STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366351	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OHIO VETERANS HOME - GEORGETOWN	2003 VETERANS BLVD GEORGETOWN, OH 45121

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy the facility failed to ensure residents had valid code status forms in their medical records. The forms were not signed by a physician. This affected one (Resident #404) of 30 residents sampled. The census was 151. Findings include: Review of the medical record for Resident #404 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Further review of the medical record revealed a sticker in the front of the hard chart indicated the resident's code status was do not resuscitate comfort care (DNRCC). Review of the DNRCC form, undated, revealed it was signed by the resident and indicated the resident was a DNRCC. There was no physician signature on the form. Review of social service progress note for Resident #404 dated 02/21/20 revealed the resident desired to be a DNRCC for code status. Interview on 03/03/20 at 9:32 A.M. with Resident #404 confirmed the resident's preference for code status was to be a DNRCC. Interview on 03/03/20 at 10:52 A.M. with Licensed Practical Nurse (LPN) #76 confirmed DNRCC form for Resident #404 was not signed by the attending physician. Review of facility policy date 08/10/18 titled Code Blue: Medical Emergency/Automated External Defibrillator revealed a DNRCC order is invalid if not signed by the resident's physician on the order and also on the DNRCC form.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure residents received written bed hold notifications upon discharge to the hospital. This affected four (#13, #56, #60 and #98) residents of four reviewed for discharge notification. The facility census was 151. Findings include: 1. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment and required extensive assistance with transfers and bed mobility. Resident #60 also required total dependence with dressing, eating, toileting and personal hygiene on the 12/15/19 MDS. Further review of the medical record revealed the resident was discharged to the hospital on [DATE] with a [MEDICAL CONDITION]. There was no evidence Resident #60 or his representative received a written bed hold notice upon discharge to the hospital on [DATE]. Interview with the Director of Nursing (DON) on 03/05/20 at 9:33 A.M. verified Resident #60 did not receive a written bed hold notice upon discharge to the hospital on [DATE]. 2. Review of the medical record revealed Resident #98 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of MDS assessment dated [DATE] revealed the resident had severe cognitive impairment and required extensive assistance with bed mobility, transfers, dressing, and toileting. Resident #98 also required total dependence with personal hygiene and eating. Further review of the medical record revealed the resident was discharged to the hospital on [DATE] with aspiration. There was no evidence Resident #98 or his representative received a written bed hold notice upon discharge to the hospital on [DATE]. Interview with the DON on 03/05/20 at 9:33 A.M. verified Resident #98 or his representative did not receive a written bed hold notice upon discharge to the hospital on [DATE]. 3. Review of the medical record revealed Resident #56 was admitted on [DATE]. [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. The resident required two plus person physical assist, was dependent or required extensive assistance for activities of daily living (ADLs). Review of the nurse's progress notes dated 02/21/20 at 4:52 P.M. by Registered Nurse (RN) #228 revealed the resident was sent to the hospital following a wound physician assessment. There was no evidence the resident and/or the resident's representative was provided a written notice about bed-hold. 4. Review of the medical record revealed Resident #13 was admitted on [DATE]. [DIAGNOSES REDACTED]. Review of the MDS dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance for eating. The resident was totally dependent for bed mobility, and transfer. Further review of the medical revealed Resident #13 went to the hospital on [DATE] and returned 12/30/19. There was no evidence the resident or the residents representative was given a notification of bed hold days. Interview with the DON on 03/05/20 at 10:50 A.M. verified the staff did not give Resident #13 or Resident #56 a bed hold notice when they went to the hospital.
