

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2024
NAME OF PROVIDER OR SUPPLIER  Shelby Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  705 Fulton Street Sidney, OH 45365	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46613</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record reviews, staff and resident interviews, facility investigation reviews, and facility policy review, the facility failed to ensure resident's medications were administered as ordered resulting in significant medication errors. This affected two (#12 and #13) out of four reviewed for medication administration. The facility census was 36.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #13 revealed an admitted [DATE] with medical diagnoses of osteoarthritis, gout, hyperparathyroidism, diabetes mellitus (DM), obesity, end stage renal disease (ESRD), and atrial fibrillation.</p> <p>Review of the medical record for Resident #13 revealed a quarterly Minimum Data Set (MDS) assessment, dated 03/19/24, which indicated Resident #13 was cognitively intact and required moderate staff assistance with toilet hygiene and bed mobility and maximum staff assistance with bathing and transfers.</p> <p>Review of a facility investigation report, dated 04/10/24, stated Resident #13 was inadvertently administered a dose of Lyrica in error. The report did not indicate the dose of Lyrica that was administered. The report stated Resident #13 complained of feeling loopy but denied any pain or dizziness. The report continued to indicate Resident #13 stated she received a white pill in the morning. The report stated Resident #13's nurse prepared another resident's medications and was interrupted during the task to assist another staff member. The report stated the nurse locked the prepared medications in the medication cart and when she returned, she mistakenly administered the wrong medication to Resident #13. Per the report, Resident #13 remained alert and oriented to person, place, time, and situation and did not have adverse reaction to the medication administration error. Per the investigation report, the facility staff monitored Resident #13 for any adverse reactions on the day of the medication error, 04/11/24, and 04/13/24. No adverse reactions were reported.</p> <p>Review of the medical record for Resident #13 revealed no documentation related to the medication administration error on 04/10/24.</p> <p>(continued on next page)</p>

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
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/08/24 at 9:21 A.M. with Resident #13 stated she was informed by the nurse that she was administered a medication in error. Resident #13 stated her lips felt numb, she felt weird, and had some mood swings after the medication was administered. Resident #13 stated staff observed her for a change of condition closely for several days. Resident #13 denied any adverse reactions related to the allegation.</p> <p>Interview on 05/08/24 at 1:18 P.M. with Director of Nursing (DON) confirmed Resident #13 received a medication that was not ordered for her on 04/10/24. DON stated Resident #13 did not experience a change of condition from the medication administration error. DON stated Resident #13 and the physician were notified of the medication administration error.</p> <p>2. Review of the medical record Resident #12 revealed an admitted [DATE] with medical diagnoses of cellulitis, multiple sclerosis, bipolar disorder, hypertension (HTN), and hypothyroidism.</p> <p>Review of the medical record for Resident #12 revealed an admission MDS assessment, dated 03/22/24 which indicated Resident #12 was cognitively intact and required moderate staff assistance with toilet hygiene, bed mobility, and bathing and supervision with transfers.</p> <p>Review of the medical record for Resident #12 revealed a physician order dated 03/16/24 for Lyrica 150 milligram (mg) capsule, give one capsule by mouth three times a day for neuropathy.</p> <p>Review of the medical record for Resident #12 revealed a nurse's progress note dated 04/23/24 at 11:55 A.M. which stated Resident #12 was given an extra dose of Lyrica with morning medication pass. No adverse effects noted, assessment done, vitals taken. The note stated the physician was notified and staff were to monitor Resident #12 for sedation per the physician.</p> <p>Review of a facility investigation report, dated 04/23/24, stated Resident #12 was given an extra dose of Lyrica 150 mg by mouth with morning medication pass. The report stated Resident #12 was alert and oriented to person, place, time, and situation and was notified of the medication administration error. The report also stated Resident #12's physician was notified of the medication administration error. The report indicated the staff monitored Resident #12 for any adverse reactions the day of the medication administration error, 04/24/24, and 04/25/24. No adverse reactions were reported.</p> <p>Interview on 05/08/24 at 1:18 P.M. with DON confirmed Resident #12 received an extra dose of Lyrica on 04/23/24. DON stated Resident #12 did not have a change of condition and remained alert and oriented to person, place, and time. DON stated Resident #12 and her physician were notified of the medication administration error.</p> <p>Review of the facility policy titled, Administering Medications, revised April 2019, stated medications are to be administered in accordance with prescriber's orders. The policy also stated any medication errors are documented, reported, and reviewed by the Quality Assurance Improvement Performance (QAPI) committee to inform process changes and or the need for additional staffing.</p> <p>As a result of the incident, the facility took actions to correct the deficient practice by 05/07/24:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/10/24, the DON provided education to Licensed Practical Nurse #9, that was responsible for the medication error involving Resident #13, on medication administration policy, Five Rights of Medication Administration, and verification of resident identity using photo identification on Medication Administration Record (MAR).</p> <p>On 04/10/24, facility physician was notified regarding the medication error for Resident #13 by DON/designee.</p> <p>On 04/10/24 A medication observation was completed by DON/designee to ensure there were no like incidents and no additional variances were identified.</p> <p>On 04/10/24, facility nurses were educated on medication administration, Five Rights of medication administration, and verification of resident identity via MAR photo by DON/designee.</p> <p>On 04/10/24, DON/designee audited medication administration by observation three times weekly for four weeks to ensure medications are administered as ordered.</p> <p>On 04/23/24, DON provided education to Registered Nurse (RN) #10, that was responsible for the medication administration error involving Resident #12, on the Five Rights of medication administration and medications errors. RN #10 was observed for medication administration prior to the next shift by DON/designee.