STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365293	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Airy Gardens Rehabilitation and Nursing Center	2250 Banning Road Cincinnati, OH 45239

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 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** 35770 Based on record review, hospital record review, staff interview, and policy review, revealed the facility failed to ensure residents medications were ordered and administered following a hospital discharge resulting in a significant medication error. This affected one (#11) of three Residents (#11, #12, and #13) reviewed of use of anti-coagulants. The facility census was 83. Findings include: Review of Resident #11's closed medical record revealed the resident was admitted to the facility on [DATE] Diagnoses included myocardial infarction (heart attack) with cardiac and vascular implants (stents), history of transient ischemic attacks (TIAs), human immunodeficiency virus (HIV), and cerebrovascular disease. Resident #11 was discharged to a local hospital on 06/01/24. Review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 had cognitive deficits and required set up assistance with activities of daily living (ADLs). Review of Resident #11's Hospital After Visit Summary (AVS) dated 05/21/24, revealed the resident was ordered to start taking the following new medications: Ticagrelor 90 milligrams (mgs) (anti-coagulant) twice daily. ferrous sulfate 325 mgs (iron supplement) daily, and metoprolol succinate 25 mgs Extended Release (ER) (anti-hypertensive) daily. Review of Resident #11's progress note dated 05/21/24 and authored by Licensed Practical Nurse (LPN) #42, revealed the resident returned to the facility from the hospital at 3:05 P.M. Resident #11's vital signs were within normal limits (WNL) with no concerns at this time. Resident #11's family was notified of the residents returning to the facility. Review of Resident #11's May and June 2024 Medication Administration Record (MAR) revealed the ferrous sulfate 325 mg, metoprolol 25 mg ER, and Ticagrelor 90mg were not listed on the MAR as being administered. Review of Resident #11's May and June 2024 physician orders, revealed ferrous sulfate 325 mg, metoprolol 25 mg extended release, and ticagrelor 90mg were never ordered upon readmission to the facility on [DATE]. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365293	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Airy Gardens Rehabilitation and Nursing Center	2250 Banning Road Cincinnati, OH 45239

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's progress note dated 06/01/24, revealed the resident was complaining of shortness of breath and vitals were as follows: blood pressure (BP) 134/65 millimeters of mercury (mm/Hg), temperature 98.1 degrees Fahrenheit, pulse 177 beats per minute, and respirations 24 breaths per minute. Resident #11 was placed on a non-breather oxygen mask and 10 Liters Per Minute (LPM) of oxygen was administered. The pulse oxygen saturation increased to 85 percent (%) (normal 95-100 %). Nine-one-one (911) was called to transfer the resident to the hospital. The Medical Director (MD) and Power-of-Attorney (POA) were notified. Review of a Nursing Policy/Procedure Manual Medication Incident Report, dated 06/02/24, revealed Resident #11 had medications that were not implemented from a hospital discharge on 05/21/24. Review of Employee Progressive Disciplinary Report, dated 06/03/24 ,revealed LPN #24 was terminated for substandard work including failing to audit hospital paperwork that resulted in a medication error. Interview on 06/11/24 at 10:57 A.M. with the Director of Nursing (DON) verified former LPN #42 did not check the physician orders for Resident #11 when he returned from the hospital on 05/21/24 and the resident's ferrous sulfate 325 mg, metoprolol ER 25 mg, and Ticagrelor 90mg was never started. The DON stated the LPN #42 was disciplined and ultimately terminated due to failure to do a proper readmission for Resident #11 that resulted in the significant medication error. Interview on 06/12/24 at 10:15 A.M. Medical Director (MD) #35 reported he was never informed of the medication error involving Resident #11 because he was on vacation when it happened. MD #35 stated Resident #11 was declining in health due to strokes, non-compliance with care and had suffered cognitive decline causing him to be on the memory care locked unit. MD #35 indicated that he was not aware that Resident #11 had been readmitted to the hospital on 06/01/24 because he was still on vacation. An additional interview on 06/12/24 at 10:30 A.M. with the DON, reveled the Assisted Director of Nursing (ADON) #34 called her on 06/02/24 to inform her that Registered Nurse (RN) #31 and LPN #32 received a call from the hospital to reconcile the resident's current medications and to question why ferrous sulfate 325 mg, metoprolol ER 25 mg, and Ticagrelor were not listed on the transfer list of medications. The DON stated that is when the facility discovered the medication error had occurred. Interview on 06/12/24 at 10:38 A.M. with ADON #34, revealed she received a phone call on 06/02/24 from RN #31 stating the hospital called her to reconcile the resident's medications when she discovered orders for Resident #11 were never transcribed upon being readmitted on [DATE]. ADON #34 stated she informed the DON, and an investigation was initiated. Interview on 06/12/24 at 10:45 A.M. with LPN #32, revealed after Resident #11 was admitted to the hospital, an unknown staff member called the facility to find out if Resident #11 was taking the Ticagrelor, metoprolol and ferrous sulfate which was ordered when he was discharged on [DATE] since it was not listed on his current medication list sent with the resident to the hospital. LPN #32 stated she pulled Resident #11's chart and there were no hospital discharge orders or physician orders for the Ticagrelor, metoprolol 25 mg, and iron and no pharmacy records which showed the medications had been ordered. LPN #32 stated she and RN #31 looked around the nurse's station for the 05/21/24 discharge orders and they were found between a bunch of folders and paperwork on the nurse's desk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365293	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Airy Gardens Rehabilitation and Nursing Center	2250 Banning Road Cincinnati, OH 45239

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/12/24 at 11:20 A.M. with RN #31, revealed the hospital called when Resident #11 was admitted reconciling the resident's medications. RN #31 stated the Ticagrelor, metoprolol and ferrous sulfate were not on the physician order sheet. RN #31 stated the nurse never transcribed the new orders from the hospital discharge when Resident #11 was readmitted to the facility on [DATE]. RN #31 stated after learning of the medications not being started, she started searching the nurse's station and found the envelope with the orders between folders and other paperwork where no one would have thought to look. Review of the undated facility policy titled Administering Medications, revealed medications must be administered in accordance with the physician orders, including any required time frames. This deficiency represents non-compliance investigated under Complaint Number OH00154602.