was increased from 0.5 mg every day to 0.5 mg three times a day (6:00 A.M., 2:00 P.M. and 9:00 P.M.). Additional orders included Divalproex capsule delayed release (DR) sprinkles 125 mg (anticonvulsant) give two capsules in the A.M. ordered 04/18/24 and Divalproex capsule DR sprinkles 125 mg give four capsules night shift ordered 07/12/24. Review of the progress note dated 12/09/24 at 12:26 P.M. completed by LPN #428 revealed new order to increase risperidone to one mg two times a day. The progress note did not express the reason for the increase in Risperidone. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 12/19/24 at 3:07 P.M. completed by Licensed Practical Nurse (LPN) #465, Resident #18 continues to yell when needing things. Yells when wanting food/fluids. Yells when wanting trash thrown out after eating snack; gets staff attention by yelling then will verbalize a need or request. Certified Nurse Practitioner (CNP) gives new order to increase Ativan to three times a day (TID). Review of the progress notes from 11/01/24 through 12/25/24 revealed Resident #18 had no episodes of being difficult to arouse or unconscious. Review of the Medication Administration Record (MAR) for Resident #18 for December 2024 revealed on 12/26/24, Resident #18 received all the scheduled doses of medication. No additional medications were administered. On 12/26/24, the evening administration of medications, LPN #499 administered Carvedilol 3. 125 mg (used to treat high blood pressure), Divalproex DR sprinkles 125 mg four capsules, Gabapentin 100 mg (used to treat epilepsy), Ativan 0.5 mg, Tamsulosin 0.4 mg (used to treat enlarged prostate), Risperidone 1 mg and Spironolactone 25 mg (used to treat high blood pressure). Review of the progress note dated 12/27/24 at 2:29 A.M. completed by LPN #499 included during P.M. medication pass Resident #18 became unresponsive. TeleMedicine (TeleMed) (use of technology to remotely deliver medical services) CNP wanted Resident #18 sent out to the hospital, paramedics arrived, and Resident #18 needed Narcan (medication to treat narcotic overdose). Resident #18 became responsive, and TeleMed was notified and ordered neuro checks per facility protocol. LPN #499 and Certified Nursing Assistant (CNA) checked on Resident #18 every 30 minutes to an hour. At 12:30 A.M. Resident #18 became unresponsive again and was aroused in five minutes. LPN #499 contacted TeleMed again, and they ordered every 15-minute checks and vital signs (VS) for an hour and hold any narcotics until the resident was seen by the doctor. LPN #499 notify the Director of Nursing (DON) and family (guardian) in the morning. Review of the progress note for Resident #18 dated 12/27/24 at 6:14 A.M. completed by LPN #499 revealed resident #18's Guardian and the DON were notified. Record review for Resident #18 revealed after the 12/26/24-12/27/24 episode, Resident #18 had no further episodes of change in mental status from the baseline. Review of the untimed Witness Statement dated 12/31/24 completed by LPN #427 included on 12/26/24 she gave Resident #18 his afternoon medication. Resident #18 was in his wheelchair, and he was alert, pleasant, and at his baseline. Review of the untimed Witness Statement dated 12/26/24 completed by LPN #304 revealed on 12/26/24 she worked the 3:00 P.M. to 7:00 P.M. shift. Resident #18 was actively yelling and talking the entire time. The CNA put Resident #18 to bed around 6:00 P.M., and Resident #18 was actively responding. (continued on next page)

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	365847	A. Building B. Wing	01/27/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the typed statement dated 12/31/24 at 2:32 P.M. completed by LPN #336 revealed on 12/26/24 at the end of medication pass, the nurse (LPN #499) came and got her and stated Resident #18 was not waking up but breathing. Upon assessment, Resident #18 was lethargic and hard to wake up. LPN #499 was saying his name and rubbing his chest. He would respond a little then go right back to sleep. LPN #336 instructed LPN #499 to call the doctor and let them decide what to do next. LPN #499 called the doctor, and they said to send the resident to the emergency room for evaluation. EMS arrived, and the nurse (LPN #499) came out and said she needed Narcan for EMS to give to the resident. LPN #336 revealed she obtained the Narcan through the stock medication supplies, gave it to the nurse (LPN #499) who then handed it to EMS in the hallway. LPN #336 revealed she did not go back into the resident while the Narcan was being administered. The nurse (LPN #499) came out of the resident's room and said he was back to normal. EMS told the nurse (LPN #499) that if he went unresponsive again to give him another dose if the Narcan. Review of the undated written statement created by LPN #499 included LPN #499 started the shift on 12/26/24 at 7:00 P.M. During the medication pass for residents she went to Resident #18's room to give him his medications. Resident #18 seemed like he was asleep. LPN #499 