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 _____	09/30/2020

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 0620 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility's admission agreement, the facility failed to ensure the facility was able to provide necessary care and treatment to residents being admitted to the facility. This affected one (Resident #18) of four residents reviewed for admissions, transfers and discharges. The facility census was 64. Findings include: Review of Resident #18's medical record revealed an admission date of [DATE] and a discharge date of [DATE]. [DIAGNOSES REDACTED]. Review of the resident's referral from the hospital to the facility, dated 03/31/20, revealed Resident #18 received a regular diet as well as 2500 calories a day. The route for additional calories was not indicated on the diet section of the referral sheet. On page four of the referral sheet, it was noted Resident #18 received intravenous medications including [MEDICATION NAME] nutrition (TPN) (a method of nutritional feeding that bypasses the gastrointestinal tract) accessed through his peripherally inserted central catheter (PICC). It stated the resident had a permanent non-function or disease of the structures that normally permit food to reach or be absorbed by the small intestine. The resident also required tube feeding to provide sufficient nutrients to maintain weight and strength. Review of the hospital discharge information, dated 04/07/20, which Resident #18 brought with him at the time of admission to the facility, revealed he was to be on TPN 75 milliliters cycled over 12 hours to provide 1330 calories per day. Interview on 09/14/20 at 8:13 A.M. with Admissions Staff (AS) #301 verified there was confusion with Resident #18's referral. She was not sure what TPN was and approved Resident #18 for admission based on payor sources and behavioral review. AS #301 reported she relied on clinical staff for medical approvals. AS #301 was not able to recall who provided her with the clinical approval for placement. Interview on 09/14/20 with the Director of Nursing (DON) stated there was no evidence was found indicating a clinical review was completed for Resident #18's admission. The DON verified the facility was not able to admit residents who required TPN nutrition due to not having consistent staff trained to support the specialized service. The DON reported the clinical staff were not aware of Resident #18's need for TPN until he handed them the discharge paperwork he brought with him from the hospital. Review of the facility's admission agreement, revised April 2017, revealed individuals that require specialized services, which are not available, based upon licensure or training of the facility staff or the facility's consultants shall not be admitted . This deficiency substantiates Complaint Numbers OH 043 and OH 75.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and review of the facility's policy, the facility failed to provide wound care treatment as physician ordered. This affected one (Resident #18) of three residents reviewed for wound care. The facility census was 64. Findings include: Review of Resident #18's medical record revealed an admission date of [DATE] and a discharge date of [DATE]. [DIAGNOSES REDACTED]. Review of the hospital discharge information form, dated 04/07/20, revealed Resident #18 was to receive wound care for epigastric region (region of the upper abdomen) twice daily as needed. Review of the baseline care plan, dated 04/07/20, revealed the resident had a pressure ulcer and skins concerns on his spine and stomach. The interventions included to provide skin and wound treatments per the treatment administration records (TAR). Review of the physicians orders, dated 04/07/20, revealed an order for [REDACTED]. Moisten with continuous length of one continuous gauze fine mesh packing with normal saline. Lightly pack (fluff) it into the wound bed including tunneling and undermining. Leave a tail so it can be removed easily. Cover it with a two by two dry gauze, followed by [MEDICATION NAME] four by four dressing. Secure it with tape. Review of the TAR, dated 04/2020, revealed Resident #18's epigastric dressing was changed one time on 04/08/20. Resident #18 was in the facility for six days and there were at least 10 opportunities for the dressing to be changed. Interview on 09/15/20 at 10:18 A.M. with the Director of Nursing (DON) verified Resident #18's epigastric wound care was not completed as physician ordered. Review of the facility's policy titled, Wound Care, revised October 2010. revealed the nurse was to verify the physician order [REDACTED].
