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	01/28/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, staff interview, and review of the facility policy, the facility failed to administer medications as ordered by the physician. This affected two residents (#11 and #12) of three reviewed for medication administration. The facility census was 83. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE]. The resident was admitted with diagnoses including diabetes mellitus type two, Chronic Obstructive Pulmonary Disease (COPD), and breast cancer. The resident was admitted to hospice on 01/18/25. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of eight, indicating impaired cognition. She required set up for meals and toileting and supervision for bed mobility and transfers. Review of the physician orders revealed an order for Gabapentin (Diabetic Neuropathy) 100 milligram (mg) capsule three times a day with a start date of 12/04/24. Review of the December 2024 Medication Administration Record (MAR) revealed Gabapentin was scheduled daily at 6:00 A.M., 2:00 P.M. and 10:00 P.M. On 12/06/24 the 10:00 P.M. dose was marked with a seven, 12/07/24 all three doses were marked as seven, on 12/08/24 the 6:00 A.M. dose was marked as seven, at 2:00 P.M. was marked as three, and 12/09/24 the 10:00 P.M. dose was marked seven. Review of the codes revealed both seven and three indicated to see nurses notes. Review of the progress notes regarding the Gabapentin on 12/07/24, 12/08/24, and 12/09/24 documented the medication was unavailable in the pyxis and awaiting delivery from pharmacy. Interview on 01/28/25 at 8:31 A.M. with the Director of Nursing (DON) verified Gabapentin had been unavailable for administration on 12/06/24, 12/07/24 and 12/08/24. 2. Review of the medical record for Resident #12 revealed an admitted [DATE]. The resident was admitted with diagnoses including stroke, diabetes mellitus type two, COPD. The resident remained at the facility. (continued on next page)

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.

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	01/28/2025

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Englewood Health and Rehab	425 Lauricella Court Englewood, OH 45322

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS assessment dated [DATE] revealed he had a BIMS score of one, indicating significantly impaired cognition. He required set up assistance for meals, maximum assistance for toileting hygiene and transfers, and moderate assistance with bed mobility. Review of the physician orders revealed an order for Gabapentin 100 mg capsule three times a day with a start date of 12/04/24. Record review of the December MAR revealed Gabapentin was scheduled daily at 5:00 A.M., 2:00 P.M. and 10:00 P.M. There was a seven entered on 12/06/24 for all three doses. Further review revealed a seven was also entered on 12/16/24 at 10:00 P.M. and on 12/17/24 at 5:00 A.M. Review of the progress notes regarding the Gabapentin on 12/06/24, 12/16/24, and 12/17/24 documented the medication was unavailable and awaiting delivery from pharmacy. Interview on 01/28/25 at 8:31 A.M. with the Director of Nursing (DON) verified Gabapentin had been unavailable for administration on 12/06/24, 12/16/24, and 12/17/24. Review of the facility policy, Administering Medication, last revised 04/2019 revealed medications were to be administered in accordance with prescriber orders. This deficiency represents non-compliance investigated under Complaint Number OH00160802.

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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	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. 44076 Based on observations, staff interviews and policy review, the facility failed to ensure medications were stored in the containers from which they had been received. This had the potential to affect eleven (#11, #12, #17, #18, #19, #20, #21, #22, #23, #24 and #25) residents with medications stored in the medication cart. The facility census was 83. Findings include: Observation on 01/24/25 at 10:06 A.M. with Registered Nurse (RN) #24 revealed while preparing to administer medications, RN #24 opened the top drawer of the medication cart. There was an unmarked medication cup amongst the over-the-counter medications which contained 16 white, oblong tablets. Interview at the time of the observation with RN #24 verified the medication had been present at the start of her shift and she did not know what the medication was. She proceeded to dispose of the medication. The facility confirmed there were eleven (#11, #12, #17, #18, #19, #20, #21, #22, #23, #24 and #25) residents with medications stored in the medication cart. Review of the facility policy, Medication and Storage date 2001 revealed medications and biologics are stores in the packaging, containers or other dispensing systems in which they were received. The following deficiency is based on incidental findings discovered during the course of this complaint investigation.