began to say Resident 18's name multiple times and put the head of the bed up. Resident #18 opened his eyes and closed them again. LPN #499 started to say his name again and rubbed his chest doing a sternal rub. LPN #499 sat Resident #18 up more and told him she had his medications. Resident #18 said, Huh and opened his mouth and took his medication. LPN #499 revealed she did watch Resident #18 swallow his medication and revealed, But (Resident #18) still did not seem right to me so I asked another nurse (LPN #336) who knew (Resident #18) longer than me to come and look at him. She agreed with me that (Resident #18) did not seem like himself. LPN #499 revealed after taking Resident #18's vital signs, she contacted TeleMed and was instructed to send Resident #18 to the emergency room . EMS arrived and assessed Resident #18's pupils and said, They are pinpointed; he needs Narcan. EMS reviewed the medications Resident #18 was given. Another facility nurse (LPN #336) obtained the Narcan from the stock medications, and EMS administered the Narcan to Resident #18. Resident #18 came to in five to ten seconds after receiving the Narcan and started to be himself again. LPN #499 revealed she never told EMS not to take Resident #18 to the hospital. They said since he was back to himself, there was no reason to take him to the hospital. LPN #499 revealed EMS instructed staff to keep an eye out or that if it happened again, to administer Narcan because of the half-life of Narcan. EMS left; Resident #18 was checked every 30 minutes. Around 12:00 A.M., the CNA reported Resident #18 was not himself again. Both staff were saying his name, and he ended up waking up. TeleMed was contacted, gave an order for the Narcan but because the resident was awake was told not to give it and monitor resident every 15 minutes. LPN #499 revealed she charted Resident 18's medical record at around 2:00 A.M., did not notify the family (Guardian) that late at night, so she informed them in the morning. (continued on next page)

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	365847	A. Building B. Wing	01/27/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Fire Department #606's Prehospital Care Report with the call dated 12/26/24 at 8:48 P.M. completed by Emergency Medical Technician (EMT) #605 revealed the unit was on scene on 12/26/24 at 9:02 P.M. related to an emergent response. The resident's name was (Resident #18). Primary Impression: Poisoning by drug/meds/biol substance, accidental. Narrative included the unit was dispatched for an unknown problem. Upon arrival, Resident #18 was lying in bed with a pulse and breathing. Staff stated they were unable to wake him. They gave him pain medication around 8:00 P.M. and when they went to check on him, he was unresponsive. Resident #18 had pinpoint pupils. Staff grabbed Narcan and wanted to administer. Staff administered two milligrams (mg) Narcan. Resident #18 woke up one minute later. Staff stated he was now acting normal, they did not want him to go to the hospital, and they would monitor him. Staff refused transport. Resident #18 was nonverbal. Review of the Refusal form included: Resident #18 refusal of service; Resident #18 advised of medical treatment and evaluation needed and further harm may result without medical treatment. Depart 12/26/24 at 9:24 P.M. Phone call placed to the Fire Department #606 on 01/22/25 at 10:55 A.M. and a request was made to have the Fire Chief or EMT #605 return the call. Interview on 01/22/25 at 1:00 P.M. with CNP #600 revealed she visited Resident #18 on 12/27/24 in the morning due to his unresponsiveness the evening prior. CNP #600 revealed on 12/27/24 when she visited him, he was the same as prior to the episode on 12/26/24. There was no change; he was completely at baseline. CNP #600 revealed she would not have given Resident #18 the medication on the evening of 12/26/24 if he was not responding. CNP #600 revealed she was unsure why Resident #18 was not sent to the emergency room (ER). CNP #600 revealed she worked with an insurance group that visited the residents at the facility routinely. When she saw Resident #18 on 12/27/24, she thought the other CNP had already ordered his drug screen. She then found out later that the other CNP did not order the labs because she thought CNP #600 ordered them. Ultimately the drug screen was not ordered timely to determine if Resident #18 had an overdose of medications/drugs on 12/26/24. Phone call made on 01/22/25 at 2:31 P.M. to the Fire Department #606. Spoke with EMS Administrator Assistant #607 who revealed she spoke with Fire Chief who will return the surveyor call today or tomorrow. Interview and observation on 01/23/25 at 7:45 A.M. with LPN #343 revealed she was Resident #18's nurse for approximately two years. Resident #18 never had an episode where he was unresponsive or even lethargic. Resident #18 had a difficult time communicating, so he normally yelled or screamed when he wanted something until he got it and then he would stop. Medications Risperidone and