| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366367 | A. Building<br>B. Wing | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Altercare of Canal Winchester Post-Acute Rc | 6725 Thrush Drive<br>Canal Winchester, OH 43110 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316<br><br>Based on medical record review and staff interview, the facility failed to ensure a resident received timely and physician ordered treatment after a change in condition. This affected one of three sampled residents ( #63). The facility census was 60.<br><br>Findings include:<br><br>Review of the closed medical record for Resident #63 revealed an admitted [DATE] and diagnoses including chronic obstructive pulmonary disorder, hypertension, and syncope. The resident was admitted from the hospital after a stay from 02/11/24 to 02/15/24 following a syncopal episode. Upon discharge from the hospital, medication orders included an albuterol inhaler two puffs every four hours as needed for wheezing (used to treat or prevent bronchospasms in individual's with lung diseases).<br><br>A nursing progress note on 02/19/24 at 2:16 P.M. revealed the physician was in to see Resident #63.<br><br>Review of a history and physical completed by the physician on 02/19/24 revealed the resident had been seen at the hospital from 02/11/24 to 02/15/24 for a syncopal episode presumed to be vasovagal. Reports feeling better in general, able to stand with a walker. The note stated she had an occasional cough. An exam documented her lungs were clear to auscultation bilaterally. Alert and oriented x 3.<br><br>Review of nurses progress notes on 02/19/24 at 7:15 P.M. by Licensed Practical Nurse (LPN) #71 revealed Resident #63 was noted to have a temperature of 99.3, oxygen saturation level of 82 (a normal level is 95% or higher) and heart rate of 115. The resident was noted to have a cough with wheezing present bilaterally. The resident was swabbed for COVID with negative results. The note stated Med One (physician service) on call notified. Physician's orders were received for Tylenol 650 milligrams every four hours as needed for fever, two liters of oxygen per nasal cannula, a chest x-ray, Mucinex Extended Release 600 milligrams twice daily for five days (relieves chest congestion and thins and loosens mucus for 12 hours), Albuterol nebulizer treatments every six hours as needed (an inhaled medication mist to treat lung conditions) for shortness of breath/wheezing, and laboratory testing on 02/20/24 to include complete blood count and comprehensive metabolic profile. The note stated the oxygen was administered and the oxygen saturation level increased to 93 percent with a heart rate of 104. The Tylenol was administered (documented on medication administration record as given at 6:21 P.M.),<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Altercare of Canal Winchester Post-Acute Rc | 6725 Thrush Drive<br>Canal Winchester, OH 43110 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the medication administration record revealed the Mucinex was not given. Record review revealed the medication was set up to be given twice daily. Once between 7:30 P.M. and 11:30 P.M. and once between 7:30 A.M. and 11:30 A.M. However, the medication was set up to start on 02/20/24 instead of 02/19/24. Therefore, the resident did not receive a dose on 02/19/24 between 7:30 P.M. and 11:30 P.M.<br><br>Review of the medication administration record revealed the Albuterol nebulizer treatment was not given after ordered on 02/19/24 for the change in condition. In addition, the Albuterol inhaler was also not used.<br><br>Review of nurses progress notes on 02/20/24 at 2:10 A.M. (approximately 7 hours later) by RN #70 revealed Resident #63 was complaining of increased shortness of breath. Resident color pallor (pale appearance), skin moist, respirations shallow, lungs clear to auscultation in the anterior but the posterior lung fields are wheezing and soft crackles. Pulse oximetry is 74 on two liters of oxygen. (no other vital signs documented). Med One (physician service) contacted and advised of assessment findings and resident complaint. Emergency services called for transport to hospital. The resident was transferred to the hospital and did not return to the facility.<br><br>Record review revealed between 6:00 P.M. on 02/19/24 and 2:10 A.M. on 02/20/24 there was no evidence Resident #63 received the Mucinex as ordered or the Albuterol nebulizer treatment as ordered. In addition, the chest x-ray had not been completed prior to transfer to the hospital.<br><br>Review of nurses progress notes revealed on 02/20/24 at 8:52 A.M. (after resident transferred to hospital) it was noted on 02/19/24 (no time) a Tylenol follow up temperature was 99.5.<br><br>Interview with LPN #71 on 03/06/24 at 12:20 P.M. confirmed she did not administer the Mucinex as ordered on 02/19/24. She stated the order was put in to start the next day and should have started that evening. She confirmed an Albuterol nebulizer treatment was not completed as ordered. She stated it was not available in the facility. She confirmed the resident had an order for an albuterol inhaler but she did not administer that as the resident's heart rate was elevated (heart rate noted to be elevated at the time the physician ordered the Albuterol nebulizer treatment). She stated the x-ray was ordered but did not occur before the resident was transferred to the hospital. She stated the change in condition occurred towards the end of her shift (she worked 7:00 A.M. to 7:30 P.M.). She stated the resident was feeling better after the Tylenol and oxygen were administered.