STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365408	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Delaware	2270 Warrensburg Road Delaware, OH 43015

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** 47990 Based on observations, staff interviews, resident interview, family interview, medical record reviews, and policy reviews, the facility failed to ensure residents were free from significant medication errors. This affected two (#85 and #14) of six residents reviewed for medication administration. The facility census was 86. Findings include: 1. Review of the medical record for Resident #85 revealed an admitted [DATE]. Medical diagnoses included neurocognitive disorder with lewy bodies, dementia, hypertension, and bradycardia (low heart rate of less than 60 beats per minute). Review of Resident #85's Minimum Data Set (MDS) quarterly assessment, dated 06/13/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 09 indicating moderately impaired cognition. Review of Resident #85's physicians orders revealed an order dated 07/19/24, for metoprolol tartrate (an antihypertensive medication used to lower blood pressure and/or heart rate) 25 milligrams (mg) by oral route twice daily. The order specified to hold the medication for a systolic blood pressure less than 100 and/or a heart rate less than 60. Review of Resident #85's Medication Administration Record (MAR) for July 2024 revealed the medication has been administered twice daily since it was ordered on 07/19/24. The MAR contained no corresponding blood pressure and heart rate levels recorded to reflect the resident's vital signs at the time of the metoprolol administration. (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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 07/23/24 at 7:56 A.M. revealed Registered Nurse (RN) #200 prepared Resident #85's morning medications. RN #200 retrieved Resident # 85's medication out of the medication cart and checked the medications against the order's on the resident's MAR. RN #200 stated the resident's medication regimen included an order for one tablet of metoprolol tartrate 25 mg. RN #200, who was looking directly at Resident #85's MAR, stated the resident's metoprolol had no vital sign parameters or instructions on when to give or not give the medication. RN #200 retrieved the card of metoprolol 25 mg and identified the resident's metoprolol were in half-tablet doses (12.5 mg each). RN #200 removed two half-tablets of metoprolol and placed them in the cup with Resident #85's other morning medications. RN #200 then retrieved her automatic blood pressure cuff and stated she would check Resident #85's blood pressure as a good nursing practice prior to giving the resident all of his morning medications. RN #200 entered Resident #85's medications where the resident was lying in bed. RN #200 gently awakened the resident and informed him she was checking his blood pressure. RN #200 applied her automatic blood pressure cuff to the resident's right arm, and obtained a blood pressure of 99/57 mg/deciliter (a low reading; a normal reading is around 120/80 mg/deciliter) and a heart rate of 53 beats per minute (a low reading; a normal value is between 60-100 beats per minute). RN #200 stated the blood pressure reading could not be correct and re-applied the blood pressure cuff to the resident's left arm and obtained a reading of 81/46 mg/deciliter (indicating a low reading) and a heart rate of 53 beats per minute. RN #200 again stated this could not be possible and exited the resident's room, retrieved a manual blood pressure cuff and stethoscope, and returned to Resident #85's room. RN #200 proceeded to rechecked Resident #85's blood pressure and reported the result was 110/60 and confirmed the heart rate was still 53 beats per minute. RN #200 administered the resident's morning oral medication, including the morning dose of metoprolol. Interview on 07/23/24 at 8:25 A.M., with RN #200 following Resident #85's medication administration confirmed she made an error and administered the resident's metoprolol when she should not have. RN #200 stated the heart rate was too low and the medication should not have been administered. RN #200 obtained a finger pulse oximeter (used to measure oxygen saturation level and heart rate) and returned to the resident's room. RN #200 obtained a heart rate reading of 48 beats per minute and stated again that she should not have administered the medication and would need to call the provider. Interview on 07/23/24 at 9:13 A.M., with Regional Director of Clinical Operations (RDCO) #410 confirmed she was aware of the medication error RN #200 made with Resident #85's morning metoprolol administration. RDCO #410 reported RN #200 contacted the provider and family, was monitoring the resident, and would be re-educated. 2. Review of the medical record for Resident #14 revealed an admitted [DATE]. Medical diagnoses included type II diabetes mellitus with diabetic neuropathy. Review of Resident #14's MDS admission assessment, dated 06/28/24, revealed the resident had a BIMS score of 11, indicating moderately impaired cognition. Resident #14 had no recorded behaviors or rejection of care. Review of Resident #14's physician's orders revealed an order dated 06/21/24, for Trulicity (a hypoglycemic medication to lower blood sugar) 0.75 mg administered by subcutaneous injection once weekly on Mondays. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's MAR for July 2024 revealed the resident's Trulicity was not recorded as administered on 07/08/24 and 07/15/24. On those two dates, a MAR entry indicated chart code 09 which indicated other/see progress notes. Review of Resident #14's interdisciplinary progress notes revealed an entry dated 07/08/24 at 10:30 A.M., which stated the Trulicity was pending delivery. An additional note dated 07/15/24 at 10:38 A.M., revealed the Trulicity medication was on order. There were no notes indicating the pharmacy or provider had been contacted to inform of the missing doses. Interview on 07/23/24 at 6:39 A.M., with Resident #14 revealed her lying in bed. The resident was awake and alert and answered questions appropriately. Resident #14 stated she had difficulty getting all of her regular medications at the facility, specifically her once-weekly injection of Trulicity. Resident #14 stated she was supposed to get the medication on Mondays but missed multiple doses since arriving at the facility and was not sure why. Interview on 07/23/24 at 9:24 A.M., with a family member of Resident #14, via telephone, revealed the resident went without her ordered Trulicity on 07/08/24 and 07/15/24, and was unsure why. The family member indicated they had provided the facility with one of Resident #14's home doses of Trulicity when Resident #14 first admitted to the facility, so she would not have to go without her ordered medication. The family member was unsure why the facility was unable to obtain this medication. Interview on 07/23/24 at 9:48 A.M., with RDCO #410 verified Resident #14's Trulicity was not recorded as administered on 07/08/24 and 07/15/24. RDCO #410 additionally confirmed the resident's record contained no evidence the pharmacy or provider was contacted regarding the missing doses of medications. Review of the policy titled, Medication Errors, dated 01/24/24, revealed to ensure residents receive care and services safely in an environment free from significant medication errors. The facility shall ensure medications will be administered according to physician's orders. The facility will consider factors indicating errors in medication administration which include medications administered not in accordance with the prescriber's order which can include an incorrect dose, route of administration, dosage form, time of administration, medication omission, or incorrect medication. Adverse drug reactions and significant medication errors will be reported to the prescriber, director of nursing, and pharmacy. These events will be reviewed as part of the facility QAPI committee for further recommendations as indicated. Review of the policy titled, Medication Administration, dated 01/17/23, revealed medications are to be administered as ordered by the physician and in accordance with professional standards of practice. The policy indicated to obtain and record vital signs when applicable or per physician's orders. When applicable, hold medication for those vial signs outside the physician's prescribed parameters. This deficiency represents non-compliance investigated under OH00155540 and is a recite to the survey dated 06/26/24.