STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365764	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTERVILLE HEALTH AND REHAB	7300 MCEWEN ROAD DAYTON, OH 45459

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 0742 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the National Alliance on Mental Illness (NAMI.org) website, observation, staff interview, pharmacy technician interview, and facility policy review, the facility staff failed to ensure a resident received ordered monthly psychoactive injections. This resulted in actual harm when the resident's behaviors escalated to include multiple episodes of violent screaming, the resident experienced a decline in her ability to complete her activities of daily living (ADLs), requiring staff to provide assistance with ambulation and eating, and the resident had a decline in her bowel and bladder functioning which led to episodes of incontinence. This affected one Resident (#01) of five reviewed for medications. The facility census was 88. Findings include: Medical record review revealed Resident #01 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #01's care plan revealed her baseline behaviors at admission on 04/12/19 included yelling, becoming agitated with excessive noise, sad, tearful, and nervous with hallucinations/delusions. The interventions included providing medications as ordered and evaluating for effectiveness and monitoring for increased behaviors every shift. Review of Resident #01's physician order [REDACTED].#01's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. The resident was able to transfer, ambulate, and used the toilet with the supervision of one staff. She required set up help only for eating and hygiene, and was always continent of bowel and bladder. Review of Resident #01's Medication Administration Record [REDACTED]#102, and on 01/17/20 by agency RN #101. Review of Resident #01's monthly notes from the visiting psychological consultant dated 12/10/19 revealed the resident's sister passed away on 11/28/19, and she was more tearful, and yelling out for family members. She was increasingly anxious and was started on [MEDICATION NAME] (antianxiety), 0.5 milligrams (mg), twice per day. Review of Resident #01's progress note dated 01/03/20 revealed the resident was yelling out for two to three hours during the night and saying the cops were going to take her brother to jail. On 01/10/20, the resident spit out all of her medications across the room, and was screaming. On 01/23/20 the resident was noted with increased agitation, delusions, and anxiety. Review of Resident #01's MDS assessment dated [DATE] revealed the resident had a significant decline and now required the extensive assistance of two staff for transfers with no ambulation, and the extensive assistance of one staff for all ADLS, including eating. She was now always incontinent of bowel and bladder, and using incontinence products Review of Resident #01's monthly note from the visiting psychological consultant dated 01/31/20, revealed the resident reported feeling an increase in anxiety and nervousness. Staff also reported the resident was more anxious On 02/07/20, Resident #01 was given [MEDICATION NAME] and it was ineffective. The staff were unsuccessful in redirecting the resident. On 02/12/20, the resident had increased agitation, delusions, and anxiety. Review of Resident #01's progress note dated 02/21/20 revealed it was noted the resident had not been administered her monthly [MEDICATION NAME] injections since October 2019. It was also noted the resident had increase behaviors, agitation, anxiety and [MEDICAL CONDITION]. Observations of Resident #01 on 03/04/20 at 9:00 A.M. to 11:00 A.M., and from 1:30 P.M. to 3:45 P.M., revealed the resident was quiet and participating in activities. Interview on 03/04/20 at 9:45 A.M. with Registered Nurse (RN) #100 revealed she had contacted the pharmacy on around 02/20/20 when she discovered the last [MEDICATION NAME] injection for Resident #01 was delivered to the facility on [DATE], and administered that date. She confirmed the resident had missed the injections on 11/17/19, 12/17/19, 01/17/20, and 02/17/20. RN #100 confirmed there were two errors, the first was failing to order the [MEDICATION NAME] injection from the pharmacy monthly as required, and the second error was the [MEDICATION NAME] injections were initialed as administered on 11/17/19 by agency RN #103, on 12/17/19 by former LPN #102, and on 01/17/20 by agency RN #101, however the injections were not given. Phone interview with Pharmacy Technician #120 on 03/04/20 at 3:17 P.M. confirmed Resident #01's monthly [MEDICATION NAME] injections had not been sent to the facility since 10/17/19, until the facility contacted them and one was sent on 02/20/20. Interview on 03/04/20 at 3:45 P.M. with LPN #105 revealed on 01/28/20 she completed a significant change MDS assessment for Resident #01 due to the decline in no longer ambulating, requiring the use of a stand up lift with two staff for transfers, requiring the extensive assistance of one staff for all ADLs, including eating. LPN #105 further revealed the resident was now was always incontinent of bowel and bladder, and was using incontinence products. LPN #105 verified the resident had been violently screaming, grabbing staff, and cursing more at the time of the significant change. The LPN revealed the past few days since the resident received the [MEDICATION NAME] injection on 02/20/20, there was some improvement with the resident's yelling out, anxiety, [MEDICAL CONDITION], and agitation, especially during the day. A group interview on 03/04/20 at 4:00 P.M. with Activity Staff #106, #107, and Activity Director #110 confirmed Resident #01 was engaged in activities today and was not yelling out. They