<br><br>Interview with RN #70 on 03/06/24 at 12:30 P.M. revealed she was working the night shift from 7:00 P.M. to 7:00 A.M. when Resident #63 had a change in condition at 2:10 A.M. She confirmed she did not administer the Albuterol nebulizer treatment or Albuterol inhaler. She stated that she increased the resident's oxygen to four liters and her oxygen saturation level went up to 88-90, (however, she confirmed she did not document this in the nurses notes).<br><br>Interview with the Director of Nursing on 03/06/24 at 1:20 P.M. confirmed the Mucinex is available in the facility and should have been started on 02/19/24. She stated Albuterol nebulizer treatments are normally available in the facility but she did not know if there was one available on the evening it was ordered for Resident #63.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00151307. |

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| Altercare of Canal Winchester Post-Acute Rc | 6725 Thrush Drive<br>Canal Winchester, OH 43110 |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316<br><br>Based on medical record review, staff interview, and resident interview, the facility failed to implement an effective and individualized pain management program for Resident #50 per physician's orders. This affected resident (#50) of three sampled residents. The facility census was 60.<br><br>Actual harm occurred on 02/25/24 when Resident #50 experienced significant physical pain when her ordered narcotic pain medication was not administered for over 26 hours. The resident indicated during this time period, the pain which she reported was to her feet was rated a nine on a scale of one to 10 (with 10 being the most severe pain) limiting her ability to get out of bed and eat and causing her to cry.<br><br>Findings include:<br><br>Review of the medical record for Resident #50 revealed an admitted [DATE] and diagnoses including chronic pain, paresthesia (a tingling or prickly pins and needles sensation), and fibromyalgia.<br><br>Review of the plan of care dated 11/03/23 revealed has pain related to paresthesia of fingers/toes related to fibromyalgia. The goal included resident would verbalize they are comfortable everyday. Interventions included administer pain medications as ordered and observe for effectiveness, remind resident that reporting pain early may improve effectiveness of pain medication (level 4 or less on pain scale or before pain becomes moderate), observe for episodes of breakthrough pain and medicate as ordered, and contact physician as needed.<br><br>Record review revealed a physician's order dated 11/10/23 for Oxycodone (a narcotic pain medication) 5 milligrams every eight hours (scheduled at 6:00 A.M., 2:00 P.M., and 10:00 P.M.).<br><br>Review of a physician's progress note dated 01/11/24 revealed the resident requested to be seen for pain management and paresthesia. The note stated chronic pain stable and no indication to increase Oxycodone. History of opioid abuse. Resident reports ongoing bilateral foot pain that is not improving with any medication. Describes as burning with lightening bolts type pain.<br><br>Review of a Minimum Data Set assessment for Resident #50 completed 01/27/24 revealed a brief interview for mental status score of 15, indicating intact cognition.<br><br>Interview with Resident #50 on 03/04/24 at 11:05 A.M. revealed the weekend before last, the facility ran out of her Oxycodone pain medication. She stated she did not get the medication for 26 hours. She stated that not receiving the medication caused her to have severe pain which she described as a 9 out of 10, with ten being the worst pain and causing her to cry. On 03/06/24 at 12:05 P.M. Resident #50 stated the pain she experienced was in her feet. She stated when her pain medication was not available, she just stayed in bed and the pain got worse as the day went on. She stated it affected her appetite and she was only able to eat some of her food.<br><br>Review of the medication administration record for February 2024 revealed Oxycodone 5 milligrams was scheduled to be given every eight hours at 6:00 A.M., 2:00 P.M., and 10:00 P.M. for chronic pain. Record review revealed a dose was given at 10:00 P.M. on 02/24/24 by Registered Nurse (RN) #70.<br><br>(continued on next page) |

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| | 366367 | A. Building<br>B. Wing | 03/06/2024 |

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| Altercare of Canal Winchester Post-Acute Rc | 6725 Thrush Drive<br>Canal Winchester, OH 43110 |

