STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365256	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Worthington, The	1030 High St Worthington, OH 43085

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 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** 36297 Based on observations, record review, interview, and policy review, the facility failed to ensure a medication error rate of less than five percent. Three medication errors out of 30 opportunities for error resulted in a medication error rate of ten percent. This affected two (Residents #38 and #66) of five residents observed for medication administration. The census was 92. Findings include: 1. Review of physician orders revealed Resident #38 had Diclofenac sodium external gel (Non-steroidal anti-inflammatory) one percent topical, apply 0.5 grams to bilateral knees two times a day for pain. During observation of medication pass for Resident #38 on 05/30/24 at 8:10 A.M., Licensed Practical Nurse (LPN) #100 revealed there was no Diclofenac sodium external gel available in the medication cart for Resident #38. During an interview on 05/30/24 at 11:07 A.M., LPN #100 confirmed the resident did not receive his Diclofenac sodium external gel to his knees as the medication was not available. 2. Resident #66 had physician orders for Divalproex sodium tablet delayed release tablets (anti-seizure medication used as a mood stabilizer) 125 milligrams (mg), give three tablets by mouth twice daily for psychosis and enteric coated aspirin, delayed release 81 mg daily for heart health. During observation of medication pass for Resident #66 on 05/30/24 at 8:35 A.M., LPN #100 crushed the Divalproex sodium delayed release tablets, and the Aspirin EC pill and administered the medication to the resident. During an interview on 05/30/24 at 8:48 A.M. LPN #100 stated she crushes medications which are allowed to be crushed. LPN #100 stated she knows what medications can be crushed or it is written on the medication administration record During interview on 05/30/24 at 2:56 P.M., the Director of Nursing (DON) stated the nursing report sheet indicated who in the facility required to have their medications crushed and if a resident required crushed medications the facility would obtain the medications in a form that was able to be crushed. The DON verified Divalproex Sodium tablets and enteric coated Aspirin were medications that were on the do not crush list the facility followed and should not have been crushed. (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
	365256	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Worthington, The	1030 High St Worthington, OH 43085

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Common Oral Dosage Forms That Should Not Be Crushed provided by the facility dated 2023 revealed Aspirin, [NAME] Aspirin EC, tablet should not be crushed. Divalproex sodium tablet delayed release should no be crushed. Review of the policy titled Medication Administration, last revised 10/17/23, revealed resident medications are administered in an accurate, safe, timely, and sanitary manner. Liquid Dosage forms are used whenever practical in place of solid tablets that would have to be crushed, especially for administration through enteral feeding tubes. This incidental deficiency represents non-compliance investigated under Complaint Number OH00153578.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365256	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Worthington, The	1030 High St Worthington, OH 43085

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36297 Based on observation, record review, interview and policy review the facility failed to ensure timed released medications were not crushed, resulting in a significant medication error. This affected one (Resident #66) of five residents reviewed for medication administration. The census was 92. Findings include: Resident #66 had physician orders for Divalproex sodium tablet delayed release tablets (anti-seizure medication used as a mood stabilizer) 125 milligrams (mg), give three tablets by mouth twice daily for psychosis and enteric coated aspirin, delayed release 81 mg daily for heart health. During observation of medication pass for Resident #66 on 05/30/24 at 8:35 A.M., LPN #100 crushed the Divalproex sodium delayed release tablets, and the Aspirin EC pill and administered the medication to the resident. During an interview on 05/30/24 at 8:48 A.M. LPN #100 stated she crushes medications which are allowed to be crushed. LPN #100 stated she knows what medications can be crushed or it is written on the medication administration record During interview on 05/30/24 at 2:56 P.M., the Director of Nursing (DON) stated the nursing report sheet indicated who in the facility required to have their medications crushed and if a resident required crushed medications the facility would obtain the medications in a form that was able to be crushed. The DON verified Divalproex Sodium tablets and enteric coated Aspirin were medications that were on the do not crush list the facility followed and should not have been crushed. Review of the Common Oral Dosage Forms That Should Not Be Crushed provided by the facility dated 2023 revealed Aspirin, [NAME] Aspirin EC, tablet should not be crushed. Divalproex sodium tablet delayed release should no be crushed. Review of the policy titled Medication Administration, last revised 10/17/23, revealed resident medications are administered in an accurate, safe, timely, and sanitary manner. Liquid Dosage forms are used whenever practical in place of solid tablets that would have to be crushed, especially for administration through enteral feeding tubes. This incidental deficiency represents non-compliance investigated under Complaint Number OH00153578.