</p> <p>On 04/23/24, all resident was assessed for adverse changes and/or sedation with no variances from baseline by DON/designee.</p> <p>On 04/23/24, Resident #12 was notified of medication administration error by DON/designee. Resident #12 was self-responsible.</p> <p>On 04/23/24, physician was notified of medication administration error involving Resident #12 with no new orders by DON/designee.</p> <p>On 04/27/24, all licensed nurses received education related to the Five Rights of medication administration and medication errors prior to or on their next scheduled shift by DON/designee.</p> <p>On 04/27/24, all licensed nurses were administered the medication competency test and passed the test prior to or on their next scheduled shift by DON/designee.</p> <p>On 04/27/24, all licensed nurses received education related to use of the electronic MAR prior to their next scheduled shift by DON/designee.</p> <p>On 04/27/24, medication pass observation was completed for all licensed nurses prior to them taking a medication cart on their next scheduled shift by the DON/designee.</p> <p>Starting on 04/27/24, DON/designee would complete medication pass observation audits five days weekly on varying shifts. As of 05/07/24, there had been no further medication errors identified.</p> <p>On 04/27/24, results of these audits would be reported to the Interdisciplinary Team (IDT) and on-going compliance will be maintained through recommendations of the IDT team.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00153184.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46613</p> <p>Based on medical record review, staff interview, and policy review, the facility failed to ensure a resident's medical record contained documentation involving a medication error. This affected one (#13) out of four residents reviewed for medication administration. The facility census was 36.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #13 revealed an admitted [DATE] with medical diagnoses of osteoarthritis, gout, hyperparathyroidism, diabetes mellitus (DM), obesity, end stage renal disease (ESRD), and atrial fibrillation.</p> <p>Review of the medical record for Resident #13 revealed a quarterly Minimum Data Set (MDS) assessment, dated 03/19/24, which indicated Resident #13 was cognitively intact and required moderate staff assistance with toilet hygiene and bed mobility and maximum staff assistance with bathing and transfers.</p> <p>Review of a facility investigation report, dated 04/10/24, stated Resident #13 was inadvertently administered a dose of Lyrica in error. The report did not indicate the dose of Lyrica that was administered. The report stated Resident #13 complained of feeling loopy but denied any pain or dizziness. The report continued to indicate Resident #13 stated she received a white pill in the morning. The report stated Resident #13's nurse prepared another resident's medications and was interrupted during the task to assist another staff member. The report stated the nurse locked the prepared medications in the medication cart and when she returned, she mistakenly administered the wrong medication to Resident #13. Per the report, Resident #13 remained alert and oriented to person, place, time, and situation and did not have adverse reaction to the medication administration error. Per the investigation report, the facility staff monitored Resident #13 for any adverse reactions on the day of the medication error, 04/11/24, and 04/13/24. No adverse reactions were reported.</p> <p>Review of the medical record for Resident #13 revealed no documentation related to the medication administration error on 04/10/24.</p> <p>Interview on 0508/24 at 1:18 P.M. with Director of Nursing (DON) confirmed the medical record for Resident #13 did not contain documentation related to the medication administration error on 04/10/24.</p> <p>Review of the policy titled, Administering Medications, revised April 2019, stated medications are to be administered in accordance with prescriber's orders. The policy also stated any medication errors are documented, reported, and reviewed by the Quality Assurance Performance Improvement committee to inform process changes and or the need for additional staffing.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153184. This deficiency represents ongoing noncompliance from the survey dated 04/14/24.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46613</p> <p>Based on medical record review, observation, staff interview, and policy review, the facility failed to follow infection control procedures during medication administration. This affected one (#14) resident out of the two residents observed for medication administration. The facility census was 36.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #14 revealed an admitted [DATE] with medical diagnoses of hypertension, chronic obstructive pulmonary disease, and encephalopathy.</p> <p>Review of the medical record for Resident #14 revealed a quarterly Minimum Data Set (MDS) assessment, dated 04/29/24, which indicated Resident #14 had severe cognitive impairment and required maximum staff assistance with toilet hygiene and bathing, moderate staff assistance with bed mobility and supervision with eating.</p> <p>Review of the medical record for Resident #14 revealed physician orders dated 01/22/24 for carvedilol 3.125 milligram (mg) one tablet by mouth every 12 hours; levetiracetam 500 mg one tablet by mouth two times per day; and senna plus 8.6 mg one tablet by mouth two times per day. The medical record revealed physician orders dated 01/23/24 for amlodipine besylate 5 mg one tablet by mouth daily; folic acid 1 mg one tablet by mouth daily; and thiamine 100 mg one tablet by mouth daily.</p> <p>Observation on 05/08/24 at 7:30 A.M. revealed Licensed Practical Nurse (LPN) #153 prepared medications for administration to Resident #14. LPN #153 was observed to drop amlodipine besylate 5 mg tablet and carvedilol 3.125 mg tablet onto the medication cart and pick both medications up with her bare hands and place the medications into the medication cup along with Resident #14's other medications. Observations revealed LPN #153 then administered medications to Resident #14 and used hand sanitizer upon exiting Resident #14's room.</p> <p>Interview on 05/08/24 at 7:33 A.M. with LPN #153 confirmed she picked the amlodipine besylate and carvedilol tablets off the medication cart with her bare hands and placed the medications into a medication cup along with Resident #14's other medications. LPN #153 confirmed she then administered the medications to Resident #14.</p> <p>Review of the policy titled, Administering Medications, revised April 2019, stated the staff would follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications as applicable.</p> <p>This deficiency is based on incidental findings discovered during the course of this complaint investigation.</p>		