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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 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the Controlled Drug Receipt/use disposition form revealed when RN #70 gave the dose of Oxycodone on 02/24/24 10:00 P.M. (signed out at 9:30 P.M.) it was the last pill available (30 pills had been received on 02/14/24).<br><br>Review of the medication administration record revealed on 02/25/24 at 6:00 A.M. RN #70 documented that the Oxycodone was not given at that time. On 02/25/24 at 2:00 P.M. Licensed Practical Nurse (LPN) #89 documented the Oxycodone was given. However, interview with LPN #89 on 03/06/24 at 11:20 A.M. revealed, even though she documented it was given (on 02/25/24 at 2:00 P.M.), she did not administer the Oxycodone to Resident #50 at that time because it was not available to give. She stated the facility had ran out of Oxycodone for Resident #50 and she was unable to get a dose out of the emergency supply because the pharmacy was unable to give authorization to do so due to a glitch in their system. She stated Resident #50 did experience pain in her feet and back during this time that she described as a level of 2.<br><br>Review of the treatment administration record revealed an order to assess pain every shift on a scale of 0-10. On 02/25/24 LPN #89 documented that Resident #50 had 0 pain from 7:30 A.M. to 7:30 P.M. Interview with LPN #89 on 03/06/24 at 11:20 A.M. confirmed that this was not an accurate documentation since Resident #50 did have pain on that shift when her pain medication was not available all day. LPN #89 further stated she did not notify the physician when Resident #50's pain medication was not available.<br><br>Review of the medication administration record revealed on 02/25/24 at 10:00 P.M. RN #70 documented that the Oxycodone was not given at that time. A note at 9:17 P.M. by RN #70 stated the medication was pending delivery and the pharmacy computer was not able to give authorization. Review of a nursing progress note on 02/26/24 at 12:30 A.M. revealed the pharmacy delivered the Oxycodone and it was given late at that time (for the 10:00 P.M. dose on 02/25/24).<br><br>Review of the Controlled Drug Receipt/Disposition Form revealed a quantity of 30 Oxycodone pills were received on 02/26/24 with the first dose signed out on 02/26/24 at 12:15 A.M. by RN #80. Review of the treatment administration record for 02/25/24 for 7:30 P.M. to 7:30 A.M. revealed RN #80 also documented that Resident #50 had no pain during the shift.<br><br>Interview with RN #80 on 03/06/24 at 12:30 P.M. confirmed she gave the last dose of Oxycodone that was available to Resident #50 on 02/24/24 for the 10:00 P.M. dose. She stated a refill sticker should be faxed to the pharmacy a couple of days before a medication runs out so the pharmacy has time to refill and deliver it before the resident runs out. She stated she did not remember if the sticker had been removed when she gave the last dose or if she removed the sticker and faxed it to the pharmacy when the last dose was administered. She stated she called the pharmacy to authorize getting a dose out of the emergency supply for the dose at 6:00 A.M. on 02/25/24 but the pharmacy was unable to authorize this due to a glitch in their system. She stated the Oxycodone was not delivered from the pharmacy until 02/26/24. She stated she then gave the 02/25/24 10:00 P.M. dose late at 12:15 A.M. on 02/26/24. She confirmed that, although she documented that Resident #50 had no pain during the shift, the resident had chronic pain so she was having pain. She stated she did not know what level of pain the resident had.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview with the Director of Nursing on 03/06/24 at 11:40 A.M. confirmed Resident #50 did not receive her scheduled pain medication (Oxycodone) from 10:00 P.M. on 02/24/24 to 12:15 A.M. on 02/26/24 (over 26 hours). She stated she did not know why the facility ran out. She stated the nurse was to reorder the medication soon enough that the pharmacy has time to deliver it.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00151307. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316<br><br>Based on medical record review, resident interview, and staff interview, the facility failed to ensure medical records were complete and accurately documented. This affected two of three sampled residents (#50, #63). The facility census was 60.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #50 revealed an admitted [DATE] and diagnoses including chronic pain, paresthesia (a tingling or prickly pins and needles sensation), and fibromyalgia. Record review revealed a physician's order 11/10/23 for Oxycodone (a narcotic pain medication) 5 milligrams every eight hours (scheduled at 6:00 A.M., 2:00 P.M., and 10:00 P.M.). Review of a Minimum Data Set assessment completed 01/27/24 revealed a brief interview for mental status score of 15, indicating intact cognition.<br><br>Interview with Resident #50 on 03/04/24 at 11:05 A.M. revealed the weekend before last, the facility ran out of her Oxycodone pain medication. She stated she did not get the medication for 26 hours. She stated that not receiving the medication caused her to have severe pain which she described as a 9 out of 10, with ten being the worst pain and causing her to cry. On 03/06/24 at 12:05 P.M. Resident #50 stated the pain she experienced was in her feet. She stated when her pain medication was not available, she just stayed in bed and the pain got worse at the day went on. She stated it affected her appetite and she was only able to eat some of her food.