STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366485	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarfield Place	8400 Market Street Boardman, OH 44512

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** 28701 Based on observation, medical record review, staff interview and policy review the facility failed to ensure peripherally inserted central catheters (PICC) were flushed appropriately and as ordered by the physician. This affected one (Resident #113) of five residents reviewed for medications. The facility identified three residents (102, 103 and 113) with current PICC line or intravenous (IV) lines for medication administration. The facility census was 52. Findings include: Observation on 04/30/24 at 12:05 P.M. revealed Licensed Practical Nurse (LPN) #372 administering ceftriaxone (antibiotic) 2000 milligram (mg) through a PICC line for Resident #113. LPN #372 had the medication solution, two 10 milliliter (ml) syringes of 0.9% normal saline (NS) and one 5 ml syringe of heparin (blood thinner) 100 units (u) per ml. LPN prepared the PICC line tubing by cleaning the caps with alcohol and then flushed with 10 ml of NS, then flushed with 3 ml of the heparin and then another flush with 10 ml of NS. At this time LPN #372 connected the ceftriaxone to the PICC line and began the medication infusion. Review of Resident #113's medical record revealed an admitted [DATE] with admission diagnoses that included chronic non-pressure ulcer to the left foot, left foot abscess, diabetes mellitus and hypertension. Physician's orders upon admission revealed the resident was prescribed ceftriaxone 2000mg daily via PICC line. An additional physician's order on 04/29/24 indicated to flush the PICC line with 10ml NS every shift. No evidence of an order from the physician for use of the SASH method (S-Saline 0.9% 5ml via 10cc syringe prior to administering the dose, A-Administration of IV medication, S-Saline 0.9% 5ml via 10cc syringe upon completion of the infusion and H-Heparin 3ml (100u/ml) after previous saline flush) was found within the medical record. Interview with LPN #372 on 04/30/24 at 1:59 P.M. regarding the flushing method to which she responded that the facility followed the SASH flush method, indicating that staff are to flush with NS, and heparin then administer the medication and flush again with NS after the medication has been infused. Interview with the Director of Nursing on 04/30/24 at 2:20 P.M. revealed staff are to flush PICC lines using the facility procedure of the SASH method - NS flush, medication administration, NS flush and finally a heparin flush. (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	Follow up interview with LPN #372 on 04/30/24 at 3:15 P.M. verified she did not flush the PICC line for Resident #113 as per physician order and facility protocol. She verified she flushed with NS, followed by heparin, then NS and finally adminsitered the medication. After the infusion she flushed with NS and then finally heparin. Review of the facility policy PICC/Peripheral/Midline Catheter undated, reviewed by medical director on 05/10/21 indicated nursing staff are to the S-A-S-H method when flushing PICC/Midline catheters. The policy further described the SASH method as: S-Saline 0.9% 5ml via 10cc syringe prior to administering the dose, A-Administration of IV medication, S-Saline 0.9% 5ml via 10cc syringe upon completion of the infusion and H-Heparin 3ml (100u/ml) after previous saline flush.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on observation, resident interview, medical record review, review of manufacturer's instructions and staff interview the facility failed to ensure respiratory equipment including continuous positive airway pressure (CPAP) equipment were properly cleaned per manufacturer's instructions. This affected one resident (Resident #9) of three residents reviewed for respiratory equipment use. The facility census was 52. Findings include: Observation of Resident #9 on 04/29/24 at 2:05 P.M. revealed a CPAP machine on the bedside stand. Interview with Resident #9 on 04/29/24 at 2:05 P.M. revealed staff do not clean her CPAP mask, tubing or machine on a routine basis. Review of Resident #9's medical record revealed an admitted [DATE] with diagnoses including obstructive sleep apnea, congestive heart failure and chronic obstructive pulmonary disease. Further review of the medical record revealed on 12/29/23 the resident was ordered the use of a CPAP machine. No evidence of any cleaning of the machine, tubing or mask was found within the medical