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, observation, staff interview and facility policy review, the facility failed to ensure the proper dispensing and administering of all drugs and failed to maintain medications in their original prescription packages until they were administered to the residents. This affected 14 residents (#20, #46, #48, #50, #52, #54, #56, #58, #60, #62, #64, #66, #68 and #70). Additionally, the facility failed to maintain a supply of necessary medications and administer those medications as ordered by the physician. This affected one resident (#56) of four residents observed for medication administration. The facility census was 64. Findings include: 1. Review of Resident #20's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #20's recapitulated physician orders, dated 09/01/20, revealed the medications due to be administered at 6:00 A.M. included [MEDICATION NAME] (calcium channel blocker) 5.0 milligrams (mg.) by mouth daily, [MEDICATION NAME] (anti-anxiety) 0.5 mg. by mouth twice daily, Multivitamin with minerals one tablet by mouth daily, [MEDICATION NAME] (antipsychotic) 5.0 mg. by mouth twice daily, [MEDICATION NAME] (treats heartburn) 20 mg by. mouth daily, Vitamin C 500 mg. by mouth daily and vitamin D3 2000 units by mouth daily. Review of Resident #46's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].M. included [MEDICATION NAME] (nerve pain medication) 600 mg. by mouth three times daily. Review of Resident #48's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed the medications due to be administered at 6:00 A.M. included [MEDICATION NAME] 600 mg. by mouth three times daily, [MEDICATION NAME] (treats [MEDICAL CONDITION], panic disorder and anxiety) 0.5 mg. by mouth three times daily, [MEDICATION NAME] (treats fluid retention and high blood pressure) one mg. by mouth twice daily, [MEDICATION NAME] (anti-anxiety) 15 mg. my mouth three times daily, [MEDICATION NAME] (treats liver disease)10 mg./15 milliliters (ml). give 30 ml. by mouth four times daily, [MEDICATION NAME] (treats nausea) 10 mg. by mouth four times daily and [MEDICATION NAME] (treats irritable bowel syndrome with diarrhea) 500 mg. by mouth twice daily. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed the

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 0755

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 1)
medication due to be administered at 6:00 A.M. included Pregabalin (nerve pain medication) 150 mg. by moth twice daily. Review of Resident #52's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed the medications due to be administered at 6:00 A.M. included [MEDICATION NAME] (treats [MEDICAL CONDITION] disease) 88 micrograms (mcg.) by mouth
daily and oyster shell with vitamin D 250 mg./125 units by mouth twice daily. Review of Resident #54's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed there were no scheduled medications due to be administered at 6:00 A.M.; however as needed medications were available. Review of Resident #56's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed the medications due to be administered at 6:00 A.M. included Nicotine patch (aides to stop smoking) seven mg./24 hours apply one patch daily, pantoprazole (treats [MEDICAL CONDITION] reflux disease) 40 mg. one tablet by mouth every morning, vitamin D3 10,000 units five tablets by mouth once weekly, [MEDICATION NAME] tablet (treats anxiety) 0.5 mg. one tablet by mouth three times daily, Folic acid one mg. by mouth daily at 6:00 A.M., [MEDICATION NAME] 300 mg. two capsules by mouth every eight hours, [MEDICATION NAME] injection (anticoagulant) 40 mg subcutaneously (SQ) every morning and [MEDICATION NAME] (treats [MEDICAL CONDITION] disease) 25 mcg. one tablet by mouth daily. Review of
Resident #58's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed the medications due to be administered at 6:00 A.M. included [MEDICATION NAME] (treats [MEDICAL CONDITION]) 20 mg. per tube three times a day, [MEDICATION NAME]
10 mg. per tube every six hours and [MEDICATION NAME] 100,000 swish and spit (treats fungal infections in the mouth) five ml. four times daily. Review of Resident #60's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed the medications due to be administered at 6:00 A.M. included [MEDICATION NAME] (treats [MEDICAL CONDITION] disorder) 500 mg. by mouth daily, [MEDICATION NAME] (treats high blood pressure) 10 mg. by mouth twice daily, pantoprazole 40 mg. by mouth
daily, [MEDICATION NAME] (treats and prevents [MEDICAL CONDITION]) 50 mg. by mouth three times daily, [MEDICATION NAME]