<br><br>On 02/25/24 at 2:00 P.M. Licensed Practical Nurse (LPN) #89 documented the Oxycodone was given. However, interview with LPN #89 on 03/06/24 at 11:20 A.M. revealed, even though she documented it was given, she did not administer the Oxycodone to Resident #50 at that time because it was not available to give. She stated the facility had ran out of Oxycodone for Resident #50 and she was unable to get a dose out of the emergency supply because the pharmacy was unable to give authorization to do so due to a glitch in their system. She confirmed she should not have documented that it was given when it was not. She stated Resident #50 did experience pain in her feet and back during this time that she described as a level of 2. Review of the treatment administration record revealed an order to assess pain every shift on a scale of 0-10. On 02/25/24 LPN #89 documented that Resident #50 had 0 pain from 7:30 A.M. to 7:30 P.M. Interview with LPN #89 on 03/06/24 at 11:20 A.M. confirmed that this was not an accurate documentation since Resident #50 did have pain on that shift when her pain medication was not available all day.<br><br>Review of the treatment administration record for 02/25/24 for 7:30 P.M. to 7:30 A.M. revealed RN #80 also documented that Resident #50 had no pain during the shift.<br><br>Interview with RN #80 on 03/06/24 at 12:30 P.M. confirmed that, although she documented that Resident #50 had no pain during the shift, the resident has chronic pain so she was having pain. She stated she did not know what level of pain the resident had.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the closed medical record for Resident #63 revealed an admitted [DATE] and diagnoses including chronic obstructive pulmonary disorder, hypertension, and syncope. The resident was admitted from the hospital after a stay from 02/11/24 to 02/15/24 following a syncopal episode.<br><br>Review of nurses progress notes on 02/19/24 at 7:15 P.M. by Licensed Practical Nurse (LPN) #71 revealed Resident #63 was noted to have a temperature of 99.3, oxygen saturation level of 82 (a normal level is 95% or higher) and heart rate of 115. The resident was noted to have a cough with wheezing present bilaterally. The resident was swabbed for COVID with negative results. The note stated Med One (physician service) on call notified. Physician's orders were received for Tylenol 650 milligrams every four hours as needed for fever, two liters of oxygen per nasal cannula, a chest x-ray, Mucinex Extended Release 600 milligrams twice daily for five days (relieves chest congestion and thins and loosens mucus for 12 hours), Albuterol nebulizer treatments every six hours as needed (an inhaled medication mist to treat lung conditions) for shortness of breath/wheezing, and laboratory testing on 02/20/24 to include complete blood count and comprehensive metabolic profile. The note stated the oxygen was administered and the oxygen saturation level increased to 93 percent with a heart rate of 104. The Tylenol was administered.<br><br>Review of nurses progress notes on 02/20/24 at 2:10 A.M. (approximately 7 hours later) by RN #70 revealed Resident #63 was complaining of increased shortness of breath. Resident color pallor (pale appearance), skin moist, respirations shallow, lungs clear to auscultation in the anterior but the posterior lung fields are wheezing and soft crackles. Pulse oximetry is 74 on two liters of oxygen. (no other vital signs documented). Med One (physician service) contacted and advised of assessment findings and resident complaint. Emergency services called for transport to hospital. The resident was transferred to the hospital and did not return to the facility. No other treatment was documented.<br><br>Review of nurses progress notes dated 02/20/24 at 8:52 A.M. (after resident transferred to hospital) it was noted on 02/19/24 (no time) a Tylenol follow up temperature was 99.5.<br><br>Interview with RN #70 on 03/06/24 at 12:30 P.M. revealed she was working the night shift from 7:00 P.M. to 7:00 A.M. when Resident #63 had a change in condition at 2:10 A.M. She stated that she increased the resident's oxygen to four liters and her oxygen saturation level went up to 88-90, (however, she confirmed she did not document this in the nurses notes).<br><br>This deficiency is based on incidental findings discovered during the course of this complaint investigation. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316<br><br>Based on observations and staff interview, the facility failed to maintain a sanitary environment for resident showers. This affected one resident (#64). The facility census was 60.<br><br>Findings include:<br><br>Observations of the shower in Resident room [ROOM NUMBER] on 03/04/24 at 1:40 P.M. revealed there were four areas of dried brown material on the floor of the shower that appeared to be bowel movement.<br><br>Interview with the Director of Nursing on 03/04/24 at 1:40 P.M. confirmed the dried brown material on the floor of the shower in Resident room [ROOM NUMBER]. She stated that there was currently not a resident residing in the this room. She stated the resident who had resided in the room had went to the hospital the previous day (Resident #64). She stated Resident #64 had not used the shower and did not use a bedside commode/bedpan. She stated that if a resident used a bedside commode/bedpan, it should be emptied in the toilet, not the shower. She stated the dried brown material should not be there.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00151307. |