STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366000	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYCAMORE GLEN HEALTH CARE	2175 LEITER ROAD MIAMISBURG, OH 45342

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 medical record review and resident representative and staff interview, the facility failed to notify the resident's representative when medications were not available for administration. This affected one (#17) of five residents review for unnecessary medication. The census was 88. Findings include: Review of the medical record for Resident #17 revealed the resident was admitted to the facility on [DATE] at 5:07 P.M. [DIAGNOSES REDACTED]. Review of an admission minimum data set (MDS) assessment dated [DATE] revealed Resident #17 required extensive assist of one person for bed mobility, locomotion, and walking. The resident required extensive assistance of two for transfers and was dependent upon staff for dressing and eating. A brief interview of mental status was not completed because the resident was rarely/never understood. The assessment revealed the resident had long term memory problems and was not able to recall the current season, location of own room, staff names/faces, or the he/she was in a nursing home. Review of a Medication Administration Record [REDACTED].M. were unavailable. The medication identified as unavailable for administration included lacosamide tablet (anticonvulsant) 200 milligram (mg); [MEDICATION NAME] (anticonvulsant/antianxiety) one mg, [MEDICATION NAME] tablet (anticonvulsant) 64.8 mg; [MEDICATION NAME] sodium (anticonvulsant) 100 mg with 30 mg give two capsules (total of 160 mg); [MED] (anticoagulant) five mg; Losartan potassium (antihypertensive) 25 mg; and [MEDICATION NAME] ([MEDICATION NAME]) 600 mg. Continued review of the MAR indicated [REDACTED].M. Review of the medical record for Resident #17 revealed there was no evidence of the representative for Resident #17 being notified of medications that were not administered on 02/19/20 or 02/20/20. Interview on 03/03/20 at 11:37 A.M. with two of Resident #17's representatives revealed the facility did not notify the representatives of the medications which were unavailable for administration on 02/19/20 and 02/20/20. Interview on 03/05/20 at 2:42 P.M. with the Director of Nursing (DON) verified the medical record for Resident #17 contained no evidence the resident's representatives were notified of the medication not administered to the resident on 02/19/20 and 02/20/20.
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 medical record review, staff interview, policy review and review of medication information from Medscape, the facility failed to ensure a resident was free from unnecessary medications when the staff failed to follow physician ordered parameters regarding the administration of a cardiac medication. This affected one (#29) of five residents reviewed for unnecessary medications. The facility census was 88. Findings included: Medical record review for Resident #29 revealed an admission date of [DATE]. Medical [DIAGNOSES REDACTED]. Review of quarterly Minimum Data Set ((MDS) dated [DATE] revealed she cognitively intact. Functional status was total dependence for bed mobility and transfers with two-person assistance. She was total dependence for toilet use with one-person assistance and supervision for eating with set-up help. Review of physician orders [REDACTED]. Review of Medication Administration Record [REDACTED]. Those dates were 12/10/19, 12/11/19, 12/14/19, 12/15/19, 12/16/19, 12/24/19, [DATE], 12/28/19 and 12/29/19. Further review of the MAR from 01/01/20 through 01/31/20 revealed there were ten dates the medication was administered with a pulse documented less than 70 bpm. Those dates were 01/01/20, 01/02/20, 01/04/20 ,01/06/20, 01/07/20, 01/10/20, 01/11/20, 01/12/20, 01/14/20, and 01/31/20. Review of the MAR from 02/01/20 through 02/29/20 revealed there was ten times the medication was given with a pulse less than 70. Those dates were 02/02/20, 02/06/20, 02/08/20, 02/12/20, 02/15/20, 02/19/20, 02/20/20, 02/22/20, 02/26/20 and 02/27/20. Interview with the Director of Nursing (DON) on 03/05/20 at 10:28 A.M. verified the above mentioned dates the [MEDICATION NAME] was given during the time frame to the resident with a pulse of less than 70. Review of policy entitled Change of Condition revised 06/01/15 revealed the facility staff will reported identified significant changes in resident's status. Documentation of the condition will be noted in the nursing notes or interdisciplinary charting. The resident's physician will be notified of significant changes in the resident's condition. Review of medication information from Medscape revealed [MEDICATION NAME] is a cardiac medication used to treat [MEDICAL CONDITION] (chest pain), hypertension, [DIAGNOSES REDACTED] (fast heart beat) and [MEDICAL CONDITION]/flutter