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** Based on medical record review and staff interview, the facility failed to ensure the accuracy of resident assessments related to antipsychotic use. This affected one (Resident #59) of five residents reviewed for unnecessary medications. The census was 151. Findings include: Review of the medical record revealed Resident #59 was admitted [DATE]. [DIAGNOSES REDACTED]. Review of physician orders [REDACTED]. Further review of the MDS section N0450 question A revealed the resident did not receive antipsychotics on a routine basis. Review of section N0450 also revealed the following subsequent questions were not answered due to the negative response to questions N0450 A regarding antipsychotic use: has a gradual dose reduction (GDR) been attempted, date of last attempted GDR, did physician document GDR as clinically contraindicated, date physician documented GDR as clinically contraindicated. Interview on 03/05/20 at 10:04 A.M., Licensed Practical Nurse (LPN) #34 confirmed she completed section N0410 of the MDS for Resident #59 dated 12/18/19 and confirmed the resident had received the routine antipsychotic medication [MEDICATION NAME] daily since fall of 2019. Interview on 03/05/20 at 10:10 A.M. with Social Worker (SW) #182 confirmed she had completed Resident #59's MDS dated [DATE] section N0450 and had coded question N0450 A to indicate the resident had not received antipsychotics. SW #182 further confirmed this was an error, and the resident had received antipsychotics routinely. SW #182 confirmed the subsequent questions included in section N0450 had not been answered due to the erroneous negative response to question N0450 A.
F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, and staff interview, the facility failed to arrange for audiological services for residents. This affected one (Resident #59) of one resident reviewed for communication. The

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366351	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OHIO VETERANS HOME - GEORGETOWN	2003 VETERANS BLVD GEORGETOWN, OH 45121

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 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) census was 151. Findings include: Review of the medical record revealed Resident #59 was admitted on [DATE]. [DIAGNOSES REDACTED]. Review of the comprehensive admission Minimum Data Set ((MDS) dated [DATE] revealed the resident was cognitively impaired, was totally dependent on staff assistance with activities of daily living, had moderate difficulty with hearing, and did not use hearing aids. Review of the Care Area Assessment (CAA) worksheet dated 06/24/19 revealed the resident had hearing deficit and had hearing aids but did not wish to use them. Further review of the worksheet revealed the facility would arrange for hearing evaluations and also observe the resident's ears for wax buildup. Review of the care plan for Resident #59 dated 06/18/19 revealed the resident was hard of hearing and had hearing aids but did not wish to wear them. Interventions included to observe resident's ears for wax build up and arrange audiology consult as needed. Review of the consent form dated 06/18/19 revealed the resident's representative had signed giving written consent for the resident to receive audiology services. Review of monthly physician's orders [REDACTED].#59. Observation on 03/02/20 at 9:47 A.M. revealed Resident #59 demonstrated moderate difficulty hearing during an interview conducted in his room with minimal background noise. The resident had moderate hearing difficulty and he did not have hearing aids or devices to assist with hearing. Interview on 03/04/20 at 11:00 A.M. with the Director of Nursing (DON) confirmed the resident had not been seen by an audiologist since his admission to the facility. Interview on 03/04/20 at 2:34 P.M. with Customer Service Assistant (CSA) #124 confirmed she scheduled residents for audiological services based on referrals from nursing. CSA #124 confirmed she had no requests to schedule Resident #59 for audiology services. Interview on 03/04/20 at 2:40 P.M. with Licensed Practical Nurse (LPN) #66 confirmed Resident #59 had not been referred for audiology services since his admission to the facility.