

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2024
NAME OF PROVIDER OR SUPPLIER  Columbus Colony Elderly Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1150 Colony Drive Westerville, OH 43081	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271</b></p> <p>Based on medical record review, medication administration observation, staff interviews, and medication administration policy review, the facility failed to ensure an medication error rate of 5% or less when medication that was noted to be delayed release was crushed, or capsule were opened during administration. Medication error rate was 9%. This affected two residents (Resident #6, and #32) of the four residents reviewed for medication administration. The facility census was 74.</p> <p>Findings included:</p> <p>1. Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included dementia, depression, and osteoarthritis.</p> <p>Review of Resident #32's quarterly Minimum data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15 indicating an severely impaired cognition for daily decision making abilities.</p> <p>Review of the plan of care dated 06/26/23 revealed Resident #32 uses antidepressant medication related to depression and weight loss. Resident is at risk for complications related to antidepressant medication including, dry mucosa, constipation, urinary retention, suicidal ideation, and increased signs/symptoms of depression. Interventions include to give antidepressant medications as ordered by physician.</p> <p>Review of physician orders for Resident #32 revealed the following:</p> <p>-Duloxetine Hydrochloride (HCL) capsule, delayed release particles, 30 milligrams (MG), give one capsule by mouth daily for depression. Ordered 07/25/2024.</p> <p>-May crush appropriate medications, ordered 08/28/24.</p> <p>-Regular diet, with regular texture, regular/thin consistency liquids. Ordered 04/26/21.</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation completed on 08/28/24 at 8:39 A.M. of Licensed Practical Nurse (LPN) #160 administer morning medication revealed after pulling the capsule Duloxetine HCL from the medication cart, LPN #160 proceeded to open the capsule up and release the sprinkles into a medication cup with pudding along with other medication that had been crushed for this resident. Also during this time, LPN #160 was noted to need medication from the medication stock room which this nurse was noted to walk away from her medication cart on two different occasions while leaving her medication cart unlocked while out of view.</p> <p>Interview on 08/28/24 at 8:40 A.M. with LPN #160 confirmed Resident #32 was ordered the medication Duloxetine HCL delayed release capsule which she just administered to this resident by opening the capsule and placing the sprinkles into a medication cup with other crushed medication and pudding for administration. LPN #160 verified when a medication is delayed released, it is not to be opened or crushed as this will alter the delayed release of the medication.</p> <p>2. Review of the medical record review for Resident #6 revealed an admitted [DATE]. Diagnoses included paranoid schizophrenia, dementia, and conversion disorder with seizures or convulsions.</p> <p>Review of Resident #6's quarterly Minimum data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 01 out of 15 indicating an severely impaired cognition for daily decision making abilities.</p> <p>Review of care plan dated 12/19/23 and revised 03/19/24 revealed Resident #6 had a seizure disorder related to past cerebral vascular accident. Interventions included to administer medication as per physician orders.</p> <p>Review of physician orders for Resident #6 revealed the following:</p> <ul style="list-style-type: none"> <li>-Divalproex Sodium oral tablet delayed release 250 milligram (mg). Give one tablet by mouth three times a day for convulsions. Ordered 11/28/23.</li> <li>-Regular diet, pureed texture, nectar thick consistency fluids. Ordered 03/25/24.</li> </ul> <p>Observation on 08/28/24 at 9:21 A.M. of Registered Nurse (RN) #34 administering medication for Resident #6 revealed the medication Divalproex Sodium, delayed release tablet was placed into a small plastic pouch along with other medication which was then then crushed into a powder form. All crushed medications were then placed into a medication cup along with pudding and administered to Resident #6.</p> <p>Interview on 08/28/24 at 9:23 A.M. with RN #34 confirmed she crushed the Divalproex Sodium medication which was also noted to be a delayed release medication and not to be crushed.</p> <p>Review of facility policy titled Administration Procedures for All Medications, revised date of 01/2018 revealed C. Review 5 Rights (3) times: 2) Prior to removing the medication from the container, a. Check the label against the order on the medication administration record. b. Note any special labeling that applies (fractional tablet, multiple tablet,s volume of liquid, shake well, give with another medication, etc.).</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155915.