STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366041	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADDISON HEIGHTS HEALTH AND REHABILITATION CENTER	**3600 BUTZ RD MAUMEE, OH 43537**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the facility's notification of change policy, the facility failed to ensure timely notification to the family/representative when a resident change in cognition occurred. This deficient practice affected one (#1) of three residents reviewed for timely notification in a total facility census of 57. Findings include: Review of the record for Resident #1 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE], the resident was identified with a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognitive impairment, with the ability to make needs known. The resident had clear speech and was dependent on staff for bed mobility, transfer, dressing, toilet use, and personal hygiene. The assessment further indicated the resident required supervised set-up help with locomotion and eating. Review of the nurses notes dated [DATE] (no time), revealed the resident was confused with dilated pupils. The physician orders indicated to hold the 2:00 P.M., Benzodiazepine medication Klonopin, and obtain a drug toxicity laboratory blood test. There was no documentation in the medical record that indicated the family or the residents representative were notified. On [DATE], the nurses notes documented at 5:35 P.M., Licensed Practical Nurse (LPN) #101 assessed Resident #1 during hourly rounds and the residents respirations were 16 breaths per minute. The resident was sliding to the side of the bed and LPN #101 woke the resident to readjust and subsequently left the room. At 6:30 P.M., State tested Nursing Assistant (STNA) #202, reported to LPN #101, something was wrong with the resident. LPN #101 and STNA #202, ran to the room. LPN #101 instructed STNA #202 to get another nurse for assistance. At that time, STNA #203 came into the room and LPN #101 instructed STNA #203 to call 911. LPN #101 documented Cardiopulmonary Resuscitation (CPR) was performed until Emergency Medical Services (EMS) arrived. Further review of the nurses note dated [DATE] (no time), revealed LPN #102 was approached by EMS who indicated Resident #1's time of death was 7:16 P.M. LPN #102 (unit manager) notified the physician and was instructed to contact the coroner's office. LPN #102 informed Resident #1's responsible party of the residents death. Interview with LPN #102 on [DATE] at 4:10 P.M., revealed Resident #1 was acting strange on [DATE]. The nurse obtained a drug toxicology screen which was negative for medications other than the resident was prescribed. On [DATE], the physician ordered more laboratory testing. LPN #102 stated she last saw Resident #1 on [DATE] at 4:00 P.M., at which time he had normal respirations and opened his eyes to acknowledge. However, he was lethargic, which was not a normal symptom, and the laboratory tests were ordered immediately (STAT). LPN #102 verified the residents mother was his responsible party. On [DATE] at 7:22 A.M., interview with LPN #101 revealed she assumed Resident #1's care on [DATE]. At 2:00 P.M., LPN#101 went in to take the resident his 2:00 P.M. medication, [MEDICATION NAME]. The resident woke and began to attempt placing on shoes at the bedside, stating he was late for his mom as he was due to discharge home the next day. No negative assessment was identified except dilated pupils and mild confusion. At 4:30 P.M., LPN #101 communicated with the physician and asked to hold the Benzodiazepine medication Klonopin for one week. LPN #101 had been in the residents room and assisted with repositioning and was told by the resident he had been up the previous night and did not sleep well. The physician ordered the Klonopin to be held and to obtain a toxicology (tox) screen. LPN #101 stated the tox screen came back negative except for the medications the resident was prescribed. At 5:35 P.M., LPN #101 looked at the clock and looked in Resident #1's room during rounds. The resident was in bed with respirations and the head of bed elevated. No distress observed. LPN # 101 confirmed she last worked with the resident at 4:30 P.M., and the resident repositioned himself after a verbal prompt. Further interview revealed at 3:00 P.M., LPN #101 asked the physician to hold the medication Klonopin for a week due to the residents change in neurological status and the physician agreed. LPN #101 verified there was no documentation in the medical record that indicated the responsible party or emergency contact was notified of Resident #1's change in health status. LPN #101 verified the facility notification policy required the facility to notify the family or responsible party when a change in health status occurred. Telephone interview on [DATE] at 9:39 P.M. with Resident #1's mother (Power of attorney (POA) who was identified on the medical record face sheet as Emergency Contact #1, revealed she was Resident #1's healthcare power of attorney. The POA stated she was not informed of Resident #1's change in mental/neurological status until approximately 7:30 P.M. on [DATE], when she was informed of the residents death. Review of the facility policy entitled, Change in a Resident's Condition or Status, revised [DATE], revealed the facility shall promptly notify the resident, physician, and representative of changes in the resident's medical/mental condition and or status. Interview with the Director of Nursing (DON) on [DATE] at 10:00 A.M., verified Resident #1's mother was listed as Emergency Contact #1. The DON confirmed there was no documentation in the medical record that indicated Resident #1's mother was contacted regarding the change in condition. This deficiency is based on an incidental finding discovered during the course of this complaint investigation.
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 record review, staff and physician interviews, and review of the facility's medications policy, the facility failed to ensure medications were administered in accordance with physician orders. This deficient practice had the potential to affect one (#1) of 10 residents reviewed for the administration of medications in a total facility census of 57. Findings include: Review of the record for Resident #1 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident was identified with a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognitive impairment with the ability to make needs known. The resident had clear speech, and was dependent on staff for bed mobility, transfer, dressing, toilet use, and personal hygiene. The assessment further indicated the resident required supervised set-up help with locomotion and with eating. The resident was assessed to be frequently incontinent of bowel and bladder. Medications included the daily use of an antipsychotic and antianxiety medications. Review of the physician order on 06/15/20, revealed [MEDICATION NAME] 120 milligrams (mg) one capsule daily was ordered. On 07/02/20, the medication was increased to 180 mg/24 one capsule by mouth daily. Review of the monthly orders from 07/02/20, noted the [MEDICATION NAME] HCL Extended Release (ER) 120 mg, was documented as taking one capsule daily. However, the hour frequency listed times of 9:00 A.M. and 9:00 P.M. Review of the August 2020 monthly orders noted the [MEDICATION NAME] HCL ER 180 mg/24 initiated on 07/02/20, was for one capsule by mouth daily. However, the hours of administration were listed at 9:00 A.M. and 9:00 P.M. Review of medication administration records (MAR) from 07/03/20, noted a hand written transcription on the MAR for [MEDICATION NAME] HCL ER 180 mg take one tab by mouth twice daily. The hours of administration were listed as 9:00 A.M. and 9:00 P.M. Review of the August 2020 MAR indicated [REDACTED]. However, the hours of administration on the MAR indicated [REDACTED].M. and 9:00 P.M. Review of the facility policy entitled, Administering Medications, revised April 2019, revealed medications were

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) administered in accordance with physicians orders, including any required timeframe. Interview with the Director of Nursing (DON) on 08/13/20 at 10:00 A.M., verified the medication [MEDICATION NAME] was not administered in accordance with facility policy or the physician orders. On 08/17/20 at 11:13 A.M., telephone interview with the physician revealed during a physician visit on 07/02/20, the physician increased the [MEDICATION NAME] HCL ER to 180 mg once daily due to increased blood pressure as recorded at 143/79. The physician stated it was not his practice to administer the medication [MEDICATION NAME] HCL ER to 180 mg twice daily. He further stated no concerns were reported to him regarding Resident #1 being hypotensive during the months of July and August 2020. This deficiency substantiates Complaint Number OH 880.