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and review of facility policy, the facility failed to ensure splints to maintain range of motion were in place. This affected one (Resident #144) of two residents reviewed for positioning and mobility. The census was 151. Findings include: Review of the medical record revealed Resident #144 was admitted on [DATE] with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for dated 02/05/20 revealed the resident had severe cognitive impairment, was totally dependent on staff for activities of daily living and had functional impairment to his bilateral upper and lower extremities. Review of care plan dated 01/30/19 revealed Resident #144 had contractures and was at risk for changes in range of motion and pain due to current contractures. Interventions included the following apply dyna splint as ordered to right lower extremity to maintain skin integrity for contracture management related to right lower extremity, soft hand roll in left palm per order, medium hand roll to right hand per order. Review of the monthly physician orders [REDACTED]. Review of the Treatment Administration Record (TAR) for Resident #144 for March 2020 revealed the soft hand roll to the left palm, the medium hand roll to the right hand, and the dyna splint were initialed off to indicate being in place. Further review of the TAR revealed it did not indicate to which extremity the dyna splint was to be applied nor did it indicate the time frame for the four-hour daily application of the dyna splint. Observation of Resident #144 on 03/03/20 at 3:20 P.M. revealed the resident had a splint on his left hand, but no splint or hand roll to his right hand. Further observation revealed the resident had no splints or devices on his lower extremities. Interview on 03/03/20 03:25 P.M. with State tested Nursing Assistant (STNA) #48 confirmed Resident #144 had a splint on his left hand and no splint or hand roll to his right hand and no splints or devices on his lower extremities. STNA #48 further confirmed she was not sure what devices the resident was supposed to have to maintain range of motion. Interview on 03/03/20 at 3:52 P.M. with Licensed Practical Nurse (LPN) #192 confirmed Resident #144 had orders for the following devices: soft hand roll in left palm at all times to maintain range of motion, medium hand roll to the right hand at all times, dyna splint to wear four hours every day as tolerated. LPN #192 further confirmed the STNAs applied the devices and she was unsure when the dyna splint was to be applied, but she thought it was supposed to be done sometime on day shift. Interview on 03/03/20 at 3:54 P.M. with STNA #181 confirmed Resident #144 was supposed to have hand roll/splint to his right hand but it was not in place. STNA #181 further confirmed the resident did not have splints on his lower extremities and she was unsure if he was supposed to have any. Observation on 03/03/20 at 3:55 P.M. revealed STNA #181 placed a hand splint on Resident #144's right hand. Interview on 03/03/20 at 4:05 P.M. with Director of Rehab, Occupational Therapist (OT) #232 confirmed Resident #144 was always to wear bilateral hand splints to prevent contractures and should wear a dyna splint to his right knee for four hours daily. OT #232 further confirmed Resident #144 was not wearing his dyna splint to his right knee, was not on therapy caseload currently, and nursing was responsible for ensuring resident's splints were in place as ordered. Review of facility policy titled Range of Motion, Balance, and Functional Limitation assessment dated [DATE] revealed staff would ensure appropriate interventions were in place to attempt to prevent decline in range of motion.
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** Based on record review, observation, staff interview, and review of facility policy the facility failed to ensure respiratory equipment was clean and failed to change tubing appropriately. This affected one (Resident #19) of two residents reviewed for respiratory care. The census was 151. Findings include: Review of the medical record revealed Resident #19 was admitted on [DATE] with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed the resident was cognitively impaired and was totally dependent on staff for activities of daily living. Review of physician orders revealed an order dated 05/14/19 for the resident to receive [MEDICATION NAME] solution via handheld nebulizer (HHN) twice daily at 9:00 A.M. and 6:00 P.M. Observation on 03/02/20 at 3:03 P.M. of Resident #19 revealed the tubing to resident's HHN was dated 02/18/20 and the chamber of the nebulizer was partially filled with clear liquid. Interview on 03/02/20 at 3:05 P.M. with Licensed Practical Nurse (LPN) #76 confirmed the tubing to Resident #19's HHN was dated 02/18/20 and the nebulizer tubing was to be changed weekly and dated. LPN #76 also confirmed Resident #19's nebulizer chamber was partially filled with clear liquid. Review of the facility policy dated 05/13/08 titled Nebulizer Equipment revealed new nebulizer tubing should be provided to the resident every week. Further review of the policy revealed following nebulizer treatment the nebulizer should be disassembled with any unused portion of medication poured out and all the nebulizer parts washed with soap and water, rinsed thoroughly and allowed to air dry on paper towels.