all stated the resident was yelling out less the past two weeks. Interview with RN #126 on 03/06/20 at 11:00 A.M. revealed the past week the resident was quieter and calmer. Interview with State tested Nursing Assistant (STNA) #130 on 03/06/20 at 11:05 A.M. revealed the resident was screaming less overall the past week. Review of the NAMI.org website revealed missing a dose of [MEDICATION NAME] could increase your risk for a relapse in symptoms. Do not stop taking the medication without talking with your healthcare provider. In order for the medication to work properly it should be taken as ordered. Review of the facility's Medication Administration policy from the Lippincott Nursing Procedures 8th Editions 2019, page 557, revealed to reduce the risk of errors, medications are to be administered at the proper time, prescribed dosage, and correct route. This was an incidental finding discovered during the complaint investigation.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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, and facility policy review, the facility failed to administer medication as ordered for one Resident (#3) of five reviewed for medications. The facility census was 88. Findings include: Medical record review revealed Resident #3 was admitted to the facility on [DATE] with [MEDICAL CONDITION]. Review of Resident #3's physician orders [REDACTED]. Review of Resident #3's Medication Administration Record [REDACTED]. Interview with the Director of Nursing (DON) on 03/06/20 at 2:30 P.M. confirmed there was no evidence Resident #3 received the Levothyroxin and [MEDICATION NAME] on 02/11/20, 02/17/20, 02/19/20 and 02/22/20. Review of medication administration policy from Lippincott Nursing Procedures 8th Editions 2019, page 557, revealed to reduce the risk of errors, medications were administered at the proper time, prescribed dosage, and correct route. This deficiency substantiates Complaint Number OH

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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CENTERVILLE HEALTH AND REHAB	**7300 MCEWEN ROAD DAYTON, OH 45459**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 329.
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, staff interview, pharmacy technician interviews, and facility policy review, the facility staff failed to ensure ordered medications were administered to one Resident (#1) of five reviewed for medications. The facility census was 88. Findings include: Medical record review revealed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's physician's orders [REDACTED]. Review of Resident #1's Medication Administration Record [REDACTED]#102, and on 01/17/20 by agency RN #101. In addition, the MAR indicated [REDACTED]. There was also no evidence the resident received the morning dose of [MEDICATION NAME] on 02/17/20 and 0[DATE], and the evening dose on 02/04/20 and 02/23/20. Interview on 03/04/20 at 9:45 A.M. with Registered Nurse (RN) #100 revealed she had contacted the pharmacy on around 02/20/20 when it was discovered the last [MEDICATION NAME] injection for Resident #1 was delivered to the facility on [DATE]. The RN confirmed the resident had missed the 11/17/19, 12/17/19, 01/17/20, and 02/17/20 injections. RN #100 confirmed there were two errors, the first was failing to order the [MEDICATION NAME] injection from the pharmacy monthly as required, and the second error was the [MEDICATION NAME] injections were initialed as administered on 11/17/19 by agency RN #103, on 12/17/19 by former LPN #102, and on 01/17/20 by agency RN #101, and actually were not given. Phone interview with Pharmacy Technician #120 on 03/04/20 at 3:17 P.M. confirmed the last monthly [MEDICATION NAME] injections was sent on 10/17/19, and then not again until the facility contacted them, and one was sent on 02/20/20. Interview with the Director of Nursing (DON) on 03/06/20 at 2:00 P.M. confirmed there was no evidence Resident #1 received the [MEDICATION NAME] and [MEDICATION NAME] on 02/04/20 and 02/23/20 for the evening dose, as well as the morning doses of [MEDICATION NAME] on 02/17/20 and 0[DATE], and the evening doses on 02/04/20 and 02/23/20. Review of medication administration policy from Lippincott Nursing Procedures 8th Editions 2019, page 557, revealed to reduce the risk of errors, medications were administered at the proper time, prescribed dosage, and correct route. This deficiency substantiates Complaint Number OH 329.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview, the facility failed to ensure the accuracy of the documentation of medications administered for one Resident (#1) of five reviewed for accuracy of documentation. The facility census was 88. Findings include: Medical record review revealed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's physician's orders [REDACTED].#1's Medication Administration Record [REDACTED]#102, and on 01/17/20 by agency RN #101. Interview on 03/04/20 at 9:45 A.M. with Registered Nurse (RN) #100 revealed she had contacted the pharmacy on around 02/20/20 when it was discovered the last [MEDICATION NAME] injection for Resident #1 was delivered to the facility on [DATE]. The RN confirmed the resident had missed the 11/17/19, 12/17/19, 01/17/20, and 02/17/20 injections. RN #100 confirmed the [MEDICATION NAME] injections were initialed as administered on 11/17/19 by agency RN #103, on 12/17/19 by former LPN #102, and on 01/17/20 by agency RN #101, and actually were not given. Phone interview with Pharmacy Technician #120 on 03/04/20 at 3:17 P.M. confirmed the last monthly [MEDICATION NAME] injection was sent on 10/17/19, and then not again until the facility contacted them, and one was sent on 02/20/20. This was an incidental finding discovered during the complaint investigation.