STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365867	A. Building B. Wing	05/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Run Healthcare of Portsmouth	1319 Spring Street Portsmouth, OH 45662

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record review and staff interview the facility failed to timely initiate a significant change Minimum Dat Set (MDS) 3.0 assessment after a change in Resident #10's condition and discharge from Hospice services. This affected one resident (#10) of one resident reviewed for Hospice services. Findings include: Record review for Resident #10 revealed the resident was admitted to the facility on [DATE] and had diagnoses including altered mental status, sepsis, edema, chronic kidney disease, type two diabetes mellitus with other specified complication and acute kidney failure. Review of the admission Minimum Data Set (MDS) assessment, dated 03/18/22 revealed the resident had mildly impaired cognition with a Brief Interview for Mental Status (BIMS) score of 11 out of 15. The resident was assessed to require limited assistance from one staff member for bed mobility, extensive assistance from one staff member for transfers and limited assistance from one staff member for eating. This resident was assessed to have received Hospice care while residing in the facility. On 05/10/22 at 8:45 A.M. interview with the Director of Nursing (DON) revealed Hospice services were discontinued for Resident #10 on 04/05/22. Review of the MDS assessments for Resident #10 revealed there was no evidence a significant change MDS 3.0 assessment was completed timely following the discontinuation of Hospice services for the resident. The MDS assessment was not initiated until 05/09/22. On 05/10/22 at 9:54 A.M. interview with Registered Nurse (RN) #121 verified a significant change MDS assessment was not initiated for Resident #10 timely after being discharged from Hospice services on 04/05/22. RN #121 verified the MDS was not initiated until 05/09/22.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record review and staff interview the facility failed to accurately code medications on the Minimum Data Set (MDS) 3.0 assessment for Resident #5. This affected one resident (#5) of five residents reviewed for unnecessary medication use. Findings include: Record review for Resident #5 revealed the resident was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia with behavioral disturbances, anxiety and depression. Review of the admission MDS 3.0 assessment, dated 03/04/22 revealed the resident was assessed to have received an anti-psychotic medication seven of seven days in the assessment reference period. Review of the active and discontinued physician's medication orders, dated 02/25/22 through 05/10/22 revealed the resident was not prescribed any anti-psychotic medication(s). On 05/11/22 at 9:10 A.M. interview with the Director of Nursing (DON) verified Resident #5 had not received any medications classified as an anti-psychotic while residing at the facility. The DON revealed staff had most likely coded an anti-psychotic medication on the admission MDS assessment, dated 03/04/22 due to receiving the medication Lamictal, which the DON verified was classified as being an anti-convulsant medication.

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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** 42728 Based on observation, record review and interview the facility failed to ensure ongoing communication with a Hospice provider regarding the care needs and services provided to Resident #10 and failed to ensure a treatment order for Resident #16 was specific to detail the actual treatment required or being provided to the resident. This affected one resident (#10) of one resident reviewed for Hospice services and one resident (#16) of three residents reviewed for change in condition. Findings include: 1. Record review for Resident #10 revealed the resident was admitted to the facility on [DATE] and had diagnoses including altered mental status, sepsis, edema, chronic kidney disease, type two diabetes mellitus with other specified complication, and acute kidney failure. Record review revealed the resident was receiving Hospice services at the time of admission to the facility. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 03/18/22 revealed the resident had mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. The resident was assessed to require limited assistance from one staff member for bed mobility, extensive assistance from one staff member for transfers and limited assistance from one staff member for eating. This resident was assessed to have received Hospice care while residing in the facility. Review of the Hospice care plan, dated 03/18/22, revised on 05/09/22 and resolved on 05/10/22 revealed the resident received Hospice services. Interventions included to consult with Hospice team to ensure needs were met. Record review revealed Resident #10 had a physician's order for Hospice services from admission through 05/08/22. On 05/10/22 at 8:45 A.M. interview with the Director of Nursing (DON) revealed the facility had no Hospice communication notes or documentation available in the facility for review prior to the Hospice provider faxing them to the facility on [DATE]. The DON revealed upon calling the Hospice provider for Resident #10 on 05/09/22 (as part of the survey process), it was discovered the resident's Hospice services had been discontinued on 04/05/22. The DON stated facility staff were unaware the resident had not been receiving Hospice services from 04/05/22 through 05/09/22 while residing in the facility. On 05/10/22 at 9:54 A.M. interview with Registered Nurse (RN) #121 revealed Resident #10 had previously received Hospice services but believed they were discontinued after the resident went to the hospital a few weeks prior. On 05/10/22 at 10:00 A.M. interview with State tested Nursing Assistant (STNA) #127 revealed Resident #10 was currently receiving hospice services. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for Resident #16 revealed the resident was admitted to the facility on [DATE] and had diagnoses including primary generalized osteoarthritis, anxiety disorder, type two diabetes mellitus, vitamin D deficiency and lymphedema. Review of the quarterly MDS 3.0 assessment, dated 04/12/22 revealed the resident had moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 06 out of 15. The resident was assessed to require extensive assistance from two staff members for bed mobility, was dependent upon two staff members for toileting and transfers and required limited assistance from one staff member for eating. Review of the active physician's orders revealed an order, dated 04/27/22 to apply bilateral lower extremities two times a day. Review of the Treatment Administration Record (TAR) from 04/27/22 through 05/09/22 revealed documentation by nursing staff the ordered treatment apply bilateral lower extremities every shift had been completed as ordered. On 05/10/22 at 10:00 A.M. observation of Resident #16 revealed the resident was lying in bed with no treatments or devices observed to be in place to the bilateral lower extremities. On 05/10/22 at 10:07 A.M. interview with Registered Nurse (RN) #121 revealed the active physician's order for Resident #16 to apply bilateral lower extremities every shift needed clarified by the physician as it did not contain instructions on what to apply. RN #121 verified staff had documented the ordered treatment as being completed per physician's order every shift from 04/27/22 through 05/09/22 despite not knowing what was ordered to be applied. On 05/10/22 at 10:05 A.M. interview with the DON verified the physician's order for the treatment for Resident #16 needed clarified as it did not contain instructions on what to apply to Resident #16's bilateral lower extremities.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure ongoing assessments/monitoring of pressure ulcers, pressure ulcer interventions and treatments were provided for Resident #10 who was admitted to the facility with pressure ulcers. This affected one resident (#10) of two residents reviewed for pressure ulcers. Findings include: Record review for Resident #10 revealed the resident was admitted to the facility on [DATE] and had diagnoses including altered mental status, sepsis, edema, chronic kidney disease, type two diabetes mellitus with other specified complication and acute kidney failure. Review of a facility Admission Nursing Observation Form, dated 03/11/22 revealed documentation the resident had pressure ulcers located on the coccyx, left heel and right heel. Review of the active physician's order, dated 03/12/22 revealed an order to cleanse the pressure ulcer to the resident's coccyx with normal saline or wound cleanser, apply Med Honey ointment and cover with a foam dressing every day at bedtime. Review of the care plan, dated 03/13/22 (revised 04/08/22) revealed the resident had impaired skin integrity. Interventions included to apply barrier cream/ointment after each incontinent episode as needed, encourage fluids, inspect skin daily during routine daily care, pressure reduction devices if ordered, turn and reposition as ordered, elevate heels off mattress and treatments per order. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 03/18/22 revealed the resident had mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 11 out of 15. The resident was assessed to require limited assistance from one staff member for bed mobility, extensive assistance from one staff member for transfers and limited assistance from one staff member for eating. The assessment revealed the resident was at risk for pressure ulcer development. Review of the Certified Nurse Practitioner (CNP) wound care note, dated 03/25/22 revealed the resident had a Stage III (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure ulcer to the right heel and an unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the left heel. The plan of care for the areas of pressure included off-loading boots, float heels while in bed and keep pressure off heels as much as possible. Review of the CNP wound care note, dated 04/15/22, revealed the resident continued to have areas of pressure located to the right and left heel. The plan of care included to continue prevalon offloading boots, float heels while in bed and keep pressure off heels as much as possible. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNP wound care note, dated 04/26/22, revealed the resident continued to have areas of pressure located to the right and left heel. The plan of care included to continue prevalon offloading boots, float heels while in bed, keep pressure off heels as much as possible and to follow up with resident in one week. Review of the Treatment Administration Record (TAR) for 05/2020 revealed there was no documentation of the ordered treatment to the pressure ulcer located on the coccyx of Resident #10 being completed on 05/05/22, 05/06/22, 05/07/22, 05/08/22 or 05/09/22. On 05/09/22 at 9:16 A.M. Resident #10 was observed lying in bed on her back with her left and right heel directly against the mattress. There were no prevalon boots applied to the left or right heel or observed in the resident's room. There was one pillow observed on the resident's bed which was located under her head. On 05/09/22 at 3:00 P.M. Resident #10 was observed lying in bed on her back with her left and right heel directly against the mattress. There were no prevalon boots applied to the left or right heel or observed in the resident's room. There was one pillow observed on the resident's bed which was located under her head. On 05/10/22 at 9:54 A.M. interview with Registered Nurse (RN) #121 verified Resident #10 had pressure ulcers to the coccyx, left heel, and right heel present upon admission to the facility on [DATE]. On 05/10/22 at 10:00 A.M. Resident #10 was observed lying in bed with no prevalon boots observed on the left or right heel. Observation of care being performed revealed the resident had no pressure ulcer dressing observed to the coccyx or in the garbage bag being used while incontinence care was being completed. On 05/10/22 at 10:00 A.M. interview with State tested Nursing Assistant (STNA) #127 during the observation verified there had not been a foam dressing in place to the coccyx of Resident #10 at that time. STNA #127 revealed the resident did not utilize prevalon boots to either heel and there were none located in the resident's room. On 05/10/22 at 1:55 P.M. Resident #10 was observed lying in bed on her back with her left and right heel directly against the mattress. There were no prevalon boots applied to the left or right heel or observed in the resident's room. There was one pillow observed on the resident's bed which was located under her head. On 05/11/22 at 9:20 A.M. Resident #10 was observed lying in bed on her back with her left and right heel directly against the mattress. There were no prevalon boots applied to the left or right heel or observed in the resident's room. There was one pillow observed on the resident's bed which was located under her head. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/11/22 at 3:00 P.M. interview with the Administrator verified the plan of care documented on the CNP wound care notes dated 03/25/22, 04/15/22, and 04/26/22 included to float heels while in bed, prevalon off-loading boots and keep pressure off the heels as much as possible. The Administrator verified there were no orders for prevalon off-loading boots to be applied to the resident's left and right heels or care planned interventions for prevalon off-loading boots to be worn by the resident. The Administrator verified there was no evidence of an assessments of the pressure ulcer to the resident's coccyx since 03/11/22 and also verified there was not evidence of weekly wound assessments being completed for the areas of pressure located on the residents left and right heels. Review of the facility policy titled Wound Care, revised 12/2020 revealed wounds would be evaluated when they were observed and weekly until resolved. Wounds were to be monitored for location, size, undermining, tunneling, exudates, necrotic tissue and the presence or absence of granulation tissue and epithelization. Wound evaluations were to be documented weekly and as needed.

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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** 31404 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure appropriate indwelling urinary catheter care was provided for Resident #18 to prevent urinary tract infections when staff failed to appropriately clean the resident's catheter. This affected one resident (#18) of two residents reviewed for catheters. Findings include: Record review for Resident #18 revealed an admitted [DATE] with most recent admission of 01/31/22 with diagnoses including pneumonia, depression, dysphagia, urinary tract infection, neuromuscular dysfunction of bladder, polyneuropathy, quadriplegia, cerebral infarction due to occlusion of cerebral artery, psychoactive substance abuse, bipolar disorder, nontraumatic intracranial hemorrhage, insomnia and chronic viral hepatitis C. Review of a physician's order, dated 02/09/22 revealed an order for catheter care each shift related to other neuromuscular dysfunction of the bladder. Review of the 04/09/22 annual Minimum Data Set (MDS) 3.0 assessment revealed Resident #18 was cognitively intact and required total dependence from staff for bed mobility, transfers, dressing, eating, toilet use, bathing and personal hygiene. The resident required extensive assistance for locomotion on and off unit. The resident used a wheelchair to aid in mobility, had an indwelling urinary catheter and was always incontinent of bowel. On 05/12/22 at 1:31 P.M. State tested Nursing Assistant (STNA) #127 was observed to empty the resident's urinary catheter bag and stated she had completed catheter care for Resident #18. The surveyor then asked the STNA to actually clean the resident's catheter (catheter care). STNA #127 gathered supplies, washed her hands and applied gloves. STNA #127 had a damp washcloth with soap and water and a washcloth with water for cleaning the catheter. The STNA cleaned the indwelling urinary catheter from the clear tubing area down to the collection bag. STNA #127 did not remove the resident's pants and did not clean the latex portion of the catheter where it was inserted into the resident's penis. On 05/12/22 at 1:52 P.M. interview with STNA #127 verified she did not clean the catheter around the area where it was inserted into the resident's penis or the tubing around the insertion area. ON 05/12/22 at 3:19 P.M. interview with the Director of Nursing revealed the facility policy does not indicate where to clean the catheter. The DON said her expectations would be for the catheter to be cleaned at least three to four inches from the insertion site (penis) down the tubing. Review of the 02/01/22 facility Catheter Care Policy and Procedure document revealed it was the policy to provide urinary catheter care that keeps the resident free from infection and cross contamination. Clean catheter in only one direction away from the body using a clean area of the cloth from each stroke.