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on medical record review, controlled substance sheet review, observation, staff interview, and review of facility policy, the facility failed to ensure proper procedures were in place regarding the storage and administration of controlled substances. This had the potential to affect a total of 20 Residents (#32, #55, #60, #101, #103, #116 on the A1 Blue Cart, Residents #4, #23, #50, #69, #92, #119 on the A2 Blue Cart, Resident #137 on the C1 Blue Cart, Residents #9, #14, #47, #53, #110, #115, #128 on the C2 Blue Cart who had controlled substances stored. The census was 151. Findings include: 1. Review of the medical record for Resident #50 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED].M., and 9:00 P.M. for chronic pain. Review of the controlled substance sheet for Resident #50's [MEDICATION NAME] revealed the 9:00 A.M. routine dose of [MEDICATION NAME], tablet #25 for resident had not been signed out as given. Observation of the [MEDICATION NAME] supply for Resident #50 on [DATE] at 9:10 A.M. with Licensed Practical Nurse (LPN) #92 revealed there were 24 tablets remaining. Interview on with LPN #92 at the time of the observation confirmed there were 24 [MEDICATION NAME] tablets remaining in the cart for Resident #50. LPN #92 indicated she administered the medication at approximately at 8:00 A.M. but she had not signed out the [MEDICATION NAME] tablet at the time of administration. 2. Review of the controlled substance shift to shift count record for the A2 Unit blue cart revealed the oncoming nurse had not signed the shift to shift count for 7:00 A.M. on [DATE]. Interview on [DATE] at 9:10 A.M. with LPN #92 confirmed she had counted the controlled substances oat 7:00 A.M. on [DATE] with the off going nurse but she had not signed the count sheet. 3. Review of the closed medical record revealed Resident #137 was admitted on [DATE] with a [DIAGNOSES REDACTED]. Observation of the C1 Blue cart on [DATE] at 1:20 P.M. with LPN #76 revealed the narcotic storage drawer contained a bottle of liquid [MEDICATION NAME] solution and four [MEDICATION NAME] tablets for Resident #137. Interview at the time of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366351	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OHIO VETERANS HOME - GEORGETOWN	2003 VETERANS BLVD GEORGETOWN, OH 45121

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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) observation with LPN #76 confirmed controlled substances for expired residents were left in the narcotic storage drawer until a Registered Nurse (RN) Supervisor could remove them. Interview on [DATE] at 11:05 A.M. with the Director of Nursing (DON) confirmed the facility did not have a written policy regarding removal of controlled substances from the carts when a resident expired. DON confirmed facility practice was for RN Supervisors to remove the controlled substances from the cart as soon as possible after a resident expired and take them to the facility safe prior to destruction. 4. Review of the controlled substance shift to shift count record for C2 blue cart revealed the oncoming nurse had not signed the shift to shift count for 7:00 A.M. on [DATE]. Interview on [DATE] at 9:41 A.M. with LPN #123 confirmed she had counted controlled substances at 7:00 A.M. on [DATE] with the off going nurse but she had not signed the count sheet. 5. Review of the controlled substance shift to shift count record for the A1 blue cart revealed the oncoming nurse had not signed the shift to shift count for 7:00 A.M. on [DATE] nor was the the time of the count or the total of narcotic sheets and narcotic containers noted. Interview on [DATE] at 8:15 A.M. with LPN #200 confirmed she had not signed the controlled substances sheet at the change of shift on [DATE] at 7:00 A.M Review of the facility policy dated [DATE] titled Security of Controlled Substances revealed narcotic counts must be done at every exchange of keys by nurses of both incoming and off going shifts and recorded on the narcotic count sheet. Further review of the policy revealed the nurse should document administration of narcotic medication at the time of administration and nurses habitually lacking proper documentation regarding narcotics might be reported to the Ohio Board of Nursing by the Director of Nursing (DON).
