STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365525	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTERBURG RESPIRATORY & SPECIALTY REHAB CTR	212 FAIRVIEW AVENUE CENTERBURG, OH 43011

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 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were adequately monitored when taking antipsychotic medications. This affected one resident (Resident #35) of five residents reviewed for unnecessary medications. The facility census was 33. Findings Include: Review of the medical record for Resident #35 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/16/20, revealed Resident #35 had intact cognition and was on antipsychotic and antidepressant medications on a routine basis. Review of the plan of care dated 12/19/19 revealed Resident #35 was at risk for side effects of [MEDICAL CONDITION], antidepressant and antipsychotic medications. Interventions included assess for [MEDICAL CONDITION] drug related complications and report to physician. Review of physician orders for March 2020 revealed Resident #35 was ordered [MEDICATION NAME] (antipsychotic) 2 milligrams (mg) daily at bedtime, with start date of 10/08/19. Review of medication administration records (MAR) for February and March 2020 revealed Resident #35 received [MEDICATION NAME] 2 milligrams (mg) daily at bedtime. Review of the medical record revealed no documentation of an Abnormal Involuntary Movement Scale (AIMS assessment) or any documentation on monitoring involuntary movement. Interview on 03/04/20 at 2:30 P.M. with the Director of Nursing (DON) revealed any resident on an antipsychotic medication should have an AIMS assessment completed on admission, start of medication and quarterly. The DON verified Resident #35 did not receive an AIMS assessment quarterly. Review of the facility policy titled [MEDICAL CONDITION] Medication Documentation and Review, revised November 2015, revealed residents receiving antipsychotic drugs would be assessed quarterly for side effects using the AIMS assessment.
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 medical record review, observation, staff interview, and facility policy and procedure, the facility failed to properly label and store medications in the medication carts. This affected one resident (Resident #6) of two residents (Resident #6 and #13) who received [MED] on the south medication cart, and had the potential to affect Resident #35 who was ordered [MEDICATION NAME] tablets on the south center medication cart. The census was 33. Findings Include: 1. A review of Resident #6's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition and he required total dependence of one staff for all activities of daily living. The resident had physician orders [REDACTED]. A care plan dated [DATE] revealed the resident was dependent on [MED] for diabetes with interventions to administer medications per orders and treat hyper/[DIAGNOSES REDACTED] per protocol. An observation and interview on [DATE] at 8:00 A.M. with Registered Nurse (RN) #159 revealed a [MEDICATION NAME]pen and a [MED] [MED] vial without a resident name. Both [MED]'s had previously been used and were in Resident #6's cubby in the medication cart. RN #159 stated they often had to pull the resident's [MED] from the emergency medication kit when he was low on his prescription, so someone must not have put his name on the [MED]'s. An interview on [DATE] at 10:00 A.M. with the Director of Nursing (DON) revealed two residents had [MED] orders in the south medication cart, Resident #6 and Resident #13. A policy titled, Medication Storage and Labeling, dated February 2017, revealed [MED] pens were meant for single-resident use only. It further stated the [MED] pens must be clearly labeled with the resident's name to verify the correct pen was being used on the correct resident. 2. A review of Resident #35's medical record revealed an admission date of [DATE] and the [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition and she required total dependence of one staff for bed mobility, and limited assistance of one staff for transfers, dressing and locomotion. The resident had physician orders [REDACTED]. A care plan dated [DATE] revealed the resident had impaired cardiovascular status related to [MEDICAL CONDITION] with interventions to report chest pain, notify the physician of chest pain, and administer medications as ordered. An observation and interview on [DATE] at 8:05 A.M. with Registered Nurse (RN) #155 revealed Resident #35's [MEDICATION NAME] tablets had expired in [DATE]. RN #155 confirmed the above findings and immediately reordered the medication.

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