STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366433	A. BUILDING _____ B. WING _____	10/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLEVIEW COUNTRY VILLA	775 SOUTH STREET CHARDON, OH 44024

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	**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 interview, record review and review of facility policy, the facility failed to have Resident #103's as needed antipsychotic medication limited to fourteen days or have Resident #103 evaluated by the physician and a new order written within 14 days. This affected one resident (Resident #103) of four residents reviewed for unnecessary medications. The facility census was 83. Findings included: Review of closed medical record for Resident #103 revealed an admission date of [DATE] and a discharge date of [DATE]. Her [DIAGNOSES REDACTED]. Review of admission physician orders [REDACTED].#103 revealed she was admitted with an order for [REDACTED].#103 dated 12/27/19 revealed she required the use of [MEDICAL CONDITION] medications with the potential for adverse reactions related to behaviors associated with dementia/Alzheimer's, [MEDICAL CONDITION] and anxiety. Interventions included monitor for adverse reactions of psychoactive medications that can include unsteady gait, frequent falls, blurred vision, dry mouth, fatigue and weight loss. Review of Pharmacy Consultant #902's pharmacy recommendation dated 12/28/19 for Resident #103 revealed she had an order for [REDACTED].#902's pharmacy recommendation revealed Resident #103's Primary Care Physician #903 signed the pharmacy recommendation on 12/30/20 and noted on the recommendation to continue the medication due to anxiety, restlessness and agitation. The physician revealed he would re-evaluate within 30 days. Review of Medication Administration Record [REDACTED].M., 12/28/19 at 8:14 P.M., 12/31/19 at 3:36 A.M. and on 12/31/19 at 7:44 P.M. Review of MAR for January 2020 revealed Resident #103 received [MEDICATION NAME] tablet 2.5 mg as needed on 01/01/20 at 7:45 P.M., 01/03/20 at 8:20 P.M., 01/07/20 at 6:30 P.M., 01/10/20 at 8:06 P.M., 01/11/20 at 6:53 P.M., 01/12/20 at 8:20 P.M., 01/15/20 at 2:18 P.M. 01/16/20 at 8:00 P.M. and on 01/21/20 at 8:03 P.M. Review of Medicare five-day Minimum Data Set 3.0 dated 01/03/20 revealed Resident #103 had impaired cognition. She had received antipsychotics on a routine basis. Review of Pharmacy Consultant #901 pharmacy recommendation dated 01/17/20 revealed she recommended to have the physician review Resident #103's as needed use of [MEDICATION NAME] as it was an antipsychotic that was limited to be used only for 14 days. She recommended if the physician believed that the [MEDICATION NAME] was appropriate for as needed use then the prescriber would have to evaluate Resident #103 and a new order would need to be written every 14 days. Review of Psychiatric Nurse Practitioner #900 progress note dated 01/22/20 revealed Resident #103 had persistent [MEDICAL CONDITION] and probable major neurocognitive disorder due to [MEDICAL CONDITION]. She recommended to discontinue the [MEDICATION NAME] 2.5 mg tablet by mouth every eight hours as needed. Review of physician order [REDACTED].#900 dated 01/22/20 revealed Resident #103's [MEDICATION NAME] as needed was discontinued. Interview on 09/30/20 at 2:05 P.M. with the Director of Nursing verified Resident #103's [MEDICATION NAME] 2.5 mg tablet as needed was ordered on admission on 12/27/19 and Resident #103's Primary Care Physician #903 did re-evaluate on 12/30/19 the use of her as needed [MEDICATION NAME] but did not have a 14 day stop date. The Director of Nursing verified the resident's [MEDICATION NAME] as needed continued until 01/22/20 without being re-evaluated and without a new order for the as needed [MEDICATION NAME]. Review of facility policy labeled, Chemical Restraint Use dated 11/13/19 revealed residents who are admitted from the community or transferred from a hospital and who are already receiving [MEDICAL CONDITION] medication will be evaluated for the appropriateness and indication for use. The policy revealed residents do not receive [MEDICAL CONDITION] medications as needed unless the resident had a diagnosed specific condition for the use of the medication was documented in the record. The policy also revealed as needed MEDICATION ORDERS FOR [REDACTED]. This deficiency substantiates Master Complaint Number OH 160 and Complaint Number OH 344.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility policy, the facility did not ensure Resident #100's medical record contained complete and accurate information regarding Resident #100's fall and documentation of notification to the facility she was transferring to. Resident #100 was discharged without regard to her fall and physician recommendation for neurological monitoring to continue. This affected one resident (Resident #100) of three residents reviewed for documentation and falls. The facility census was 83. Findings included: Review of Resident #100's medical record revealed an admission date of [DATE] and a discharge date of [DATE]. Her [DIAGNOSES REDACTED]. Review of facility incident report form labeled #2151 Fall dated 09/15/19 at 2:30 P.M. completed per Registered Nurse (RN)/Wound Nurse #612 revealed a State tested Nursing Assistant (STNA) called her to Resident #100's room. Resident #100 was observed lying on the floor on her left side with right arm under her body. Resident #100 was previously sitting in her wheelchair eating her lunch. She had a skin tear to the back of her hand and complained of no pain. Neurological checks were completed and were within normal limits. The incident report revealed frequent observations were completed prior to Resident #100's transfer to the independent living center. The incident report revealed Primary Care Physician #903 was notified on 09/15/19 at 2:45 P.M., and the family was notified on 09/15/19 at 2:45 P.M. There was no documentation the independent living center was notified of Resident #100's fall or that the family or independent living center was notified that the physician recommended neurological checks to continue. The form noted that the form was not part of the medical record. Review of nursing notes for Resident #100 revealed no documentation regarding a fall on 09/15/19. Review of nursing note dated 09/15/19 at 3:54 P.M. for Resident #100 per RN #800 revealed she reviewed the discharge instructions with the resident and family. Resident #100 was discharged to an independent living center. She revealed the patient and family had no complaints or concerns, and she assisted the patient to the car. Review of facility form labeled, Discharge Summary- V3 dated 09/15/19 revealed Resident #100 was discharged to an independent living facility. The discharge summary included the summary of the stay as Resident #100 was admitted for skilled nursing aftercare following total hip replacement and received therapy. The discharge summary was signed by Resident #100's responsible party on 09/15/19. The discharge summary did not contain any information regarding Resident #100's fall that had occurred on 09/15/19 prior to discharge and the physician recommendation to continue neurological checks. Interview on 09/22/20 at 2:29 P.M. with RN/Wound Nurse #612 revealed she was the RN supervisor on duty on 09/15/19. She revealed Licensed Practical Nurse (LPN) #801 was Resident #100's nurse when Resident #100 fell . RN/Wound Nurse #612 revealed she was called to Resident #100's room because she fell from her