(treats depression) 100 mg. by mouth daily, [MEDICATION NAME] (treats depression) 30 mg. by mouth daily, [MEDICATION NAME]
(treats high blood pressure) 180 mg. by mouth daily, [MEDICATION NAME] powder (immune and digestive support) four grams, one pack three times daily, donepezil (can treat [MEDICAL CONDITION]) five mg. by mouth daily, [MEDICATION NAME] (treats
depression) 20 mg. by mouth daily and Eliquis (anticoagulant) five mg. two tablets by mouth twice daily. Review of Resident #62's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed the medication due to be administered at 6:00 A.M. included Pantoprazole 40 mg. by mouth every morning before breakfast. Review of Resident #64's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed the medications due to be administered at 6:00 A.M. included Aspirin 81 mg. by mouth daily, [MEDICATION NAME] (treats high blood pressure) 50 mg. by mouth daily, Atrovent inhaler (treats wheezing and shortness of breath) 17 mcg. two puffs by mouth four times daily, [MEDICATION NAME] (antidepressant) 100 mg. SR two tablets every twelve hours, [MEDICATION NAME] (treats [MEDICAL CONDITION], nerve pain and [MEDICAL CONDITION] disorder) 200 mg. ER
by mouth every twelve hours, [MEDICATION NAME] sulfate 325 mg by mouth daily, [MEDICATION NAME] (treats high blood pressure) 100 mg. by mouth three times daily, [MEDICATION NAME] (muscle relaxant) 1,000 mg. by mouth every eight hours, [MEDICATION NAME] (treats heartburn) 20 mg. by mouth twice daily, sodium [MEDICATION NAME] (vitamin) 650 mg. by mouth three times daily and Vitamin D3 1000 mg. two tablets by mouth daily. Review of Resident #66's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed the medications due to be administered at 6:00 A.M. included Atorvastatin (lowers cholesterol) 40 mg. by mouth daily, [MEDICATION NAME] sulfate 325 mg. by mouth daily, [MEDICATION NAME] 25 mg. by
mouth twice daily, Pantoprazole 40 mg. by mouth daily, [MEDICATION NAME] 25 mg. by mouth daily, Mupirocin ointment (antibiotic ointment) apply twice daily, [MEDICATION NAME] acid (vitamin) 500 mg. by mouth daily and Vitamin D3 2000 units by mouth daily. Review of Resident #68's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20 revealed the medications due to be administered at 6:00 A.M. included Acampro (helps to not drink alcohol) 333 mg. by mouth twice daily, [MEDICATION NAME] treats [MEDICAL CONDITION]) 80/4.5 inhaler two puffs by mouth twice daily, [MEDICATION NAME] (diuretic) one mg. by
mouth every morning, Drizalma (treats depression) 30 mg. by mouth daily, Eliquis 2.5 mg. by mouth daily, folic acid (vitamin) one mg. by mouth daily, Pantoprazole 40 mg. by mouth every morning before breakfast, [MEDICATION NAME] (antacid) one gram by mouth four times daily, Vitamin B-1 100 mg. by mouth daily, Vitamin B-12 1,000 mcg. by mouth daily, [MEDICATION NAME] 75 mcg. by mouth daily, [MEDICATION NAME] 12.5 mg. by mouth twice daily, [MEDICATION NAME] 17 grams by mouth daily,
[MEDICATION NAME] (treats [MEDICATION NAME] caused by [MEDICAL CONDITION]) 18 mcg. inhaler by mouth daily and [MEDICATION
NAME] 100 mg. by mouth three times daily. Review of Resident #70's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].M. included [MEDICATION NAME] caplets 500 mg., [MEDICATION NAME] 600 mg by
mouth three daily, oyster shell 500 mg. with Vitamin D 200 units two tablets by mouth daily, polyethylene [MEDICATION NAME] powder (treats constipation) 17 grams by mouth daily, Senna-s (treats constipation) 8.6 mg./50 mg., two tablets by mouth twice daily, stool softener 100 mg. by mouth twice daily and [MEDICATION NAME] (treats pain) 10 mg. by mouth three times daily. Observation conducted on 09/28/20 at 4:59 A.M. revealed Licensed Practical Nurse (LPN) #205 was standing next to the 400-hall medication cart, preparing medications and placing them in a medication cup when this surveyor approached for an interview. LPN #205 was then observed using an orange marker and wrote a room number on the outside of the medication cup, opened the top drawer of the medication cart and placed the medication cup in the top drawer, next to other cups already in the drawer. Further observation revealed nine medication cups containing multiple pills and identified on the outside of the cup with only a room number written in orange marker. The medications were no longer in their original prescription package. Interview with LPN #205 verified she was presetting medications (including narcotic medications) for the residents' 6:00 A.M. medication administration time. LPN #205 stated