Ativan were increased due to the yelling behaviors. Observation of medication administration revealed LPN #343 crushed all Resident #18's medications including the Divalproex DR capsules. LPN #343 opened the two Divalproex capsules, 125 mg each, and placed the sprinkles that were inside the capsules into a small clear pouch with the remainder of the 7:00 A.M. medications and crushed all the medications together in one pouch to a fine powder using a pill crusher. LPN #343 then placed the powder in applesauce and administered the medications to Resident #18. Review of the patient information leaflet for Divalproex DR capsules revealed the capsules should be swallowed whole and should not be crushed or chewed, the capsule can be opened and sprinkled on food. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review of Resident #18's medications on 01/23/25 at 10:00 A.M. with the facility Pharmacist Consultant #602 revealed monthly reviews were completed on each resident reviewing all medications. For Resident #18, there were no indications in the physician orders that the medications were being crushed. The Divalproex DR could be opened and added to food, but the sprinkles should not be crushed or chewed. The medication was used for schizophrenia. The idea is to extend the absorption time to the next dose which if they were crushed or chewed, would not happen. Reviewed all other medications with Pharmacist Consultant #602 who revealed there were no other concerns with the ordered medications. Pharmacist Consultant #602 revealed he would not expect that reaction with Divalproex DR even if it was crushed due to he was taking it for so long. Ativan would have an immediate action which was started three times a day on 12/19/24. The Risperidone increase on 12/09/24 may take a few days but would not expect the unresponsive episode one time. The Narcan was like a drug test, it would not be effective if it was not an overdose causing Resident #18 to be unresponsive then suddenly wake up with the administration of Narcan, he had to have something in his system for the Narcan to block that would allow him to wake up. Pharmacist Consultant #602 revealed the facility never requested him to review the medications due to possible overdose. Interview on 01/23/24 at 10:31 A.M. with LPN #370 revealed she worked on 12/25/24 night shift. She stayed over the morning of 12/26/24 until 9:00 A.M. due to a call off. LPN #370 revealed she gave Resident #18 all his morning medications on 12/26/24 as ordered. There was nothing unusual with Resident #18. His behavior was baseline. At 9:00 A.M. she handed the keys off to Unit Manager LPN #427 and left the facility. Phone interview on 01/23/25 at 11:15 A.M. with LPN #499 revealed on 12/26/24 she started her shift at 7:00 P.M. She got a report from the previous nurse and started her medication pass. LPN #499 stated, When I got to him, (Resident #18) he was unresponsive; I gave a sternum rub, sat him up, said (Resident #18's name) I got your meds. He said huh, so I gave them to him. There was no report of a med error, so then I called TeleMed, got an order to send him out. Two EMT's came, the paramedic checked his vital signs and said his eyes were pinpointed; he needed Narcan. The other nurse went to get the Narcan then EMS administered it. (Resident #18) woke up right after and was himself; he started screaming. I told the paramedic that it was normal for him. The paramedic said if he was normal, there was no need to go to the ER. LPN #499 revealed she did not know who signed the form to refuse transport, no one signed anything while she was there. Resident #18 became lethargic again but was responsive. The physician said to monitor him. Phone call made on 01/23/25 at 12:09 P.M. to the Fire Department #606. Spoke with EMS Administrator Assistant #607 who revealed she spoke with Fire Chief who is waiting for a response from the attorneys before he will return the surveyor's call. An interview on 01/23/25 at 2:52 P.M. with the DON revealed she reviewed the incident on 12/26/24 -12/27/24 with Resident #18. She asked LPN #499 why she would give medications to a drowsy or sleepy resident. LPN #499 revealed when she did a sternal rub, he said huh, so she felt it was okay to give him his medications. The DON revealed she reviewed the narcotic forms throughout the whole facility, and there were no discrepancies. The DON confirmed the facility never consulted with the pharmacy to assist in determining the change in condition on 12/26/24 for Resident #18 that required Narcan administration. The DON also confirmed that a drug screen was not done timely to determine the change in condition on 12/26/24 for Resident #18 that required Narcan administration. As of 01/27/25, no call was received from Fire Department #606. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365847	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bath Manor Special Care Centre	2330 Smith Road Akron, OH 44333

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint Number OH00161054.