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility policy the facility failed to ensure the consultant pharmacist completed a thorough monthly review of each resident's medication regimen which included documentation of the presence or absence of irregularities. This affected four Residents (355, #59, #60, and #110) of five reviewed for unnecessary medications. The census was 151. Findings include: 1. Review of the medical record revealed Resident #59 was admitted on [DATE] with a [DIAGNOSES REDACTED]. regimen. 2. Review of the medical record revealed Resident #55 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment and required extensive assistance with transfers, dressing, toileting and personal hygiene. Resident #55 also required limited assistance with bed mobility and supervision with eating. Resident #55 was reported to take anti psychotics and anti depressants. Review of the monthly physician order sheets for January 2020 and February 2020 revealed the consultant pharmacist signed indicating resident medications were reviewed but did not indicate the presence or absence of irregularities noted to the resident's medication regimen. 3. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE] with the following diagnoses; [MEDICAL CONDITIONS] and [MEDICAL CONDITION] disease. Review of the MDS dated [DATE] revealed the resident had severe cognitive impairment and required extensive assistance with transfers and bed mobility. Resident #60 also required total dependence with dressing, eating, toileting and personal hygiene. Resident #60 was reported to take antipsychotics, anti-anxiety, anti-coagulants, antibiotics and opioids. Review of the monthly physician order sheets for January 2020, February 2020 and March 2020 revealed the consultant pharmacist signed indicating resident medications had been reviewed but did not indicate the presence or absence of irregularities noted to the resident's medication regimen. 4. Review of the medical record revealed Resident #110 was admitted on [DATE]. [DIAGNOSES REDACTED]. Review of the MDS dated [DATE] revealed the resident was cognitively intact. The resident was totally dependent on staff for transfers with the use of a mechanical lift at all times. Further review of the medical record revealed the pharmacist reviewed the record monthly but there was no way to determine if there was a recommendation or no irregularities. Interview with the Director of Nursing (DON) on 03/04/20 at 11:00 A.M. confirmed the consultant pharmacist signed the residents monthly physician orders upon review but did not include documentation regarding the presence or absence of irregularities noted to the resident's medication regimen. Review of facility policy entitled Drug Regimen Review dated 03/31/09 revealed the drug regimen of each resident should be reviewed at least once a month by a licensed pharmacist and irregularities should be reported to the attending physician and the DON.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of online resources and Food and Drug Administration (FDA) black box warning the facility failed to ensure as needed (PRN) [MEDICAL CONDITION] medication orders were limited to 14 days or that a rationale and duration of the PRN [MEDICAL CONDITION] medication was indicated in the medical record. The facility also failed to ensure a resident's antipsychotic medication had appropriate indications for use. This affected three residents (#59, #60 and #133) of five reviewed for unnecessary medications. The facility census was 151. Findings include: 1. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment and required extensive assistance with transfers and bed mobility. Resident #60 also required total dependence with dressing, eating, toileting and personal hygiene. Resident #60 was reported to take antipsychotics, anti-anxiety, anti-coagulants, antibiotics and opioids. Review of physician orders [REDACTED]. Physician order [REDACTED]. Further review revealed the [MEDICATION NAME] was discontinued on 12/10/19, the [MEDICATION NAME] injection was discontinued on 02/07/20 and the [MEDICATION NAME] by mouth was discontinued on 02/12/20. Resident #60's PRN orders did not have stop dates. Resident #60's physicians orders did not indicate a rationale for the continued use of the resident's PRN orders. Review of Resident #60's physician's notes dated 10/29/19, 10/30/19, 11/05/19, 11/07/19, 12/11/19, 12/18/19, 12/19/19, 01/17/20, 01/24/20 and 02/04/20 revealed no documentation regarding a rationale for the continued use of Resident #60's PRN medications. Interview with the Director of Nursing (DON) on 03/05/20 at 12:25 P.M. verified Resident #60's PRN intramuscular and by mouth [MEDICATION NAME], and PRN [MEDICATION NAME] did not have a rationale for exceeding 14 days. The DON also verified the medications exceeded 14 days and did not have stop dates until they were discontinued. 