STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365088	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Englewood Health and Rehab	425 Lauricella Court Englewood, OH 45322

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	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** 36303 Based on review of medical records, observation, staff interview, and review of facility policy, the facility failed to ensure staff observed a resident consume oral medications. The facility also failed to ensure medications were stored properly. This affected two (#84 and #24) of two residents observed for medication administration. The census was 89. Findings include: 1. Review of Resident #84's medical record revealed an admitted [DATE]. Diagnoses listed included congestive heart failure, type two diabetes mellitus, depression, anxiety disorder, and restless leg syndrome. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #84 had moderate cognitive impairment. Observation of Resident #84's medication administration on 10/09/24 at 8:11 A.M. revealed Licensed Practical Nurse (LPN) #110 pulled ten oral medications for administration. The medications were aspirin 81 milligrams (mg), Buspar 10 mg, Coreg 12.5 mg, digoxin 0.25 mg, Fenofibrate 160 mg, isosorbide dinitrate 30 mg two tablets, Lisinopril 10 mg, Metformin 500 mg two tablets, Omeprazole 20 mg, and Prosight Multivitamin. LPN #110 took the the medications in a medication cup to Resident #84's room on 10/09/24 at 8:17 A.M. LPN #110 gave the medications to Resident #84 and left the room. LPN #110 did not observe Resident #84 take any of the medications before exiting the room. Interview with LPN #110 on 10/09/24 at 8:20 A.M. confirmed she had left medications with Resident #84 and had not watched them be taken/consumed. Further review of Resident #84's medical record revealed there was no physician order, care plan, or other documentation permitting the resident to self-administer medications. Review of the facility's policy titled Administering Oral Medications dated October 2010 revealed staff should remain with the resident until all s are taken. (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
	365088	A. Building B. Wing	10/09/2024

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #24's medical record revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, anemia, kidney failure, depression. heart failure, seizures, morbid obesity, dysphagia, and hypothyroidism. Review of an annual MDS assessment dated [DATE] revealed Resident #24 had severe cognitive impairment. Observation of Resident #24's medication administration on 10/09/24 at 8:24 A.M. revealed Registered Nurse (RN) #200 pulled nine oral medications for administration. The medications were Prednisone 20 mg, folic acid 1 mg, levothyroxine 75 micrograms (mcg), potassium chloride 20 milliequivalent's (mEq), multivitamin, vitamin B12 500 mg, Venlafaxine 150 mg, and Depakote 125 mg eight capsules. RN #200 crushed all medications except Venlafaxine and Depakote which were capsules that were opened and potassium chloride that was left whole. All medications were mixed in pudding for administration. Observation on 10/09/24 at 8:52 A.M. revealed Resident #24 would not awaken for RN #200 to administer medications. RN #200 then took the medications mixed in pudding and placed the medication cup uncovered in the top drawer of the medication cart. RN #200 stated she did not know if this was the correct way to store Resident #24's medications, but did not want Resident #24 to miss taking them. Observation on 10/09/24 at 9:17 A.M. revealed Resident #24's medication in pudding remained in a medication cup in the top drawer of the medication cart. Interview with the Director of Nursing (DON) and RN #200 confirmed Resident #24's medications in pudding should not be stored in the medication cart. Review of the facility's policy titled Medication Labeling and Storage dated 2001 revealed medications and biological's are stored n the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. This deficiency represents an incidental finding discovered during the course of the complaint investigation.