she has always preset medications and has never been told not to in the [AGE] years time being a nurse. LPN #205 also stated there was no way to get the medication pass completed on time if she didn't preset the medications and that she always presets the medications. LPN #205 stated she was not the only nurse who presets medications in the medication cups. LPN #205 continued to preset medications during the interview, wrote a room number on another medication cup with pills in it and placed the medication cup in the top drawer of the 400-hall medication cart, for a total of ten medication cups containing unidentified medications, which were no longer in their original prescription packages. LPN #205 stated she had also preset medication for the 300-hall. Observation revealed the 300-hall medication cart contained four medication cups containing multiple pills no longer in their original prescription package and identified with only a room number written in orange marker on the outside of the pill cup. LPN #205 verified the medication were no longer in their original prescription containers and did not contain any identifying information other than the hand-written room numbers on the outside of the cups. LPN #205 identified the affected residents based on the room numbers included Residents #20, #46, #48, #50, #52, #54, #56, #58, #60, #62, #64, #66, #68 and #70. 2. Observation of medication administration on 09/28/20 at 5:33 A.M. revealed LPN #205 was asked to administer medications to Resident #56. LPN #205 opened the 400-hall medication cart top drawer and removed a pill cup from the top drawer. During the interview at the time of the observation, LPN #205 verified the cup contained preset medication for Resident #56. LPN #205 then proceeded to administer an unknown number of unknown drugs to Resident #56. LPN #205 did ask Resident #56 if she wanted her physician ordered nicotine patch, which Resident #56 declined. LPN #205 also stated the ordered [MEDICATION NAME] injection would be administered separately at 6:00 A.M. LPN #205 stated she administered [MEDICATION NAME], Vitamin D3 units and [MEDICATION NAME] 300 milligrams (mg.), two tablets. LPN #205 verified she did
not administer the physician ordered folic acid because the Medication Administration Record [REDACTED]. LPN #205 also verified she did not administer the physician ordered [MEDICATION NAME] or [MEDICATION NAME] because Resident #56 was out
of these two medications and they were unavailable for administration. LPN #205 stated she ordered the missing medications this morning and she did not know when the medications would be given. LPN #205 verified she did not obtain the missing medications and did not notify the physician the [MEDICATION NAME] and [MEDICATION NAME] were not administered. Review of
the MAR for Resident #56 for September 2020 revealed the order for folic acid was included on the MAR but no administration time was documented. The folic acid was not signed at any time from 09/01/20 to 09/28/20 indicating it had not been administered at any time during the month of September 2020. The [MEDICATION NAME] (ordered three times daily) was not

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) signed as administered since 09/24/20 indicating the last ten doses were not administered. The [MEDICATION NAME] was not signed as administered on 09/27/20 or 09/28/20 indicating the last two doses were not administered. Vitamin D3 10,000 units was signed every day except 09/04/20 and 09/06/20, indicating the medication had been administered nearly every day when this medication was ordered once weekly. Interview with Director of Nursing (DON) on 09/28/20 at 12:30 P.M. verified the folic acid was not administered at any time during the month of September 2020. The DON verified the [MEDICATION NAME] was not signed as administered since 09/24/20 and the last ten doses were not administered. The [MEDICATION NAME] was not signed as administered on 09/27/20 or 09/28/20 and the last two doses were not administered. The DON verified the Vitamin D3 was administered daily, except for two days, instead of weekly as ordered. Review of the facility's policy titled Storage of Medications, revised April 2019, revealed the facility shall store all drugs and biologicals in a safe, secure and orderly manner. Drugs and biologicals shall be stored in the containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. Drugs shall be stored in an orderly manner in cabinets, drawers, carts or automatic dispensing systems. Each residents' medications shall be assigned