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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 interview, record review and review of the Emergency Medical Services (EMS) Prehospital Care Report, the facility failed to involve pharmacy services related to a possible overdose involving Resident #18 who was administered Narcan. This affected one resident (#18) of three residents reviewed for a potential overdose. The facility census was 109. Findings include: Record review for Resident #18 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease with early onset, schizophrenia, mood disorder, impulse disorder, restlessness and agitation, and need for assistance with personal care. Record review revealed Resident #18 had a Legal Guardian. Resident #18 had no known allergies. Review of the care plan dated 07/15/24 revealed Resident #18 had behavioral symptoms not directed to others verbal/vocal symptoms like screaming, disruptive sounds, and refused to be shaved. Interventions included when the resident yells out, ask the resident if he needs anything. Provide encouragement and calmness. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18 was severely cognitively impaired, had no hallucinations or delusions, no verbal or physical behaviors exhibited no rejection of care and no wandering in the seven-day assessment reference period. Resident #18 required set up or clean up assist with eating, dependent upon staff for toileting hygiene, bathing, dressing, and personal hygiene. Resident #18 required substantial/maximal assistance for bed mobility, dependent for transfers, used a wheelchair and was dependent upon staff for mobility. Review of the physician orders for Resident #18 revealed changes in medications for December 2024 included on 12/09/24 Risperidone (antipsychotic) was increased from 0.5 milligrams (mg) two times a day to one mg two times a day (7:00 A.M. to 11:00 A.M. and 7:00 P.M. to 11:00 P.M.) and on 12/19/24 Ativan 0.5 mg (antianxiety) was increased from 0.5 mg every day to 0.5 mg three times a day (6:00 A.M., 2:00 P.M. and 9:00 P.M.). Additional orders included Divalproex capsule delayed release (DR) sprinkles 125 mg (anticonvulsant) give two capsules in the A.M. ordered 04/18/24 and Divalproex capsule DR sprinkles 125 mg give four capsules night shift ordered 07/12/24. Review of the progress note dated 12/09/24 at 12:26 P.M. completed by LPN #428 revealed new order to increase risperidone to one mg two times a day. The progress note did not express the reason for the increase in Risperidone. Review of the progress note dated 12/19/24 at 3:07 P.M. completed by Licensed Practical Nurse (LPN) #465, Resident #18 continues to yell when needing things. Yells when wanting food/fluids. Yells when wanting trash thrown out after eating snack; gets staff attention by yelling then will verbalize a need or request. Certified Nurse Practitioner (CNP) gives new order to increase Ativan to three times a day (TID). (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	Review of the progress notes from 11/01/24 through 12/25/24 revealed Resident #18 had no episodes of being difficult to arouse or unconscious. Record review for Resident #18 revealed after 12/26/24 episode, Resident #18 had no further episodes of change in mental status from the baseline. Review of the undated written statement created by LPN #499 included LPN #499 started the shift on 12/26/24 at 7:00 P.M. During the medication pass for residents she went to Resident #18's room to give him his medications. Resident #18 seemed like he was asleep. LPN #499 began to say Resident 18's name multiple times and put the head of the bed up. Resident #18 opened his eyes and closed them again. LPN #499 started to say his name again and rubbed his chest doing a sternal rub. LPN #499 sat Resident #18 up more and told him she had his medications. Resident #18 said, Huh and opened his mouth and took his medication. LPN #499 revealed she did watch Resident #18 swallow his medication and revealed, But (Resident #18) still did not seem right to me so I asked another nurse (LPN #336) who knew (Resident #18) longer than me to come and look at him. She agreed with me that (Resident #18) did not seem like himself. LPN #499 revealed after taking Resident #18's vital signs, she contacted TeleMed and was instructed to send Resident #18 to the emergency room . EMS arrived and assessed Resident #18's pupils and said, They are pinpointed; he needs Narcan. EMS reviewed the medications Resident #18 was given. Another facility nurse (LPN #336) obtained the Narcan from the stock medications, and EMS administered the Narcan to Resident #18. Resident #18 came to in