STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GENEVA VILLAGE RETIREMENT COMMUNITY, LTD	1140 SOUTH BROADWAY GENEVA, OH 44041

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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure Resident #3's indwelling Foley catheter (a thin sterile tube inserted into the bladder to drain urine) bag was emptied properly to prevent potential complications for the resident. This affected one resident (#3) of one resident reviewed for catheters. Findings include: Review of the medical record for Resident #3 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the care plan, dated 11/25/19 revealed Resident #3 required alternate means of urinary elimination of a Foley catheter due to [MEDICAL CONDITION] bladder, [MEDICAL CONDITION] with lower urinary tract symptoms, urinary tract infection [MEDICAL CONDITION]. Interventions included catheter care every shift and as needed, monitor catheter patency every shift, position drainage bag below the level of the bladder and keeping the bag and tubing off the floor always. There was nothing in the care plan regarding emptying the catheter drainage bag. Review of physician's orders for March 2020 revealed Resident #3 had an order for [REDACTED]. Observation on 03/02/20 at 11:29 A.M. revealed Resident #3's indwelling Foley catheter drainage bag laying on the floor while Resident #3 was in bed. Resident #3's catheter drainage bag was all the way full of urine and the urine was backing up into the catheter tubing. His drainage bag was leaking out the bottom of the catheter bag and the bag was laying in a puddle of urine. Interview and observation with the Director of Nursing on 03/02/20 at 11:32 A.M. verified the indwelling Foley catheter bag was overfull causing the urine to back up into the catheter tubing as well as leak out of the bottom of the catheter bag. She verified the catheter bag should have been emptied and not had this amount of urine in the bag. The Director of Nursing emptied the urinary catheter bag and measured the urine content and she revealed the urinary output measured 3000 cubic centimeters (cc). Review of manufacturer guidelines, SteriGear the Fig Leaf with a model number of revealed Resident #3's urinary drainage bag had a capacity of 2000 milliliters. The guidelines revealed to hang the bag utilizing the hanger or rope and do not place the bag on the floor. The guidelines also revealed to periodically check the fluid level in the bag by lifting the Fig Leaf cover or by viewing through the Quick View Port and empty the bag. Review of facility policy titled, Catheter Care, Urinary dated 05/22/13 revealed it was the policy of the facility to provide appropriate care for urinary catheters and to prevent catheter- associated urinary tract infections. The policy revealed to be sure the catheter tubing and drainage bag were kept off the floor and empty the drainage bag regularly using a separate clean collection container for each resident. The policy revealed the bag should be emptied at least every eight hours.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to maintain a medication rate less than five percent. The facility medication error rate was calculated to be 12.90% and included four medication errors out of 31 medication administration opportunities. This affected one resident (#43) of five residents observed for medication administration. Findings include: Review of the medical record for Resident #43 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of Resident #43's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 02/12/20 revealed she had intact cognition. Observation on 03/03/20 at 8:25 A.M. of medication administration for Resident #43 completed by Licensed Practical Nurse (LPN) #600 revealed Resident #43 requested her medication be crushed and placed in applesauce. LPN #600 crushed all Resident #43's medications including [MEDICATION NAME] capsule delayed release 30 milligrams one capsule by mouth for [MEDICAL CONDITION], [MEDICATION NAME] tablet extended release 30 milligram by mouth for chest pain, NAME] delayed release 40 milligram tablet by mouth for gastro-[MEDICAL CONDITION] reflux and Potassium chloride extended release 20 milliequivalent tablet by mouth for [DIAGNOSES REDACTED] (low potassium). LPN #600 did not educate Resident #43 prior to administering the delayed release or extended release medication on risk factors of these medications being crushed or call the physician prior to these medications being crushed and administered. Interview on 03/03/20 at 8:30 A.M. with LPN #600 verified she crushed all of Resident #43's medications including her [MEDICATION NAME] delayed release, [MEDICATION NAME] extended release, NAME] delayed release and her Potassium chloride extended release. She verified these medications should not have been crushed and she revealed she should have called the physician prior to crushing the medications and administering. Interview on 03/03/20 at 9:55 A.M. with Facility Pharmacist #601 verified Resident #43's [MEDICATION NAME] delayed release, [MEDICATION NAME] extended release, NAME] delayed release and her Potassium chloride extended should not be crushed as extended release medications were formulated for a resident to receive the medication slowly over time and delayed release medications were [MEDICATION NAME] coated designed to delay the release of the medication until the tablet had passed through the stomach to prevent the medication from being destroyed or inactivated by gastric juices or where it may irritate the gastric lining. Review of facility policy titled Medication Administration- Crushing of Medications, dated 06/21/17 revealed medications which were [MEDICATION NAME] coated, extended release, sublingual or otherwise noted by the manufacturer as inappropriate to crush, may not be crushed. If crushing of the medication was authorized by the physician, the pharmacy should be notified, and documentation must be made in the resident's record. If the physician orders [REDACTED].

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.