STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365147	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Oaks Health Center	4114 North State Route 376 NW McConnelsville, OH 43756

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 - Some	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** 28923 Based on observation, staff interview, and policy review, the facility failed to ensure medications were properly dated when first accessed/ used. This involved three of four medication administration carts and affected a total of eight residents (#30, #32, #50, #54, #55, #63, #75, and #77). The facility's census was 87. Findings include: 1 a.) On 09/23/24 at 10:09 A.M., an observation of the 400 hall medication administration cart with Licensed Practical Nurse (LPN) #35 revealed there were three multi-use vials of Lantus (slow acting insulin) 100 units/ milliliter (ml) 10 ml vials in the top drawer of the medication administration cart for Resident #32. The vials were stored in one bag and all three vials had been opened. The label on the bag the insulin vials were stored in provided directions under a high alert. The directions indicated the insulin should be refrigerated and, once opened, it should be discarded after 28 days. There was a place on the label to indicate the date when the vial had been opened. A date was not added on the label and none of the three multi-use vials had a date written on them to show when they had been opened/ accessed. Findings were verified by LPN #35 at the time of the observation. There was also three vials of Lantus 100 units/ ml 10 ml vials in a bag for Resident #77. All three of the vials had been opened and none of the three were dated when first accessed. The label on the bag the insulin vials were being stored in included a high alert that indicated once opened it was to be discarded after 28 days. The label included a place to write the date the vial was opened, but was intended to hold only one vial. There was the numbers 7-16 written on the label, but it was not clear if that was a date one of the vials had been opened or not. If it was a date one of the vials were opened, it would have exceeded the 28 days in which it should have been discarded. Findings were verified by LPN #35 at the time of the observation. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the 400 hall medication administration cart revealed there was a small box in the top of the medication cart that contained Latanoprost 0.005% ophthalmic (eye) solution for Resident #75. The plastic bottle inside the box that held the eye drops had been opened. There was no date on the bottle or the box to indicate when the medication bottle was opened. The label on the box the eye drops came in provided direction on the storage of the medication. The label revealed the opened bottle could be stored at room temperature and was to be discarded after six weeks. Without a date, it was not clear as to when the ophthalmic eye drops should be discarded. Findings were verified by LPN #35 at the time of the observation. On 09/23/24 at 10:15 A.M., an interview with LPN #35 revealed all multi- use vials and other medications that were multi-use should be dated when first accessed/ opened. She confirmed you would not know when to discard the medication, after it had been opened, in accordance with the instructions included on the medication labels. 1 b.) On 09/23/24 at 10:35 A.M., an observation of the 300 hall medication administration cart with Registered Nurse (RN) #500 present revealed there were three bottles of liquid medicine found in the medication administration cart that was not dated when opened. One bottle was a stock bottle of Maalox 12 fluid ounce (355 ml) that was in the bottom drawer of the medication cart and had been opened. There was no date on the outside of the bottle to indicate when it had been opened. There was also a bottle of Lactulose solution 10 Grams (Gms)/ 15 ml for Resident #55 that had been opened and not dated. A third bottle of [NAME]/ PSE/ DM syrup 2/30/10 for Resident #30 that was found in one of the lower pull out drawers that had been opened. It was not dated after it had been opened. Findings were verified by RN #50 at the time of the observation. On 09/23/24 at 10:39 A.M., an interview with RN #500 revealed bottles containing liquid medication should be dated when first opened. She was not able to determine when the three bottles found in the medication administration cart had been opened. 1 c.) On 09/23/24 at 10:55 A.M., an observation of the medication administration cart for the 200 hall with RN #100 present revealed there was a Lantus 100 unit/ ml flexpen that was found in the top drawer of the medication cart that belonged to Resident #63. The flexpen had been used, but was not dated to reflect when it was first used. The label on the bag the flexpen was stored in included a high alert that indicated once opened it could be stored at room temperature for 26 days. There was a place on the label for them to indicate the date it was opened but no date was added. Findings were confirmed with RN #100 at the time of the observation. She confirmed flexpens should be dated when first used, so the nurses knew when to discard them by. There was a Novolog 100 unit/ ml flexpen for Resident #54 found in the top drawer of the 200 hall medication cart that was being used. There was no date written on the flexpen or on the label on the bag the flexpen was stored in that indicated when it had first been used. The label included a high alert that directed the nurses the flexpen could be stored at room temperature for up to 28 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was also two Tresiba (insulin) 100 units/ ml flexpens for Resident #50 that were found in the top drawer of the medication cart. One of the flexpens was dated 09/12/24 to show when it was first used. The other flexpen was not dated and could not be determined if it had been used or not. The label on the bag it came in had a high alert that instructed the staff to refrigerate and once opened it could be stored at room temperature for up to 65 days. RN #100 confirmed Resident #50 should not have two Tresiba flexpens stored in the medication cart at the same time. She stated the flexpen that was not in use should have been stored in the refrigerator, as the label indicated, until it was put in use. She further acknowledged all multi-use flexpens should be dated when first used, so the nursing staff would know the date the flexpens should be discarded by. She confirmed none of the insulin flexpens mentioned above had a date on the flexpen or on the bag they came in to show when they were first used. Review of the facility's policy on Storage of Medications (revised 04/2007) revealed the facility should store all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals should be stored in the packaging, containers or other dispensing systems in which they were received. Only the issuing pharmacy was authorized to transfer medications between containers. The facility should not use discontinued, outdated, or deteriorated drugs or biologicals. This deficiency represents non-compliance investigated under Complaint Number OH00157490.