2. Review of the medical record revealed Resident #133 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the MDS dated [DATE] revealed the resident had severe cognitive impairment and required extensive assistance with transfers, bed mobility, dressing, toileting and personal hygiene. Resident #133 also required supervision with eating. Review of physician orders [REDACTED]. Resident #133's orders did not contain a rationale for the continued use of the resident's PRN [MEDICATION NAME]. Review of Resident #133's physician notes dated 06/24/19, 07/03/19, 08/27/19, 09/23/19, 09/26/19, 10/01/19, 10/29/19, 11/10/19, 11/19/19, 12/06/19, 01/07/20, 01/30/20, 02/05/20, 02/14/20, 02/25/20 and 03/03/20 revealed no rational was provided for the continued use of the resident's PRN [MEDICATION NAME]. Interview with the DON on 03/05/20 at 12:25 P.M. verified Resident #133's medical record did not contain any rationale for the continued use of his PRN [MEDICATION NAME]. 3. Review of the medical record revealed Resident #59 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the modified MDS dated [DATE] revealed the resident was cognitively impaired and required extensive assistance with activities of daily living. Review of the care plan dated 06/18/19 revealed the resident was at risk for fluctuations in mood and behavior due to [DIAGNOSES REDACTED]. Interventions included to encourage to participate in group activities, monitor for signs and symptoms of depression, one on one visit as needed, psychiatric consult as needed, medications as ordered, monitor effectiveness, monitor behaviors. Review of the nurse practitioner progress note dated 10/28/19 revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366351	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OHIO VETERANS HOME - GEORGETOWN	2003 VETERANS BLVD GEORGETOWN, OH 45121

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 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) antipsychotic medication, [MEDICATION NAME] was ordered 12.5 milligrams (mg) for depression with delusional behaviors. Review of the consent form dated 10/28/19 revealed it was signed by the resident's representative and the nurse practitioner and indicated the resident was receiving [MEDICATION NAME] for treatment of [REDACTED]. Review of the nurse progress note dated 10/30/19 revealed the resident received [MEDICATION NAME] to treat depression. Review of consultant pharmacist report dated 11/09/19 and 02/04/20 revealed the resident was on three medications, [MEDICATION NAME], and [MEDICATION NAME], and the recommendation was for [MEDICATION NAME] be discontinued. The reports did not include a recommendation regarding the use of [MEDICATION NAME]. Review of nurse progress note dated 11/17/19 revealed the [MEDICATION NAME] dose was increased to 25 mg to treat depression with delusions as evidenced by resident calling out and resisting care. Review of the psychiatric consult note dated 11/20/19 revealed the resident was receiving [MEDICATION NAME] for treatment of [REDACTED]. Review of the facility quarterly antipsychotic medication assessment dated [DATE] revealed the resident received [MEDICATION NAME] for treatment of [REDACTED]. Interview on 03/04/20 at 10:38 A.M. with Social Worker (SW) #182 confirmed Resident #59 received [MEDICATION NAME] since 10/28/19 for treatment of [REDACTED].M. with the DON confirmed Resident #59 received routine [MEDICATION NAME] since 10/28/19 for treatment of [REDACTED]. Review of the online resource, The Beers Criteria for Potentially Inappropriate Medication Use in Older Adults at http://www.healthinaging.org/medications-older-adults/ revealed use of [MEDICATION NAME] could increase the risk of stroke or even death in older adults with dementia and could also cause tremors and other side effects, as well as increase the risk of falls. Review of the Food and Drug Administration (FDA) black box warning regarding [MEDICATION NAME] https://www.fda.gov/media/ revealed [MEDICATION NAME] could cause increased risk of death in elderly resident with dementia and was not appropriate for treatment of [REDACTED].