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record review and interviews the facility failed to ensure dietary recommendations were implemented and/or failed to ensure resident weights were obtained as ordered. This affected two residents (#10 and #16) of the three residents reviewed for nutrition. Findings include: 1. Record review for Resident #10 revealed the resident was admitted to the facility on [DATE] and had diagnoses including altered mental status, sepsis, edema, chronic kidney disease, type two diabetes mellitus with other specified complication and acute kidney failure. Review of the physician's orders revealed an order, dated 03/11/22 to obtain weight every day for three days after admission. Review of the care plan, dated 03/15/22 revealed the resident had protein malnutrition. Interventions included 30 milliliters (ml) of ProStat (a protein supplement) twice a day and an 1,800 ml fluid restriction. Review of the dietary progress note, dated 03/15/22 revealed a recommendation to add 30 ml of ProStat twice a day and implement an 1,800 ml fluid restriction due to edema. Review of the physician's orders from 03/11/22 through 05/10/22 revealed no orders for 30 ml of ProStat twice a day or an 1,800 ml fluid restriction. Review of the admission Minimum Data Set (MDS) assessment, dated 03/18/22 revealed the resident had mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 11 out of 15. The resident was assessed to require limited assistance from one staff member for bed mobility, extensive assistance from one staff member for transfers and limited assistance from one staff member for eating. There was no weight or height documented in the assessment as a dash was documented where the information was to be located. Review of documented weights for Resident #10 revealed the resident weighed 176.6 pounds on 04/11/22. No other weights were available for review. On 05/10/22 at 11:51 A.M. interview with the Director of Nursing (DON) verified there were not any weights available for Resident #10 except for the one documented on 04/11/22. The DON verified there was no follow up completed for the dietary recommendations dated 03/15/22 for an 1,800 ml fluid restriction or 30 ml of ProStat twice a day. On 05/11/22 at 10:15 A.M. interview with Registered Dietitian (RD) #800 verified the dietary recommendations made for Resident #10 on 03/15/22 had included 30 ml of ProStat twice a day to assist in wound healing and an 1,800 ml fluid restriction daily due to documented edema. RD #800 verified no weight or height had been documented on the admission MDS assessment dated [DATE] as there was not a height or weight available. RD #800 verified it was very difficult to accurately assess a resident's nutritional status without documentation of weights or height. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for Resident #16 revealed the resident was admitted to the facility on [DATE] and had diagnoses including primary generalized osteoarthritis, anxiety disorder, type two diabetes mellitus, vitamin D deficiency and lymphedema. Review of the care plan, dated 10/13/15 (revised 02/17/22) revealed the resident had the potential for/alteration in nutrition and hydration. Interventions included to weigh at the same time of day and record as ordered, provide and serve diet as ordered and obtain and monitor lab/diagnostic work as ordered. Review of a dietary progress note, dated 08/31/21 revealed a recommendation for a low concentrated sweets diet with Juven (a protein supplement taken by mouth) twice a day to aid in wound healing and prevent elevated blood glucose and weight gain. Review of the resident's current physician's orders revealed an order for a low concentrated sweet diet and Juven twice a day. The order had been in place since 09/2021. Review of the dietary progress note, dated 01/12/22 revealed a recommendation to discontinue Juven twice a day. There was no evidence this recommendation was followed up or changes to the physician's order were made. Review of the Medication Administration Record (MAR) from 09/02/21 through 05/10/22 revealed no documentation of the administration of Juven twice a day as ordered Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/12/22 revealed the resident had moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 06 out of 15. The resident was assessed to require extensive assistance from two staff members for bed mobility, was dependent upon two staff members for toileting and transfers and required limited assistance from one staff member for eating. On 05/11/22 at 10:35 A.M. interview with Registered Nurse (RN) #121 revealed orders for Juven would be put in the computer and administration would be documented by the nurse. RN #121 verified Resident #16 had not been receiving Juven as ordered.