

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/24/2024
NAME OF PROVIDER OR SUPPLIER  Ohio Valley Manor Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  5280 State Routes 62 68 Ripley, OH 45167	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33023</p> <p>Based on medical record review, review of the facility investigation, staff interview, and review of the facility handbook, the facility failed to ensure the resident environment was free of potentially hazardous substances/prescription medications. This affected one (Resident #130) of three residents reviewed for accidents and accident hazards. The facility census was 130.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #130 revealed an admitted [DATE] with diagnoses including frontotemporal neurocognitive disorder, diabetes mellitus type two, rhabdomyolysis, dementia, anxiety, dehydration, falls, hematuria, and polyosteoarthritis.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #130 dated 04/15/24 revealed the resident had severely impaired cognition.</p> <p>Review of the progress note for Resident #130 dated 05/24/24 timed at 10:35 A.M. revealed the resident was sent to the hospital for evaluation and possible treatment for ingestion of medications not prescribed for the resident.</p> <p>Review of facility investigation revealed on 05/02/24 staff found Resident #130 in his room with two medications that belonged to State tested Nursing Assistant (STNA) #30 in the resident's possession. The resident had found medication bottles containing Wellbutrin (an antidepressant) and Adderall ER (a stimulant medication and a controlled substance) in STNA #30's purse which had been left unattended in the resident dining room. Resident #130 had the bottles of Wellbutrin and Adderall in his possession with one bottle opened and the other remaining closed. Interview with STNA #30 confirmed she could not recall or verify how many individual medications were in either bottle, or how many were taken. STNA #30 further confirmed she had left her purse on the table in the resident dining room while she took her lunch break. A visiting family member had informed staff that Resident #130 was looking through the purse when no staff was around. Two staff members went searching for the resident and found him in his room with both medicine bottles.</p> <p>Review of facility transfer report revealed Resident #130 was sent to the hospital on 05/02/24 after possible ingestion of two medications that were not prescribed to him.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of hospital records for Resident #130 dated 05/02/24 revealed the hospital conducted blood tests to determine if the resident had ingested Wellbutrin or Adderall and determined the resident's blood was negative for both substances. The resident returned to the facility with no new orders.</p> <p>Interview on 05/24/24 at 11:00 A.M. with the Director of Nursing (DON) and Administrator confirmed STNA #30 acknowledged she did not properly secure her personal belongings on 05/02/24 when she left her purse containing bottles of Wellbutrin and Adderall unattended in the resident dining area. Further interview confirmed Resident #130 was found in his room with STNA #30's purse and the bottles of Wellbutrin and Adderall in his possession with one pill bottle open.</p> <p>Interview on 05/24/24 at 12:15 P.M with Registered Nurse (RN) #10 confirmed she responded to the room of Resident #130 on 05/02/24 when staff reported the resident had taken two bottles of medication from a staff members' personal belongings.</p> <p>Review of the employee handbook undated under the section titled Personal Property on page 25 revealed all employees were responsible for securing/storing their own personal property.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00153629.</p>		