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 medical record review, cubex (emergency medication box) supply list review, staff, Nurse Practitioner and physician interviews, policy review and review of medication information from Medscape, the facility failed administer medications as ordered by the physician resulting in significant medication errors. This affected one (#17) of five residents review for unnecessary medication. The census was 88. Findings include: Review of the medical record for Resident #17 revealed the resident was admitted to the facility on [DATE] at 5:07 P.M. [DIAGNOSES REDACTED]. Review of an admission minimum data set (MDS) assessment dated [DATE] revealed Resident #17 required extensive assist of one person for bed mobility, locomotion, and walking. The resident required extensive assistance of two for transfers and was dependent upon staff for dressing and eating. A brief interview of mental status was not completed because the resident was rarely/never understood. The assessment revealed the resident had long term memory problems and was not able to recall the current season, location of own room, staff names/faces, or the he/she was in a nursing home. Review of a Medication Administration Record [REDACTED].M. were unavailable. The medication identified as unavailable for administration included lacosamide tablet (anticonvulsant) 200 milligram (mg); [MEDICATION NAME] (anticonvulsant/antianxiety) one mg, [MEDICATION NAME] tablet (anticonvulsant) 64.8 mg; [MEDICATION NAME] sodium (anticonvulsant) 100 mg with 30 mg give two capsules (total of 160 mg); [MED] (anticoagulant) five mg; Losartan potassium (antihypertensive) 25 mg; and [MEDICATION NAME] ([MEDICATION NAME]) 600 mg. Continued review of the MAR indicated [REDACTED].M. Review of a document titled, Cubex Formulary undated revealed the medications [MED] 2.5 mg (supply of eight), [MEDICATION NAME] 600 mg (supply of 10), [MEDICATION NAME] 32.4 mg (supply of 10), [MEDICATION NAME] 100 mg (supply of six), [MEDICATION NAME] 50 mg chew tablet (supply of five), [MEDICATION NAME] one mg (supply of two), Losartan 25 mg (supply of 10) where listed as available for resident use in the facilities emergency medication supply. The only medication not listed as available in the emergency medication supply was lacosamide. Interview on 03/04/20 at 8:33 A.M. with the Director of Nursing (DON) revealed when a resident was admitted to the facility and had physician ordered medication due for administration, the medications could be obtained from the facilities emergency medication supply. The DON further revealed if a medication was not available in the emergency box supply then the physician would be notified for further direction. Continued interview with the DON revealed the code 16, when documented on a residents MAR, indicated the medication was not available from pharmacy. The DON verified documentation on the MAR indicated [REDACTED].M. on 02/19/20, which included [MEDICATION NAME] one mg; [MEDICATION NAME] 64.8 mg; [MEDICATION NAME] sodium 160 mg; lacosamide 200 mg; [MED] 5 mg; Losartan potassium 25 mg; and [MEDICATION NAME] 600 mg was not not available

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) from pharmacy. The DON further verified the [MEDICATION NAME] scheduled on 02/20/20 at 9:00 P.M. was documented as unavailable. The DON confirmed the medications that were documented as unavailable on 02/19/20 and 02/20/20 were not administered to Resident #17. Continued interview with the DON verified six of the seven medications that were documented on the resident MAR indicated [REDACTED]. Interview on 03/04/20 at 8:58 A.M. with Physician #239 (Resident #17 primary care physician) revealed when medication were available in the facilities emergency supply and there was a valid prescription, it would be expect that the medications would be administered. Interview with the physician revealed the only medication that should have been held for Resident #17 on 02/19/20 at 9:00 P.M. was the lacosamide, because it was not available in the emergency box. Continued interview with Physician #239 revealed on this day, 03/04/20, the facility spoke with this physician in regards to the medications that were placed on hold on 02/19/20 by the on call nurse practitioner. The interview revealed it was this physician's professional opinion that the available medications should have been administered as ordered. Interview with the physician revealed the physician was made aware of the 02/19/20 medications being placed on hold on 03/04/20 and the physician was asked to sign the telephone ordered for the held medication on 03/04/20, even though the telephone order indicated the order was signed by this physician on 02/19/20. The physician did not know who documented the sign date as 02/19/20. Interview 03/04/20 at 10:37 A.M. with Nurse Practitioner (NP) #238 (on call for Physician #239 on 02/19/20) revealed facility staff called the NP on 02/19/20, and a verbal order was given to hold unavailable medications until they were available the next morning. Interview with NP #238 revealed the NP was not aware of the facility having an emergency medication supply. Further interview with the NP revealed it was the NP's expectation that any medications which had a valid order and was available in the emergency supply would be administered to Resident #17 and not be held until the next morning. Review of a policy titles, Emergency Boxes and On-Site Stores, dated 06/21/17, revealed the pharmacy supplies an emergency box and other on-site stores of medications to be utilized by he facility in the case of new admissions, urgent new orders received after hours, or when immediate medication administration was required. When receiving a new medication order that needs to be administered prior to the next pharmacy delivery, the nurse obtaining the order should check the on-site store list prior to accepting the order from the physician to see if that medication is available in the facility. If not, the physician should be informed of the available medications to determine if an alternative can be ordered. Review of medication information from Medscape revealed the following: [MEDICATION NAME] is used as an antianxiety; [MEDICATION NAME] is an anticonvulsant (anti-[MEDICAL CONDITION]); [MEDICATION NAME] sodium is an anticonvulsant; [MED] is an anticoagulant; Losartan is used to treat hypertension and [MEDICATION NAME] is used to treat a cough.