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.

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) wheelchair. She revealed LPN #801 completed neurological checks that were within normal limits and assessed Resident #100. RN/Wound Nurse #612 revealed she filled out the incident report, and notified the family and physician regarding Resident #100's fall. She revealed the physician was still in agreement that Resident #100 could be discharged to the independent living center but recommended the neurological checks to continue since the fall was unwitnessed. She revealed she had instructed LPN #801 to notify the independent living facility regarding her fall and continued neurological monitoring but was unaware if she did. She revealed after any unwitnessed fall the resident is placed on neurological checks. Interview on 09/29/20 at 10:05 A.M. with the Director of Nursing revealed they did not have a policy on nursing documentation. The Director of Nursing verified there was no documentation in Resident #100's medical record regarding her fall on 09/15/19 or any documentation that the independent living center was notified regarding her fall and the physician recommendation to continue neurological checks. The Director of Nursing verified the Discharge Summary for Resident #100 that was sent to the independent living facility and with the family that there was no documentation regarding Resident #100's fall and recommendation for neurologic checks to continue. Interview on 09/29/20 at 2:38 P.M. with LPN #801 who was previously employed by the facility verified she was the nurse on duty for Resident #100 on 09/15/19 when Resident #100 fell . She revealed that it was so long ago she honestly can not say if she notified the independent living prior to discharge of Resident #100's fall and physician recommendations that neurological monitoring was to continue. She revealed she did notify the family prior to discharge. LPN #801 verified this should have been documented in Resident #100's medical record. Review of facility policy titled, Falls-Clinical Protocol dated 11/13/19 revealed the staff will document falls that occur while the individual is in the facility and should be identified as witnessed or unwitnessed. This deficiency substantiates Complaint Number OH 588.