five to ten seconds after receiving the Narcan and started to be himself again. LPN #499 revealed she never told EMS not to take Resident #18 to the hospital. They said since he was back to himself, there was no reason to take him to the hospital. LPN #499 revealed EMS instructed staff to keep an eye out or that if it happened again, to administer Narcan because of the half-life of Narcan. EMS left; Resident #18 was checked every 30 minutes. Around 12:00 A.M., the CNA reported Resident #18 was not himself again. Both staff were saying his name, and he ended up waking up. TeleMed was contacted, gave an order for the Narcan but because the resident was awake was told not to give it and monitor resident every 15 minutes. LPN #499 revealed she charted Resident 18's medical record at around 2:00 A.M., did not notify the family (Guardian) that late at night, so she informed them in the morning. Review of the Fire Department #606's Prehospital Care Report with the call dated 12/26/24 at 8:48 P.M. completed by Emergency Medical Technician (EMT) #605 revealed the unit was on scene on 12/26/24 at 9:02 P.M. related to an emergent response. The resident's name was (Resident #18). Primary Impression: Poisoning by drug/meds/biol substance, accidental. Narrative included the unit was dispatched for an unknown problem. Upon arrival, Resident #18 was lying in bed with a pulse and breathing. Staff stated they were unable to wake him. They gave him pain medication around 8:00 P.M. and when they went to check on him, he was unresponsive. Resident #18 had pinpoint pupils. Staff grabbed Narcan and wanted to administer. Staff administered two milligrams (mg) Narcan. Resident #18 woke up one minute later. Staff stated he was now acting normal, they did not want him to go to the hospital, and they would monitor him. Staff refused transport. Resident #18 was nonverbal. Review of the Refusal form included: Resident #18 refusal of service; Resident #18 advised of medical treatment and evaluation needed and further harm may result without medical treatment. Depart 12/26/24 at 9:24 P.M. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/25 at 1:00 P.M. with CNP #600 revealed she visited Resident #18 on 12/27/24 in the morning due to his unresponsiveness the evening prior. CNP #600 revealed on 12/27/24 when she visited him, he was the same as prior to the episode on 12/26/24. There was no change; he was completely at baseline. CNP #600 revealed she would not have given Resident #18 the medication on the evening of 12/26/24 if he was not responding. CNP #600 revealed she was unsure why Resident #18 was not sent to the emergency room (ER). CNP #600 revealed she worked with an insurance group that visited the residents at the facility routinely. When she saw Resident #18 on 12/27/24, she thought the other CNP had already ordered his drug screen. She then found out later that the other CNP did not order the labs because she thought CNP #600 ordered them. Ultimately the drug screen was not ordered timely to determine if Resident #18 had an overdose of medications/drugs on 12/26/24. Interview and observation on 01/23/25 at 7:45 A.M. with LPN #343 revealed she was Resident #18's nurse for approximately two years. Resident #18 never had an episode where he was unresponsive or even lethargic. Resident #18 had a difficult time communicating, so he normally yelled or screamed when he wanted something until he got it and then he would stop. Medications Risperidone and Ativan were increased due to the yelling behaviors. Observation of medication administration revealed LPN #343 crushed all Resident #18's medications including the Divalproex DR capsules. LPN #343 opened the two Divalproex capsules, 125 mg each, and placed the sprinkles that were inside the capsules into a small clear pouch with the remainder of the 7:00 A.M. medications and crushed all the medications together in one pouch to a fine powder using a pill crusher. LPN #343 then placed the powder in applesauce and administered the medications to Resident #18. Review of the patient information leaflet for Divalproex DR capsules revealed the capsules should be swallowed whole and should not be crushed or chewed, the capsule can be opened and sprinkled on food. Interview and record review of Resident #18's medications on 01/23/25 at 10:00 A.M. with the facility Pharmacist Consultant #602 revealed monthly reviews were completed on each resident reviewing all medications. For Resident #18, there were no indications in the physician orders that the medications were being crushed. The Divalproex DR could be opened and added to food, but the sprinkles should not be crushed or chewed. The medication