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42728 Based on review of daily staffing sheets, review of employee time clock punches and staff interview the facility failed to ensure a Registered Nurse was on-duty and present in the facility for at least eight hours daily as required. This had the potential to affect all 22 residents residing in the facility. Findings include: Review of the facility sheets titled Report of Nursing Staff Directly Responsible for Resident Care, dated 05/02/22 and 05/03/22, revealed documentation a Registered Nurse (RN) was only present for six hours each day at the facility. Review of the employee time clock punches for 05/02/22 and 05/03/22 revealed there was not an RN clocked in for work on 05/02/22 or 05/03/22. Review of the facility list provided by Business Office Manager #350 titled Agency Staffing/Hours and Other Buildings, not dated, revealed on 05/02/22 and 05/03/22 RN #805 was documented to have worked at the facility from 4:00 P.M. to 10:00 P.M. for a total of six hours each day. On 05/12/22 at 3:00 P.M. interview with the Administrator verified the facility only had an RN present in the facility for six hours each day on 05/02/22 and 05/03/22. The Administrator revealed here had been issues with the RN who was the Director of Nursing on those days and was therefore not present in the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record review, facility policy and procedure review and interview the facility failed to timely address pharmacy recommendations for Resident #20. This affected one resident (#20) of five residents reviewed for unnecessary medication use. Findings include: Record review for Resident #20 revealed the resident was admitted to the facility on [DATE] and had diagnoses including unspecified psychosis, anxiety, major depressive disorder and insomnia. Review of the Consultant Pharmacist Recommendation for Provider, dated 07/08/21 revealed a recommendation to evaluate and consider tapering off Pantoprazole at the time. The recommendation contained no documentation of the review of the recommendation. There were no documented signature(s) by the physician or facility staff present on the recommendation. Review of the Consultant Pharmacist Recommendation for Provider, dated 09/13/21 revealed the recommendation to evaluate and consider tapering off Pantoprazole at the time. The recommendation contained no documentation of the review of the recommendation. There were no documented signature(s) by the physician or facility staff present on the recommendation. Review of the Consultant Pharmacist Recommendation for Provider, dated 03/11/22 revealed the recommendation to evaluate and consider tapering off Pantoprazole at the time. The recommendation was signed and dated as being reviewed by the Cerified Nurse Practitioner on 05/11/22. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/13/22 revealed the resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15. The resident was assessed to require extensive assistance from one staff member for bed mobility, was dependent on two staff members for transfers, required extensive assistance from two staff members for toileting and required supervision with setup assistance only for eating. On 05/10/22 at 11:30 A.M. interview with the Director of Nursing (DON) verified the pharmacy recommendations dated 07/08/21 and 09/13/21 contained no evidence they had been reviewed and the 03/11/22 recommendation was not addressed until 05/11/22 (two months later). Review of the facility policy titled Pharmacy: Pharmacy Recommendations Policy, dated 01/01/16 revealed the DON or Assistant DON would review the recommendations with the physician and/or Medical Director, implement any changes into the medical record within 30 days, and the recommendations would be marked on the recommendation form by the intials of the DON or Assistant DON to show it had been completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365867	A. Building B. Wing	05/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Run Healthcare of Portsmouth	1319 Spring Street Portsmouth, OH 45662

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on record review and interview the facility failed to ensure the anti-histamine medication, Vistaril (for anxiety/agitation) was administered to Resident #11 with a current physician's order to ensure the medication was necessary. This affected one resident (#11) of five residents reviewed for unnecessary medication use. Findings include: Record review for Resident #11 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, altered mental status, sepsis, malignant neoplasm of prostate, dementia without behaviors, displaced intertrochanteric fracture of right femur, protein calorie malnutrition, dehydration and pneumonia. Record review revealed a physician's order, dated 04/21/22 for Vistaril (hydroxyzine pamoate), an anti-histamine medication sedative hypnotic medication 25 milligrams (mg) every eight hours as needed (PRN) for anxiety/agitation. The order for the medication was for 14 days. Review of the medication administration record Resident #11 received the Vistaril on 05/10/22 at 9:48 P.M. On 05/12/22 at 11:00 A.M. interview with the Director of Nursing (DON) verified the Vistaril order was for 14 days and should have ended on 05/04/22. The resident did not have a physician order for the medication at the time it was administered on 05/10/22.

