STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366271	A. Building B. Wing	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Ridge Rehabilitation and Care Center	7055 High Mill Avenue NW Canal Fulton, OH 44614

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07943 Based on interview and record review the facility failed to ensure a thorough fall investigation for Resident #44. This affected one (Resident #44) of four (Residents #24, #42, #43 and #44) reviewed for accidents. The facility census was 63. Findings include: Resident #44 was admitted to the facility on [DATE] with diagnoses of end stage renal disease, hypoglycemia, pseudobulbar, anxiety, delirium, depression, auditory hallucinations, altered mental status and muscle weakness. Review of the comprehensive assessment for a significant change dated 11/14/19 revealed the resident required extensive assistance with bed mobility and transfers. The resident was unsteady moving from seated to standing position, moving on and off the toilet, and surface-to surface transfers. Review of the resident record revealed the resident sustained a fall on 07/08/19 during the supper meal in the dining room. Review of the incident report dated 07/09/19 indicated the resident fell trying to carry two meal trays. The resident was sent to the hospital via 911 for hip pain. The discharge diagnoses from the hospital was right shoulder contusion and right hip contusion. There were no new orders written for the injuries. There was no time the incident occurred, whether the witness attempted to stop the resident from carrying the trays, and what staff were in the dining room at the time of the fall. The investigation was incomplete. Interview on 12/18/19 at 9:18 A.M. with the Director of Nursing (DON) and Registered Nurse (RN) #815 revealed they had problems with agency staff and that may have been an agency nurse. They verified the investigation was incomplete.

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 32652 Based on staffing schedule review and interview, the facility did not ensure a registered nurse (RN) was employed for eight consecutive hours in a day. This had the potential to affect all 63 residents in the facility at the time of the survey. Findings include. Review of the staffing schedule for 11/22/19 through 11/24/19 revealed the facility had failed to employee a RN for eight consecutive hours on 11/22/19, 11/23/19 and 11/24/19. Review of the staffing schedule for 12/06/19 through 12/08/19 revealed the facility failed to employee a RN for eight consecutive hours on 12/07/19 and 12/08/19. Review of the staffing schedule for 12/15/19 through 12/17/19 revealed the facility failed to employee a RN for eight consecutive hours on 12/16/19 and 12/18/19. Interview with the Director of Nursing verified the facility had not employed a RN on the days identified.