to an individual cubicle, drawer or other holding area to prevent the possibility of mixing medication of several residents. Review of the facility's policy titled Administering Medications, revised April 2019, revealed medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with prescriber orders including any required time frame. Medications are administered within one hour of the prescribed time. The individual administering the medication checks to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR indicated [REDACTED]. Review of the facility's policy titled Controlled Substances, revised December 2012, revealed controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents. This deficiency substantiates Complaint Numbers OH 099, OH 043 and OH 775
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 medical record review, observation, staff interview, review of the manufacturer's insert and facility policy review, the facility failed to administer medications to the residents with less than a five percent medication error rate. There were five observed medication errors out of 23 medication administration opportunities, resulting in a 21% medication error rate. This affected two (Resident #56 and #72) of four residents observed for medication administration. The facility census was 64. Findings include: 1. Review of Resident #56's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the most recent recapitulated physician orders, dated 09/01/20, revealed the medications due to be administered at 6:00 A.M. included Nicotine patch (aides to stop smoking) seven milligrams (mg.)/24 hours apply one patch daily, pantoprazole (treats [MEDICAL CONDITION] reflux disease) 40 mg. one tablet by mouth every morning, vitamin D3 10,000 units five tablets by mouth once weekly, [MEDICATION NAME] tablet (treats anxiety) 0.5 mg. one tablet by mouth three times daily, Folic acid one mg. by mouth daily at 6:00 A.M., [MEDICATION NAME] 300 mg. two capsules by mouth every eight hours, [MEDICATION NAME] injection (anticoagulant) 40 mg. subcutaneously (SQ) every morning and [MEDICATION NAME] (treats [MEDICAL CONDITION] disease) 25 microgram (mcg.) one tablet by mouth daily. Observation of medication administration on 09/28/20 at 5:33 A.M. revealed Licensed Practical Nurse (LPN) #205 was asked to administer medications to Resident #56. LPN #205 opened the 400-hall medication cart top drawer and removed a pill cup from the top drawer. During the interview at the time of the observation, LPN #205 verified the cup contained preset medication for Resident #56. LPN #205 then proceeded to administer an unknown number of unknown drugs to Resident #56. LPN #205 did ask Resident #56 if she wanted her physician ordered nicotine patch, which Resident #56 declined. LPN #205 also stated the ordered [MEDICATION NAME] injection would be administered separately at 6:00 A.M. LPN #205 stated she administered [MEDICATION NAME], Vitamin D3 10,000 units and [MEDICATION NAME] 300 milligrams (mg.), two tablets. LPN #205 verified she did not administer the physician ordered folic acid because the Medication Administration Record [REDACTED]. LPN #205 also verified she did not administer the physician ordered [MEDICATION NAME] or [MEDICATION NAME] because Resident #56 was out of these two medications and they were unavailable for administration. LPN #205 stated she ordered the missing medications this morning and she did not know when the medications would be given. LPN #205 verified she did not obtain the missing medications and did not notify the physician the [MEDICATION NAME] and [MEDICATION NAME] were not administered. Review of the resident's MAR for September 2020 revealed the order for folic acid was included on the MAR but no administration time was documented. The Folic acid, [MEDICATION NAME] and [MEDICATION NAME] were not signed at any time on 09/28/20 indicating it had not been administered at any time. Vitamin D3 10,000 units was sign off as administered. This was a total of four medication errors. Interview with the Director of Nursing (DON) on 09/28/20 at 12:30 P.M. verified the Folic acid, [MEDICATION NAME] and [MEDICATION NAME] were not administered as physician ordered on [DATE]. The DON verified the Vitamin D3 was administered daily, except for two days, instead of weekly as ordered. 