STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366469	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIENA GARDENS REHABILITATION & TRANSITIONAL CARE	1055 STATE ROUTE 125 CINCINNATI, OH 45245

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	**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, staff interview, review of medication error reports and review of facility policy, the facility failed administer resident's medications as physician ordered. This affected four (#1, #2, #4 and #6) out of five residents reviewed for medication administration. The facility census was 76. Findings include: 1. Review of the medical record for Resident #6 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED].#6 dated 03/22/20 revealed resident was cognitively impaired and required extensive assistance of two staff with activities of daily living (ADLs). Review of physician orders [REDACTED]. Review of the nurse progress note for Resident #6 dated 05/11/20 timed at 7:50 A.M. revealed resident's blood sugar was 29 and nurse attempted to administer glucose gel solution by mouth but resident spit it out and was not able to swallow. Resident #6's blood sugar was rechecked at 8:00 A.M. and was 41 and was checked again at 8:05 A.M. and was 40. Nurse called 911 and resident was sent to the hospital. Review of the Medication Administration Record [REDACTED]. Review of the hospital note for Resident #6 dated 05/11/20 revealed the resident arrived in the emergency room at 8:36 A.M. and the emergency personnel reported the resident's blood sugar was 42 when they picked resident up from the facility. Further review of the hospital note revealed the resident's blood sugar was checked frequently while at the hospital and ranged from 113 to 347. Review of the note revealed the resident was sent back to the facility on [DATE] after her blood sugar had stabilized. Interview on 06/22/20 at 4:28 P.M. with Registered Nurse (RN) #600 confirmed she had been Resident #6's nurse on 05/11/20 and had checked resident's blood sugar at 7:50 A.M. at 29, at 8:00 A.M. at 41, and at 8:05 A.M. at 42. RN #600 confirmed she attempted to care for resident's [DIAGNOSES REDACTED] by administering oral glucose gel, but resident couldn't swallow so it was ineffective. RN #600 confirmed she was aware Resident #6 had a physician's orders [REDACTED]. RN #600 confirmed the [MEDICATION NAME] was not available in the facility and if [MEDICATION NAME] injection had been available, she would have administered it as she felt it would have been effective at stabilizing the resident's blood sugar. 2. Review of the medical record for Resident #2 revealed an admission date of [DATE] and a [DIAGNOSES REDACTED].#2 dated 05/18/20 revealed resident was cognitively impaired and required extensive assistance of two staff with ADLs. Review of the May 2020 physician orders [REDACTED].#2 dated 05/26/20 revealed resident was at risk for hypo/[MEDICAL CONDITION] episodes related to insulin dependent diabetes mellitus. Interventions included the following: monitor blood sugar levels as ordered, monitor for signs and symptoms of [DIAGNOSES REDACTED], treat hypo/[MEDICAL CONDITION] episodes as ordered Review of the nurse progress note for Resident #2 dated 05/26/20 timed at 3:00 P.M. revealed. resident was noted to be minimally responsive with a blood sugar of 46. Further review of the note revealed the nurse attempted to obtain [MEDICATION NAME] to administer by injection to treat the resident's [DIAGNOSES REDACTED], but it was not available, and resident was sent to the emergency room via 911. Review of the nurse progress note for Resident #2 dated 05/26/20 timed at 8:36 P.M. revealed the resident had been admitted to the hospital with [REDACTED]. Review of hospital record for Resident #2 dated 05/26/20 revealed resident arrived at the emergency room with altered mental status and blood sugars in the 30's. Further review of the hospital record revealed the resident was given [MEDICATION NAME] (sugar) intravenously in the emergency room and his blood sugar returned to the normal range. Review of the record revealed resident was admitted with a [DIAGNOSES REDACTED].M. with the Director of Nursing (DON) confirmed [MEDICATION NAME] was not available for administration to Resident #6 on 05/11/20 nor for Resident #2 on 05/26/20. Review of facility policy titled [DIAGNOSES REDACTED] dated April 2015 revealed if a resident's blood glucose level was less than 70 milligrams per deciliter and the resident was unable to swallow and/or was unresponsive staff should administer [MEDICATION NAME] via intramuscular injection when ordered. 3. Review of the medical record for Resident #1 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #1 dated 05/20/20 revealed resident was cognitively intact and required supervision with activities of daily living. Review of nurse progress note for Resident #1 dated 06/11/20 revealed the resident reported the night shift nurse had given her something to drink earlier for her potassium and she only took a few drinks because it tasted like sand and resident didn't think there was anything wrong with her potassium levels. Review of facility medication error report dated 06/11/20 revealed Licensed Practical Nurse (LPN) #700 had administered Kayexelate (a medication to treat high potassium levels) to Resident #1, but resident did not have a physician's orders [REDACTED]. Interview on 06/22/20 at 2:30 P.M. with the Administrator confirmed Resident #1 received Kayexelate per LPN #700 on 06/11/20, but the medication was supposed to be administered to Resident #4. 4. Review of the medical record for Resident #4 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED].#4 dated 04/14/20 revealed resident was cognitively impaired and required extensive assistance of one staff with ADLs. Review of care plan for Resident #4 dated 01/20/20 revealed resident had impaired cardiac function related to [MEDICAL CONDITION], hypertension, and [MEDICAL CONDITION]. Interventions included the following: medications as ordered, monitor for side effects of cardiac medications. Review of lab results for Resident #4 dated 06/10/20 revealed resident's potassium level was 5.6 which was elevated with a normal range being 3.5-5.3. Review of nurse progress note for Resident #4 dated 06/11/20 per LPN #300 revealed nurse received a physician's orders [REDACTED]. Further review of Medication Administration Record [REDACTED]. Review of nurse progress note for Resident #4 dated 06/15/20 per LPN #300 revealed order for Kayexelate was discontinued. Interview on 06/23/20 at 9:16 A.M. with the Director of Nursing (DON) confirmed LPN #700 had administered Kayexelate to Resident #1 without a physician's orders [REDACTED]. Review of the facility medication error log for June 2020 revealed only one error in which Resident #1 was administered Kayexelate per LPN #700 without a physician's orders [REDACTED]. This deficiency substantiates Complaint Number OH 378.