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** Based on medical record review, observation, staff interview, review of facility policy, and review of online resources the facility failed to ensure cardiac medication was administered in a safe manner as ordered by the physician. This affected one (Resident #135) of six residents observed for medication administration. The census was 151. Findings include: Review of the medical record revealed Resident #135 was admitted on [DATE] with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed the resident was cognitively intact and required extensive assistance of one staff with activities of daily living. Review of March 2020 physician orders [REDACTED]. Observation of medication administration on 03/04/20 at 9:25 A.M. for Resident #135 per Licensed Practical Nurse (LPN) #123 revealed the nurse crushed the [MEDICATION NAME] ER tablet and gave it in in pudding to the resident. Interview at the time of the observation with LPN #123 confirmed she crushed [MEDICATION NAME] ER for Resident #135 prior to administration and gave it to the resident mixed with pudding. Review of a nurse progress note dated 03/04/20 at 2:30 P.M. revealed the nurse notified the resident's physician the [MEDICATION NAME] ER had been crushed and administered to the resident. Further review of the note revealed the physician confirmed the [MEDICATION NAME] should not be crushed and gave an order to monitor the resident and call back if any adverse effects were noted related to the administration. Review of online resource https://www.ismp.org/recommendations/do-not-crush of the Institute for Safe Medication Practices revealed [MEDICATION NAME] should not be crushed because it was supposed to be released slowly. Review of Medscape online resource revealed [MEDICATION NAME] tablets should not be crushed. Review of facility policy titled Medication Administration dated 07/08/19 revealed nurses would be responsible for being knowledgeable about the method of preparation and administration of medications and medications should be administered in a safe manner in accordance with any special precautions related to medication administration of specific medications.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and review of facility policy and manufacturer recommendation the facility failed to properly store resident medications and failed to discard expired medications. This directly affected Residents #90 and #404 and had the potential to affect all residents. The census was 151. Findings include: 1. Review of the medical record revealed Resident #90 was admitted on [DATE] with a [DIAGNOSES REDACTED].M. with Licensed Practical Nurse (LPN) # 92 revealed two bottles of [MEDICATION NAME] sulfate with Resident #90's name on them had an expiration date of 02/29/20. Interview with LPN #92 at the time of the observation confirmed the two bottles of [MEDICATION NAME] sulfate for Resident #90 were expired and should have been discarded. Review of facility policy dated 10/02/14 titled Medication Storage reveled medications were not to be kept after the expiration date, and outdated medications should be immediately removed from stock. 2. Observation of the A1 blue cart on 03/05/20 at 8:15 A.M. with LPN #200 revealed the cart contained an unlabeled plastic cup with three loose pills stored in the top drawer. Interview with LPN #200 at the time of the observation confirmed she did not know who had placed the three loose pills in the cart, what medications they were and if they were intended for a specific resident. Review of facility policy dated 10/02/14 titled Medication Storage revealed medications were to be kept and stored in the containers in which they were received from the dispensing pharmacy until administration. 3. Review of the medical record revealed Resident #404 was admitted on [DATE] with a [DIAGNOSES REDACTED].#404 revealed an order for [REDACTED].M. with LPN #66 revealed an open undated Ozempic pen for Resident #404 was stored in the refrigerator. Interview with LPN #66 at the time of the observation confirmed Ozempic pen for Resident #404 was opened and undated and she was not sure when it should be discarded. Review of manufacturer's recommendations for Ozempic revealed the medication should be discarded 56 days after opening. Review of facility policy titled Medication Storage dated 10/02/14 revealed multi dose vials of injectable medication should be dated at the time of opening.