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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** 31404 Based on observation, record review, medication insert review and interview the facility failed to maintain a medication error rate of less than five percent (%). The medication error rate was calculated to be 7.14% and included two medication errors of 28 medication administration opportunities. This affected two residents (#6 and #9) of three residents observed for medication administration. Findings include: 1. Record review for Resident #9 revealed an admitted [DATE] with pertinent diagnoses of: fracture of superior rim of left pubis, overactive bladder, history of COVID-19, hypothyroidism, type two diabetes mellitus, hypertension, Alzheimer's disease, epilepsy, dementia, hyperlipidemia, Parkinson's disease, major depressive disorder, insomnia and tremor. Review of a physician's order, dated 03/31/22 revealed an order for Primidone Tablet 250 milligrams (mg) give one tablet by mouth in the morning for tremors. On 05/11/22 at 8:46 A.M. Registered Nurse (RN) #121 was observed administering medications to Resident #9. RN #121 obtained a blister pack containing the medication Primidone 250 mg and administered a half of a tablet (125 mg). On 05/11/22 at 9:52 A.M. interview with RN #121 verified she only administered Resident #9 one half tablet of the Primidone 250 mg (125 mg) instead of a full tablet. RN #121 revealed the resident was to receive one tablet in the morning and half a tablet at bedtime. RN #121 revealed there was not a blister pack with a full tablet of 250 mg Primidone in the medication cart. 2. Record review for Resident #6 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, COVID-19, hypothyroidism, brief psychotic disorder and type two diabetes mellitus. Review of a physician's order, dated 07/26/21 revealed an order for Aspart Solution (insulin) 100 unit/milliliter, inject 14 units subcutaneously before meals for diabetes. Review of the physician's orders, revealed an order dated 03/29/22 for Novolog (insulin) FlexPen Solution Pen-injector 100 unit/milliliter (Insulin Aspart) per sliding scale for blood sugar (Accu checks) before meals and at bedtime. If blood sugar less than 70 call physician, for blood sugar of 150 to 200 give two units, for blood sugar 201 to 250 give four units, blood sugar 251 to 300 give six units, blood sugar 301 to 400 give nine units, blood sugar 402 to 450 give 12 units and for blood sugar 451 or above, call physician. On 05/12/22 at 10:32 A.M. Licensed Practical Nurse (LPN) #333 was observed during medication administration. At the time of the observation, the LPN was observed to obtain Resident #6's Insulin Aspart insulin pen and turned the dial to 23 units to administer insulin to the resident. At the time of the observation, LPN #333 failed to first prime the insulin pen prior to administering the dose of insulin. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/12/22 at 10:42 A.M. interview with LPN #333 verified she did not prime the insulin pen prior to administrating Resident #6 insulin. LPN #333 revealed she did not know how to prime an insulin pen. Review of the Insulin Aspart FlexPen medication insert, dated 11/01/19 revealed before each injection small amounts of air may collect in the cartridge. To avoid injecting air and to ensure proper dosing, turn the dose selector to select two units. Hold the FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect to the top of the cartridge. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. If you do not see a drop of insulin after six times, do not use the Insulin Aspart FlexPen.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42728 Based on record review and staff interview the facility failed to ensure all required members of the Quality Assessment and Assurance (QAA) committee attended meetings at least quarterly. This had the potential to affect all 22 residents residing in the facility. Findings include: Review of the QAA committee meeting minutes, dated 04/20/22 revealed the absence of the signature of the Director of Nursing (DON) to indicated the DON's presence at the meeting. On 05/12/22 at 3:00 P.M. interview with the Administrator verified the DON had not been in attendance at the QAA meeting held on 04/20/22 due to another work commitment.