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, review of facility policy, and review of online resources, the facility staff failed to appropriately use facemask's at the facility entrance when screening employees and essential visitors and while moving throughout the resident care area in order to prevent the potential transmission of Coronavirus Disease 2019 (COVID-19). This had the potential to affect all 76 residents residing in the facility. Additionally, the facility staff failed to appropriately disinfect glucometers between resident use which had the potential to affect Residents #2 and #59, two facility-identified insulin-dependent diabetics residing on the 500 Hall. Additionally, the facility failed to use appropriate infection control measures during medication administration which had the potential to affect Resident #72. The census was 76. Findings include: 1. Observation on 06/16/20 at 10:30 A.M. revealed State tested Nursing Assistant (STNA) #100 screened a visiting x-ray technician at the front desk prior to permitting admittance to the facility. STNA #100 was at less than six feet from the visitor while she asked questions regarding possible signs and symptoms of COVID-19 and took the visitor's body temperature. STNA #100 was wearing a facemask which was pulled down below

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) her nose. Observation on 06/16/20 at 10:35 A.M. revealed STNA #100 attempted to take surveyor's body temperature and did not pull her facemask up over her nose until requested to do so by the surveyor. Interview on 06/16/20 at 10:40 A.M. with STNA #100 confirmed she had screened the visiting x-ray technician with her facemask exposing her nose. Observation on 06/16/20 at 10:43 A.M. of Medical Records Clerk #200 revealed she was talking to Resident #58 in the common area of the facility, and they were within six feet of one another. Both Medical Records Clerk #200 and Resident #58 were wearing facemask's but both individuals had their masks pulled down exposing their noses and mouths. Interview on 06/16/20 at 10:45 A.M. with Medical Records Clerk #200 confirmed her facemask was pulled down exposing her nose and mouth while conversing with Resident #58. Medical Records Clerk #200 further confirmed she and Resident #58 were within six feet of one another and the resident's mask was also pulled down exposing his nose and mouth. Interview on 06/16/20 at 10:48 A.M. with the Administrator confirmed facemask's should be worn inside the facility especially when coming into contact with other persons and should cover the nose, mouth, and chin. The facility confirmed this had the potential to affect all residents residing in the facility. Review of facility policy titled Novel Coronavirus Prevention and Response dated 04/09/20 revealed the facility would educate the staff on the proper use of personal protective equipment (PPE) and would implement staff wearing of facemask's in accordance with local, state, and national directives. 2. Observation of medication administration on 06/16/20 at 11:07 A.M. with Licensed Practical Nurse (LPN) #300 revealed nurse cleaned glucometer following a blood sugar check for Resident #59 using an alcohol pad. Interview on 06/16/20 at 11:08 A.M. with LPN #300 confirmed she usually used a disinfectant wipe to clean glucometers, but she didn't have any available on her cart. LPN #300 confirmed the glucometer was used for two residents on the 500 Hall, Residents #2 and #59. Interview on 06/23/20 at 9:16 A.M. with the Director of Nursing (DON) confirmed nurses should clean glucometers with disinfectant wipes and an alcohol pad was not effective for properly cleaning glucometers. Review of facility policy titled Glucometer Cleaning dated April 2015 revealed glucometers should be cleaned after each use with an approved disinfectant wipe. Review of online resource shared per facility https://www.cloroxpro.com/products/Clorox/Clorox-disinfecting-wipes/ on 06/22/20 revealed wipes were appropriate for use on nonporous hard surfaces and for proper disinfection to wipe the surface so it would remain visibly wet for four minutes. Further review of the directions revealed the surface should be allowed to air dry after disinfectant wipe was used and wipes were effective in killing a wide variety of bacteria [MEDICAL CONDITION] including human immunodeficiency virus ,[MEDICAL CONDITION]. and coronavirus. 3. Review of record for Resident #72 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED].M. of medication administration per LPN #400 revealed nurse sanitized her hands, opened the medication cart, unlocked the narcotic drawer, and attempted to obtain a dose of [MEDICATION NAME] for Resident #72. The [MEDICATION NAME] tablet fell into the bottom of the narcotic drawer adjacent to other resident's narcotic medication cards. LPN #400 retrieved the [MEDICATION NAME] tablet with her bare hands, placed it in plastic cup, locked the narcotic drawer and the medication cart, and walked to the Resident #72's room to administer the [MEDICATION NAME]. The surveyor interviewed LPN #400 on 06/16/20 at 11:44 A.M. and asked LPN #400 regarding the potential administration of a dose of [MEDICATION NAME] which had been touched with bare hands and had fallen into the narcotic drawer. Interview on 06/16/20 at 11:44 A.M. with LPN #400 confirmed if surveyor had not interviewed/asked her about the [MEDICATION NAME] tablet, she would have administered the dose of [MEDICATION NAME] to Resident #72. Interview on 06/23/20 at 9:16 A.M. with the Director of Nursing (DON) confirmed nurses should not touch resident medication with their bare hands and if a medication falls on the ground or another surface during retrieval it should be wasted and not administered to a resident. Review of facility policy titled Medication Administration dated 06/21/17 revealed the nurse should never touch the resident's medication with their fingers.