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, interview, review of dining spreadsheets, review of list of residents receiving pureed meals and review of facility policy the facility failed to ensure the portion sizes reflected in the menu spreadsheet were followed to ensure residents received adequate nutrition. This affected seven residents (#36, #60, #98, #99, #101, #133 and #143) of a total census of 151. Findings include: Review of the dining spreadsheet for lunch for 03/03/20 revealed residents pureed diets were to receive 4 ounces (oz) of pureed chicken Alfredo, 4 oz of pureed fettuccine, 5 oz of pureed broccoli, 4 oz of pureed peaches and 2 oz of pureed garlic bread. Observation of the tray line in the A1 unit kitchenette on 03/03/20 at 11:54 A.M. revealed Food Service Worker #134 prepared a tray for Resident #101. Resident #101 received a regular pureed diet. Food Service Worker #134 was observed to give Resident #101 4 oz of pureed chicken Alfredo, 3 oz of pureed fettuccine, 5 oz of pureed broccoli, 4 oz of pureed peaches and 2 oz of pureed garlic bread. Interview with Food Service Worker #134 at the time of the observation verified giving all pureed diets including Resident #101 only 3 oz of pureed fettuccine. Review of an undated list of residents receiving pureed diets on the A1 unit revealed Resident #36, #60, #98, #99, #101, #133 and #143 were to receive pureed diets. Review of the facility's undated Portion Control policy revealed serving too small of portions results in the resident not receiving the nutrients needed.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on medical record review, observation, interview, review of residents diets and review of facility policy, the facility failed to ensure food items on the C2 unit were kept at a safe temperature during food service. The facility also failed to ensure staff utilized sanitary practices when handling a resident's food items. This had the potential to affect 40 Residents (#9, #10, #13, #14, #17, #20, #29, #35, #39, #40, #42, #45, #47, #49, #53, #61, #64, #67, #70, #76, #80, #85,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366351	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OHIO VETERANS HOME - GEORGETOWN	**2003 VETERANS BLVD GEORGETOWN, OH 45121**

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) #87, #94, #96, #100, #109, #110, #112, #115, #117, #124, #128, #130, #134, #135, #138, #139, #148 and #254) out of 151 residents residing in the facility. The facility census was 151. Findings include: 1. Review of the medical record revealed Resident #138 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Sets ((MDS) dated [DATE] revealed the resident had severe cognitive impairment and required extensive assistance with transfers, bed mobility, dressing, toileting and eating. Resident #138 also required total dependence with personal hygiene. Review of Resident #138's diet revealed the resident was to receive finger foods. Observation on 03/04/20 at 5:14 P.M. revealed Resident #138 was sitting in the A1 unit dining room for dinner. Hospital Aide #133 was observed sitting next to Resident #138 and was placing food items off his plate into his hands with her bare hands. Hospital Aide #133 was not wearing gloves. Interview with Licensed Practical Nurse (LPN) #144 at the time of the observation verified Hospital Aide #133 was placing food items in Resident #138's hand without wearing gloves. 2. Observation of the tray line in the C2 unit kitchenette on 03/03/20 at 12:45 P.M. revealed Food Service Worker #148 was serving food items from the steam table. Food Service Worker #148 took the temperature of the food items on the steam table in the middle of food service. The noodles were 150 degrees Fahrenheit (F), the chicken Alfredo was 138 degrees F, the broccoli was 121 degrees F, the pureed chicken Alfredo was 120 degrees F, the pureed broccoli was 125 degrees F and the pureed noodles were 110 degrees F. Interview with Food Service Worker #148 at the time of the observation verified the broccoli, pureed chicken Alfredo, pureed broccoli and pureed noodles were not above 135 degrees F. Review of a list of diets dated 03/04/20 for the C2 unit revealed Residents #9, #10, #13, #14, #17, #20, #29, #35, #39, #40, #42, #45, #47, #49, #53, #61, #64, #67, #70, #76, #80, #85, #87, #94, #96, #100, #109, #110, #112, #115, #117, #124, #128, #130, #134, #135, #138, #139, #148 and #254 received regular, mechanical soft and pureed diets. Review of the facility's undated Food Temperatures policy revealed hot food items may not fall below 135 degrees F after cooking.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on review of infection control surveillance documents, staff interview review of facility policy the facility failed to maintain an infection prevention and control program that monitored monthly infection control trends. This had the potential to affect all 151 facility residents. Findings include: Review of the infection control surveillance documents revealed there was no evidence of monthly tracking of infection control trends. Interview with Registered Nurse (RN) #131 on 03/05/20 at 11:20 A.M. revealed she was in charge of the infection control program and she verified the facility did not have monthly surveillance of infection control trends including lists of organisms and infections and the location of the residents with the infections. Review of the facility policy titled Infection Prevention Program dated 10/01/19 revealed the surveillance process consists of documenting data on the infection surveillance form and the data is aggregated monthly quarterly and annually and compared monthly quarterly and annually.