was used for schizophrenia. The idea is to extend the absorption time to the next dose which if they were crushed or chewed, would not happen. Reviewed all other medications with Pharmacist Consultant #602 who revealed there were no other concerns with the ordered medications. Pharmacist Consultant #602 revealed he would not expect that reaction with Divalproex DR even if it was crushed due to he was taking it for so long. Ativan would have an immediate action which was started three times a day on 12/19/24. The Risperidone increase on 12/09/24 may take a few days but would not expect the unresponsive episode one time. The Narcan was like a drug test, it would not be effective if it was not an overdose causing Resident #18 to be unresponsive then suddenly wake up with the administration of Narcan, he had to have something in his system for the Narcan to block that would allow him to wake up. Pharmacist Consultant #602 revealed the facility never requested him to review the medications due to possible overdose. (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	An interview on 01/23/25 at 2:52 P.M. with the DON revealed she reviewed the incident on 12/26/24 -12/27/24 with Resident #18. The DON confirmed the facility never consulted with the pharmacy to assist in determining the change in condition on 12/26/24 for Resident #18 that required Narcan administration. The DON also confirmed a drug screen was not done timely to determine the change in condition on 12/26/24 for Resident #18 that required Narcan administration. This deficiency was an incidental finding identified during the complaint investigation.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review, observation, interview and review of the facility policy, the facility failed to ensure blood sugars were assessed prior to meal for Residents #82 and #112 as ordered by the physician to ensure accurate dosage of the sliding scale insulin and failed to ensure Resident #18's medication was administered correctly, (not to be crushed). This affected three residents (#82, #112, and #18) of four residents reviewed for medication administration. The facility census was 109. Findings include: 1. Record review for Resident #82 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #82 was cognitively intact. Resident #82 used a wheelchair for mobility and was dependent upon staff for transfers. Active diagnosis included diabetes mellitus. Review of the physician order dated 01/19/25 for Resident #82 included insulin lispro solution 100 units (u) per milliliter (ml) subcutaneously per sliding scale with meals scheduled at 8:00 A.M., 12:00 P.M. and 5:00 P. M. If blood sugar is 111 to 150, give one u; If blood sugar is 151 to 200, give three u; If blood sugar is 201 to 250, give six u; If blood sugar is 251 to 300, give nine u; If blood sugar is 301 to 350, give 12 u; If blood sugar is 351 to 400, give 15 u. Observation of medication administration on 01/22/25 at 8:42 A.M. with Licensed Practical Nurse (LPN) #418 administering medications to Resident #82 revealed Resident #82 was sitting up in his bed and confirmed he had completed his breakfast meal. Resident #82 revealed he had bacon, waffles, syrup, and juice. LPN #418 assessed Resident #82's blood sugar via fingerstick glucometer. Resident #82 revealed his concern to the nurse that he already ate all that food, that will push the blood sugar high. LPN #418 revealed it was okay, and she would check it anyway. Observation revealed Resident #82's blood sugar was 120. LPN #418 administered Lispro one unit. LPN #418 confirmed Resident #82's blood sugar should have been assessed prior to eating his meals and revealed sometimes things happen, and she was unable to check residents blood sugars until after the meal. Phone interview on 01/22/25 at 4:33 P.M. with Resident #82's Primary Care Physician #609 revealed Resident #82's blood sugar was to be assessed prior to the meals to determine the correct amount of the sliding scale insulin to be given. 2. Record review for Resident #112 revealed an admitted [DATE]. Diagnoses included dependence on respirator (ventilator) and diabetes mellitus. Review of the physician order dated 07/12/24 for Resident #112 revealed Humulin R Regular U-100 Insulin 100 u/ml per sliding scale, if blood sugar is 201 to 250, give four u; If blood sugar is 251 to 300, give six u; If blood sugar is 301 to 350, give eight u; If blood sugar is 351 to 400, give 10 u; If blood sugar is 401 to 450, give 12 u before meals and at bedtime. (continued on next page)

