STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365497	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE AT THE GREENE	4381 TONAWANDA TRAIL DAYTON, OH 45430

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 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 and staff interview the facility failed to ensure a less than five percent medication error rate. There were two observed errors, of 26 opportunities, with a calculated medication error rate of 7.69 % (percent). This affected two (#4 and #8) of seven resident's observed for medication administration. The facility in-house census was 84. Findings include: 1. Record review revealed Resident #04 was admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. Review of the resident's physician's orders [REDACTED]. Another order revealed may crush medications unless contraindicated. Observation on 08/24/20 at 8:47 A.M. during medication administration with Registered Nurse (RN) #125 revealed Resident #4 received one tablet of [MEDICATION NAME] (an antidepressant medication) 20 milligrams (mg) , one tablet of Losartan-Hydrochlorothyazide (a medication for high blood pressure) 100-25 mg, and one Potassium Chloride 10 meq Extended Release tablet. RN #125 crushed all three tablets, placed them in applesauce and administered to Resident #4. Interview on 08/24/20 at 4:18 P.M. with RN #125 verified she crushed the medications and put them in applesauce and that an Extended Release tablet was not able to be crushed. 2. Record review revealed Resident #08 was admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. Review of the resident's physicians' orders dated 08/01/20 revealed the resident was ordered [MEDICATION NAME] (a medication for chest pain and high blood pressure) 100 mg give two tablets by mouth twice daily. Observation on 08/24/20 at 9:34 A.M. during medication administration with Licensed Practical Nurse (LPN) #88 revealed Resident #8 received one tablet of [MEDICATION NAME] 100 mg. During the observation a total pill count was completed and verified with LPN #88 prior to administration. At 4:30 P.M., observation of the medication packages and verified pill count revealed one tablet of [MEDICATION NAME] 100 mg was given. This deficiency substantiates Complaint Number OH 156.
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, observation, staff interview and review of the manufacturer recommendations the facility failed to ensure residents were free from significant medication errors. This affected one resident (#04) of seven residents observed during medication administration. The facility in-house census was 84. Findings include: Record review revealed Resident #04 was admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. Review of the resident's physician's orders [REDACTED]. Another order revealed may crush medications unless contraindicated. Observation on 08/24/20 at 8:47 A.M. during medication administration with Registered Nurse (RN) #125 revealed Resident #04 received one tablet of [MEDICATION NAME] (an antidepressant medication) 20 milligrams (mg) , one tablet of Losartan-Hydrochlorothyazide (a medication for high blood pressure) 100-25 mg, and one Potassium Chloride 10 meq Extended Release tablet. RN #125 crushed all three tablets, placed them in applesauce and administered to Resident #4. Interview on 08/24/20 at 4:18 P.M. with RN #125 verified she crushed the medications and put them in applesauce and that an Extended Release tablet was not able to be crushed. Review of the manufacturers recommendations revealed extended release Potassium should not be crushed. This deficiency substantiates Complaint Number OH 156.

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.