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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 and interview, the facility failed to ensure a medication error rate of less than 5% (percent). This finding affected one (Resident #35) of four residents observed for medication administration. A total of twenty-seven medications were observed with six errors for a medication error rate of 22.2%. Findings include: Review of Resident #35's medical record revealed the resident was readmitted to the facility on [DATE] with diagnoses including dysphagia, chronic respiratory failure and type two diabetes. Review of Resident #35's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #35's physician orders revealed an order dated 11/27/19 for a lidocaine patch 5% apply to right should topically in the morning for pain, an order dated 11/27/19 for a multivitamin give one tablet by mouth in the morning for vitamin deficiency, an order dated 11/27/19 for a Spiriva aerosol inhaler two puffs inhale orally in the morning for respiratory, an order dated 12/04/19 for Budesonide suspension two ml (milliliters) inhale orally two times a day for chronic obstructive pulmonary disease/asthma, an order dated 11/27/19 for vitamin d give 1000 units by mouth two times a day for deficiency and an order dated 11/27/19 for Humalog (fast acting insulin) inject six units subcutaneously with meals for diabetes. Observation on 12/15/19 at 8:20 A.M. with Registered Nurse (RN) #801 revealed the nurse administered seven medications in applesauce and the fast acting insulin to Resident #35. The nurse did not prime the insulin injector Kwikpen prior to dialing up the six units and administering the insulin as required. Interview on 12/15/19 at 1:11 P.M. with RN #801 confirmed she did not prime the Kwikpen prior to dialing up the six units and administering the insulin to the resident. RN #801 also confirmed she did not administer the lidocaine patch, multivitamin, Spiriva inhaler, Budesonide suspension and vitamin D as ordered by the physician. A total of twenty-seven medications were administered with six errors for a medication error rate of 22.2%.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review and interview, the facility failed to ensure the appropriate orders were obtained and infection control measures were maintained while providing Resident #162's wound care, cleaning Resident #41's resident room and obtaining physician orders for isolation precautions for Residents #41 and #162. This finding affected one (Resident #162) of three residents reviewed for pressure ulcers and one resident room (Resident #41) with the potential of affecting all twenty-five residents residing in the general population (excluding the memory care unit) and two (Residents #41 and #162) of two residents reviewed for isolation precautions. The census at the time of the survey was 63. Findings include: 1. Review of Resident #162's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including sepsis, spina bifida and pressure ulcer of the right buttock. Review of Resident #162's physician order dated 12/13/19 indicated to cleanse the open area to the right buttock with normal saline, pat dry and cover with a comfort foam every other day and as needed. Review of Resident #162's physician order dated 12/13/19 indicated to cleanse the open area to the left buttock with normal saline, pat dry, apply Aquacel dressing (absorbent dressing for drainage) then cover with a comfort foam dressing every other day and as needed. Observation on 12/17/19 at 6:05 A.M. with Registered Nurse (RN) #817 revealed the nurse wiped the table, placed a barrier on the table, put on gloves, removed the resident's old dressing on her left buttock, cleansed the left buttock with normal saline, placed the Aquacel dressing and a foam dressing on the resident. RN #817 then removed her gloves and washed her hands before completing care on the right buttock. The resident was on isolation precautions for gram positive cocci and gram negative rods in the residents wounds in her left buttock and extended spectrum beta-lactamase (ESBL) in the urine. Interview on 12/17/19 at 6:40 A.M. with RN #817 confirmed she did not use the appropriate infection control technique by removing her gloves after removing Resident #162's soiled dressing on the left buttock and prior to cleaning the left buttock with normal saline. The resident did not have a physician order for contact isolation precautions. 2. Review of Resident #41's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including type two diabetes, major depressive disorder and acquired absence of left leg above the knee. Review of Resident #41's MDS 3.0 assessment dated [DATE] confirmed the resident exhibited intact cognition. Observation on 12/16/19 at 3:33 P.M. revealed State tested Nursing Assistant (STNA) #812 was cleaning the resident's room with gloves and no yellow isolation gown on. STNA #812 confirmed she did not need to wear an isolation gown to complete her cleaning of the resident's room including making the resident's bed and cleaning the resident's overbed table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/17/19 at 2:31 P.M. with RN #815 confirmed Resident #41 was admitted with Klebsiella pneumonia (infectious bacteria) in his urine and the resident was in contact precautions which included donning an isolation gown and gloves when entering the resident's room. RN #815 indicated the facility did not need a physician order to place residents on infection control precautions including contact precautions. Review of the Isolation Based Precautions policy revised 01/12 indicated transmission-based precautions shall only be used when transmission cannot be reasonably prevented by less restrictive measures. The personal protective equipment included to wear a gown upon entering the contact precautions room. Upon admission, Resident #41 was identified as having Vancomycin resistant Enterococci (VRE) of the urine. This required isolation precautions including wearing a gown and gloves when performing care along with restrictions when entering the public areas. Review of the medical record and physician orders was void of a physician order indicating the resident was placed on isolation precautions. An interview was completed on 12/17/19 at 12:40 P.M. with Licensed Practical Nurse (LPN) #818 and during the interview it was stated any resident who was on isolation precautions would have a physician order obtained. In an interview on 12/17/19 at 1:00 P.M. with the Director of Nursing it was stated any resident coming from the hospital would have a physician's order attached for isolation precautions. In an interview with the DON on 12/17/19 at 1:50 P.M. it was stated he did not have an order for the isolation interventions put in place for Resident #41.