STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365770	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE CARE AND REHABILITATION	1471 WILLS CREEK VALLEY DRIVE CAMBRIDGE, OH 43725

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to maintain sufficient nursing staff to ensure medications were administered timely and to ensure all residents received adequate and timely care. This affected nine residents (#1, #3, #11, #23, #34, #41, #50, #51 and #67) and had the potential to affect all 75 residents residing in the facility. Findings include: 1. Observation of medication administration on 03/10/20 revealed the nurses were unable to complete the medication administration within the two hour window of the scheduled medication time. Observation of medication administration revealed there were five timing errors in 28 opportunities for a 17.86% medication error rate (See findings under F759). Interview on 03/10/20 at 9:29 A.M. with Licensed Practical Nurse (LPN) #84 verified medications were not administered timely within the one hour time frame before and after the hour scheduled. LPN #84 revealed she started to pass medication at 6:30 A.M. but was unable to administer medications to the 49 residents on the South side by 9:00 A.M. LPN #84 included it takes until 10:00 A.M. or after if nothing goes wrong, LPN #84 revealed at this time she still had Resident #1 and #67's 8:00 A.M. medications to administer at the time of the interview. Interview on 03/10/20 at 9:33 A.M. with Registered Nurse (RN) #87 revealed she still needed to pass 8:00 A.M. medication to Resident #3 and #50. RN #87 revealed she never gets finished by 9:00 A.M. RN #87 revealed she started her medication administration at 6:00 A.M. and usually finished at 10:00 A.M. if nothing happens. RN #87 revealed there was nothing out of the ordinary that happened on this date and it would be 10:00 A.M. before she finished. RN #87 revealed there were a lot of order changes, retrieving and ordering of medications, labs, therapy interruptions with skilled residents, and appointments that create delays. Weekends were even worse. It was rough because there was no one extra around to help. Interview on 03/10/20 at 1:25 P.M. with the Administrator verified medications were not administered in the required time frame. 2. During the onsite complaint survey on 03/09/20 and 03/10/20 interviews with five residents, Resident #11, #23, #34, #41 and #51 revealed concerns related to staffing. The residents all indicated they thought the facility could use more staff to assist residents. An interview on 03/09/20 at 3:56 P.M. with Resident #34 revealed the resident was aware she was supposed to wait for staff to help to transfer but she was impatient and had fallen because she doesn't want to wait. She indicated she was a transfer assist of two staff but there were usually only two State tested nursing assistants (STNAs) working for the whole floor at times. Review of Resident #34's record revealed the resident sustained [REDACTED]. 3. Interview with STNA #80, #81, #83 and #85, LPN #84 and #86, RN #87 and Activities #82 on 03/09/20 between 12:47 P.M. and 3:56 P.M. revealed concerns related to facility staffing. The staff interviewed revealed there were times the South Hall had worked with one STNA at least part of the shift for over 35 residents on dayshift. The staff revealed work would get pushed to the next shift, like bathes and showers. Interview on 03/09/20 at 3:22 P.M. with LPN #84 revealed on the 6:00 A.M. to 6:00 P.M. shift staff were busy all the time. Medication pass for high 40's to 50 plus residents was three times a day and was not able to be completed on time. Nurses were responsible to do their own treatments, answer the phone, speak with families, call the physician with laboratory test, address any new developments, transfer residents to appointments, therapy, the emergency room and complete documentation. For new admissions, day shift nurses typically are able to just start the process and the night shift staff were left most of the work. This deficiency substantiates Complaint Number OH 640.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review and interview the facility failed to maintain a medication error rate of less than five percent (%). The medication error rate was calculated to be 17.86% and included five medication errors of 28 medication administration opportunities. This affected one resident (#66) of four residents observed during medication administration. Findings include: On 03/10/20 at 9:23 A.M. Licensed Practical Nurse (LPN) #84 was observed administering medications to Resident #66. During the observation, the LPN obtained and prepared medications including [MEDICATION NAME] 7.5 milligrams (mg), [MEDICATION NAME] 5 mg, [MEDICATION NAME] 325 mg, [MEDICATION NAME] 0.25 mg and a Stool Softener 100 mg. The medications were administered to the resident at 9:27 A.M. Review of the resident's physician's orders [REDACTED].M. to Resident #66. Review of the facility undated Medication Administration policy revealed medications would be administered within 60 minutes before or after the facility's dosing schedule, except before or after meals orders and non routine time ordered medications. Interview on 03/10/20 at 9:29 A.M. with LPN #84 verified the medications were not administered timely within the one hour time frame before and after the hour scheduled for Resident #66. LPN #84 revealed she started to pass medication at 6:30 A.M. but was unable to administer medications to the 49 residents on the South side by 9:00 A.M. This deficiency substantiates Complaint Number OH 640.

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.