2. Review of Resident #72's medical record revealed she was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the most recent recapitulated and signed physician orders ,dated 09/01/20, revealed medication due to be administered at 6:00 A.M. included Aspirin 81 mg. by mouth daily, [MEDICATION NAME] sulfate (vitamin) 325 mg. by mouth daily, [MEDICATION NAME] (diuretic) 40 mg. by mouth daily, [MEDICATION NAME] (treats hypothryoidism) 25 mcg. by mouth daily, Losartan (antihypertensive) 50 mg. by mouth daily, [MEDICATION NAME] (treats high blood pressure) 100 mg. by mouth daily, [MEDICATION NAME] (treats anxiety) five mg. by mouth three times a day, Eliquis (anticoagulant) 2.5 mg. by mouth twice daily, Memantine (treats [MEDICAL CONDITION]) five mg. by mouth twice daily and [MEDICATION NAME] (treats [MEDICAL CONDITION]) 80-4.5 mcg. two puffs by mouth twice daily. Observation on 09/28/20 with LPN #206 at 5:49 A.M. revealed LPN #206 obtained and administered the physician ordered medications to Resident #72. Upon entering the room, Resident #72 requested to use the [MEDICATION NAME] inhaler first. LPN #206 assisted Resident #72 in using the inhaler, then proceeded immediately with administering Resident #72's oral medications with a cup of water. At no time did LPN #206 offer or advise Resident #72 that she should rinse her mouth after using the [MEDICATION NAME] nor did Resident #72 rinse her mouth at any time after using the inhaler. Interview with LPN #206 at the time of the observation she verified she did not have Resident #72 rinse her mouth after using the [MEDICATION NAME] inhaler resulting in one medication error. Review of the [MEDICATION NAME] Manufacturer's Warnings and Precautions insert revealed infections of the mouth and throat may occur. Advise the patient to rinse her mouth with water without swallowing after inhalation to help reduce the risk. Review of the facility's policy titled Administering Medications, revised April 2019, revealed medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with prescriber orders including any required time frame. Medications are administered within one hour of the prescribed time. The individual administering the medication checks to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR indicated [REDACTED]. Review of the facility policy titled Oral Inhalation Administration of a Metered Dose Inhaler, revised April 2019, revealed the purpose was to allow for safe, accurate and effective administration of dedication using an oral inhaler the procedure included to review the packaging insert if unfamiliar with the inhalation device. For steroid inhalers, provide the resident with a cup of water and instruct her to rinse mouth and spit water back into the cup. This deficiency substantiates Complaint Numbers OH 099, OH 307, OH 043 and OH 775.

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 review, the facility failed to maintain controlled drugs in the locked drawer of the medication cart specified for controlled drugs. This affected one(Resident #46) of four residents observed for medication administration. The facility census was 64. Findings include: Review of Resident #46's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].M. revealed Resident #46 approached Licensed Practical Nurse (LPN) #205 and requested his morning medications. LPN #205 opened

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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 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) the top drawer of the 400-hall medication cart, removed a preset medication cup and administered the medications to Resident #46. LPN #205 stated the medication cup contained one 800 mg. of [MEDICATION NAME] and one [MEDICATION NAME] (narcotic pain medication) 15 mg. She verified the narcotic pain medication was not in locked in a drawer inside the medication cart. Review of the Medication Administration Record [REDACTED].M. revealed the physician order [REDACTED]. and [MEDICATION NAME] (narcotic pain medication) 15 mg. The [MEDICATION NAME] was already signed off and LPN #205 signed off for the [MEDICATION NAME] at this time. Interview with LPN #202 regarding the discrepancy between what was ordered and what LPN #205 stated was in the medication cup, LPN #205 recanted her statement regarding the medications ([MEDICATION NAME] 800 mg. and [MEDICATION NAME] 15 mg.) and stated she actually administered [MEDICATION NAME] 600 mg. and [MEDICATION NAME] 15 mg. Additional review of the most recent physician orders [REDACTED]. or for [MEDICATION NAME] at any dose. Review of the facility's policy titled Controlled Substances, revised December 2012, revealed controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents. This was an incidental finding discovered during the course of the complaint investigation.