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	365847	A. Building B. Wing	01/27/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #112 was cognitively intact. Active diagnosis included diabetes mellitus. Observation of medication administration on 01/22/25 at 9:15 A.M. with Registered Nurse (RN) #608 administering medications to Resident #112 revealed Resident #112 ate 100 % of her breakfast. Resident #112 revealed she had biscuits and gravy, milk and Jello and confirmed she ate 100 % of her breakfast. Observation revealed RN #608 assessed Resident #112's blood sugar via fingerstick glucometer with a result of 260. Observation revealed RN #608 administered Humulin R insulin six u. Interview with RN #608 confirmed he did not check Resident #112's blood sugar until after breakfast because he was running behind. Interview on 01/22/25 at 9:34 A.M. with Resident #112 revealed some nurses check blood sugars before meals and some do it after the meals. 3. Record review for Resident #18 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease with early onset, schizophrenia, mood disorder, impulse disorder, restlessness and agitation, and need for assistance with personal care. Review of the care plan dated 07/15/24 revealed Resident #18 had behavioral symptoms not directed to others verbal/vocal symptoms like screaming, disruptive sounds, refused to be shaved. Interventions included when the resident yells out, ask the resident if he needs anything. Provide encouragement and calmness. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #18 was severely cognitively impaired, had no hallucinations or delusions, no verbal or physical behaviors exhibited, no rejection of care and no wandering during the seven-day assessment reference period. Resident #18 required set up or clean up assist with eating, dependent upon staff for toileting hygiene, bathing, dressing, and personal hygiene. Resident #18 required substantial/maximal assistance for bed mobility, dependent upon staff for transfers, used a wheelchair and was dependent for mobility. Resident #18 had an ostomy and was always incontinent of urine. Review of the physician orders for Resident #18 revealed changes in medications for December 2024 included on 12/09/24 Risperidone (antipsychotic) was increased from 0.5 milligrams (mg) two times a day to one mg two times a day (7:00 A.M. to 11:00 A.M. and 7:00 P.M. to 11:00 P.M.) and on 12/19/24, Ativan 0.5 mg (antianxiety) was increased from 0.5 mg every day to 0.5 mg three times a day (6:00 A.M., 2:00 P.M. and 9:00 P.M.). Additional orders included Divalproex capsule delayed release (DR) sprinkles 125 mg (anticonvulsant) give two capsules in the A.M., ordered 04/18/24 and Divalproex capsule DR sprinkles 125 mg give four capsules night shift, ordered 07/12/24. Observation on 01/23/25 at 7:45 A.M. with LPN #343 revealed she was Resident #18's nurse for approximately two years. Resident #18 had a difficult time communicating, so he normally yelled or screamed when he wanted something until he got it then he would stop. Resident #18's medications Risperidone and Ativan were increased due to behaviors. (continued on next page)

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	365847	A. Building B. Wing	01/27/2025

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of medication administration revealed LPN #343 crushed all Resident #18's medications including the Divalproex DR capsules. LPN #343 opened the two Divalproex DR capsules, 125 mg each, and placed the sprinkles that were inside the capsules into a small clear pouch with the remainder of the medications and crushed all the medications together in one pouch to a fine powder using a pill crusher. LPN #343 then placed the powder in applesauce and administered the medications to Resident #18. LPN #343 confirmed she crushed Resident #18's medications including the Divalproex DR sprinkles. Review of the patient information leaflet for Divalproex DR capsules (Depakote) revealed Divalproex DR capsules should be swallowed whole and should not be crushed or chewed, the capsule can be opened and sprinkled on food. Interview and record review of Resident #18's medications on 01/23/25 at 10:00 A.M. with the facility Pharmacist Consultant #602 revealed Resident #18 had no indications in the physician orders that the medications were being crushed. The Divalproex DR capsules could be opened and added to food, but the sprinkles should not be crushed or chewed. The medication was used for schizophrenia. The idea is to extend the absorption time to be effective longer, which if they were crushed or chewed, would not happen. Review of the facility policy titled, General dose Preparation and Medication Administration revised 01/01/13 revealed facility staff should crush oral medications only in accordance with pharmacy guidelines as set forth in Appendix 16: common oral dosage forms that should not be crushed and/or facility policy. Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time. The deficiency was an incidental finding identified during the complaint investigation.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, review of the label directions on the cleaning wipes and review of the facility policy, the facility failed to ensure infection control practices were maintained while assessing Residents #82 and #112's blood glucose levels via fingerstick. This affected two residents (#82 and #112) and had the potential to affect an additional 19 residents (#1, #7, #13, #14, #17, #21, #31, #49, #50, #53, #63, #65, #66, #69, #74, #80, #91, #94, and #97) identified by the facility as receiving blood glucose levels via fingerstick. The facility census was 109. Findings include: 1. Record review for Resident #82 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus. Review of the physician order dated 01/19/25 for Resident #82 included insulin lispro solution 100 units (u) per milliliter (ml) subcutaneously per sliding scale with meals scheduled at 8:00 A.M., 12:00 P.M. and 5:00 P. M. Observation on 01/22/25 at 8:42 A.M. of a blood sugar assessment via glucometer revealed Licensed Practical Nurse (LPN) #418 took the glucometer out of the top drawer of the medication cart. The glucometer was not covered or stored in a pouch. LPN #418 did not clean the glucometer before assessing Resident #82' blood sugar via fingerstick. LPN #418 then returned the glucometer to the medication cart, wiped the glucometer off for approximately five seconds then placed the glucometer in a cup (without a cleaning wipe). LPN #418 verified she was done cleaning the glucometer. LPN #418 confirmed the glucometer was used for all residents residing in her hall that required fingerstick blood sugars. LPN #418 confirmed she worked in all areas of the facility. LPN #418 then reviewed the directions on the Sani wipes for cleaning the glucometer and confirmed she did not allow the surface on the glucometer to remain wet two minutes. 2. Record review for Resident #112 revealed an admitted [DATE]. Diagnoses included dependence on respirator (ventilator) and diabetes mellitus. Review of the physician order dated 07/12/24 for Resident #112 revealed Humulin R Regular U-100 Insulin 100 unit/ml per sliding scale before meals and at bedtime. Observation on 01/22/25 at 9:15 A.M. of a blood sugar assessment via glucometer revealed with Registered Nurse (RN) #608 took the glucometer out of the top drawer of the medication cart. The glucometer was not covered or stored in a pouch. RN #608 did not clean the glucometer before assessing Resident #112's blood sugar via fingerstick. RN #608 then returned the glucometer to the medication cart, sat the glucometer on top of the medication cart, opened the drawer and placed the glucometer directly on top of the opened box of lancets. RN #608 then closed the drawer and locked the medication cart. RN #608 confirmed he did not clean the glucometer before or after use and confirmed he sat the soiled glucometer directly on top of multiple lancets used to obtain blood from residents' fingers. RN #608 then removed the glucometer from the cart and wiped the glucometer with an alcohol wipe for approximately five seconds revealing that was how he would clean the glucometer between each use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365847	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bath Manor Special Care Centre	2330 Smith Road Akron, OH 44333

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/25 at 9:45 A.M. and review of the Sani wipes directions for cleaning glucometer's with Regional Director of Clinical Services (RDCS) #601 revealed the facility used Super Sani cloth wipes to clean all glucometer's. RDCS #601 revealed alcohol wipes were not an approved method for cleaning glucometers. Review of the label directions on the container of the Super Sani cloth wipes for cleaning hard surfaces including glucometers revealed to thoroughly wet surface. Allow the surface to remain wet for two minutes, let air dry. Review of the facility policy titled, Glucometer/Point of Care Blood Testing and Disinfection Procedure revised 12/27/23 revealed whether shared or assigned to a singular resident, blood testing meters will be disinfected between each use (before use the clinician should assume the meter is dirty and disinfect before use according to manufacturer instructions and infection prevention guidelines). This deficiency was an incidental finding identified during the complaint investigation.