record. Review of the care plan for Resident #9 revealed the use of a CPAP related to sleep apnea. No evidence of any intervention related to cleaning of CPAP equipment. Review of the manufacturer's guidelines for the ResMed AirCurve 10 CPAP revealed the following instructions for cleaning and care: it is important that you regularly clean your AirCurve 10 device to make sure you receive optimal therapy. Cleaning - you should clean the device weekly as described. Refer to the mask user guide for detailed instructions on cleaning your mask. Wash the humidifier and air tubing in warm water using mild detergent. Rinse the humidifier and air tubing and allow to dry out of direct sunlight and/or heat. Wipe the exterior of the device with a dry cloth. Cleaning you CPAP mask cushion, frame and headgear - cushion should be cleaned daily, headgear and frame should be cleaned weekly. Interview with the Director of Nursing on 04/30/24 at 2:45 P.M. verified no evidence of cleaning for Resident #9's CPAP machine and equipment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, record review, interview and review of facility policy, the facility failed to ensure food was served in a sanitary manner. This had the potential to affect all 52 residents in the facility, as the facility identified all 52 residents received meals from the kitchen. The facility census was 52. Findings include: 1. Observation of the kitchen on 04/30/24 from 11:12 A.M. to 11:26 A.M. revealed Food Service Director (FSD) #406 had a noticeable growth of facial hair and wasn't wearing a beard guard in the kitchen as he ran the bowl and lid to the commercial blender and a spatula through the dish machine. Interview on 04/30/24 at 11:26 A.M. with FSD #406 confirmed he wasn't wearing a beard guard and had never worn a beard guard in the kitchen. Interview on 04/30/24 at 11:26 A.M. with Dietitian #331 stated staff with beards in the kitchen should be wearing beard guards and confirmed FSD #406 had not been wearing a beard guard and should have been. Review of the facility's undated policy Proper Use of Hair Restraints revealed food employees shall effectively restrain hair by wearing hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, or linens; or unwrapped single-service or single-use articles. 2. Observation on 04/30/24 between 8:35 A.M. and 8:46 A.M. revealed one cart of resident breakfast trays and one beverage cart with carafes of hot beverages and a tray of empty coffee cups was sitting across from Station two's nurse's station. At 8:40 A.M., State tested Nursing Assistant (STNA) #369 poured a cup of coffee from the beverage cart and placed the uncovered cup on a resident's meal tray and proceeded to walk past the nurse's station, past the Director of Nursing's office and into room [ROOM NUMBER]. At 8:42 A.M., Licensed Practical Nurse/Wound Care Nurse #341 poured a cup of coffee from the beverage cart and placed the uncovered cup on a resident's tray and proceeded to walk past the nurse's station and one resident's room, and into room [ROOM NUMBER]. At 8:43 A.M. STNA #369 poured a cup of coffee from the beverage cart and placed the uncovered cup on a resident's tray and proceeded to walk past the nurse's station and two resident's rooms, and into room [ROOM NUMBER]. Interview on 04/30/24 at 8:46 A.M. with STNA #369 confirmed she had poured hot coffee from the beverage cart and had walked the coffee uncovered on the meal trays to the residents' room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/30/24 from 8:46 A.M. to 8:48 A.M. revealed one cart of residents' meal trays and one beverage cart with carafes of hot beverages and a tray of empty coffee cups was sitting next to Station One's nursing station. At 8:46 A.M. the Director of Nursing poured a cup of coffee from the beverage cart and placed the uncovered cup on a resident's tray and proceeded to walk past three residents' rooms and into room [ROOM NUMBER]. At 8:48 A.M., STNA #357 poured a cup of coffee from the beverage cart and placed the uncovered cup on the resident's tray and proceeded to walk past four residents' rooms and into room [ROOM NUMBER]. Interview on 04/30/24 at 11:26 A.M. with Dietitian #331 revealed the staff were to take the meal carts and beverages down the hallway as they deliver meal trays. Staff were not to take meal trays with uncovered cups of beverages up and down hallways due to a risk of contamination. Review of facility policy Meal/Tray Delivery, dated 01/01/10, revealed staff would practice universal precautions related to infection control during meal delivery.