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>41271</p> <p>Based on observations, staff interview, and facility policy review, this facility failed to ensure medication carts were locked at all times unless in use and under direct observation of the medication administration personnel. This had the potential to affect all 26 residents who were noted to be mobile on the 300 and 500 unit. The facility census was 74.</p> <p>Findings include:</p> <p>Observation on 08/28/24 at 8:15 A.M. of Registered Nurse (RN) #34 completing medication administration for residents who resided on the 500 unit revealed this units medication cart was noted to be unlocked and RN #34 was not in view of this medication cart and was noted to be in a residents room.</p> <p>Observation completed on 08/28/24 at 8:39 A.M. of Licensed Practical Nurse (LPN) #160 administer morning medication revealed there was a medication that was not available in the 300 unit medication cart. LPN #160 was noted to leave the 300 unit medication cart unlocked and walk away from the cart to a different facility unit to obtained the needed medication from the facility's medication storage room. During this time, the medication cart on the 300 until remained unlocked and out of view of LPN #160.</p> <p>Interview on 08/28/24 at 8:40 A.M. with LPN #160 confirmed her medication was left unlocked while out of sight.</p> <p>Interview on 08/28/24 at 9:23 A.M. with RN #34 confirmed she had her medication cart had been left unlocked and out of sight earlier that morning.</p> <p>Review of the facility policy titled, Administration Procedures for All Medication revision date of 01/2018 revealed All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication administration personnel.</p> <p>This was an incidental finding identified during investigation for Complaint Number OH00155915.</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** 41271</b></p> <p>Based on medication administration observation, staff interview and facility policy review, this facility failed to ensure infection control measures were maintained during medication administration. This affected two residents (Resident #32 and #42) out of the four residents observed during medication administration. The facility census was 74.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included dementia, depression, and osteoarthritis.</p> <p>Review of Resident #32's quarterly Minimum data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15 indicating an severely impaired cognition for daily decision making abilities.</p> <p>Review of the plan of care dated 06/26/23 revealed Resident #32 uses antidepressant medication related to depression and weight loss. Resident is at risk for complications related to antidepressant medication including, dry mucous, constipation, urinary retention, suicidal ideation, and increased signs/symptoms of depression. Interventions include to give antidepressant medications as ordered by physician.</p> <p>Observation on 08/28/24 at 8:39 of Licensed Practical Nurse (LPN) #160 removing medication from the medication bottle revealed this nurse using her ungloved thumb to pull multiple tablets of Vitamin D 3 25 microgram (mcg) from the bottle and placing them into a medication cup for administration.</p> <p>Continued observation completed on 08/28/24 at 8:40 A.M. of LPN #160 revealed this nurse grabbing a pair of gloves from the box on the medication cart when one glove was put on and the other glove was dropped. LPN #160 was observed picking that glove up off the floor with her gloved hand, throwing it away, followed by grabbing another glove from the box and putting that new glove on. Hand hygiene was not completed after picking the glove up off the floor and prior to touching a resident's medication with that same gloved hand.</p> <p>Interview on 08/28/24 at 8:40 A.M. with LPN #160 confirmed she used her bare hands to obtain medication from a medication bottle follow by placing that medication into a medication cup for administration. LPN #160 also confirmed she had dropped a glove on the floor and using her one gloved hand, picked the glove up off the floor and failed to complete hand hygiene as per facility policy.</p> <p>2. Review of the medical record for Resident #42 revealed an initial admitted [DATE] and a re-entry date of 07/29/22. Diagnoses included cerebral palsy, dysphasia, and Vitamin D deficiency.</p> <p>Review of Resident #42's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities.</p> <p>Review of physician orders for Resident #42 revealed the following:</p> <p>(continued on next page)</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>-Labetalol Hydrochloride (HCL) 300 milligrams (mg) tablet, give one tablet daily for hypertension. Ordered 07/30/22.</p> <p>-Losartan Potassium-HCTZ 50-12.5 mg tablet, give one tablet by mouth daily for hypertension. Ordered on 07/15/23.</p> <p>-Multiple Vitamins-minerals tablet, give one tablet by mouth daily for supplement. Ordered 10/21/22.</p> <p>-Pioglitazone HCL 15 mg tablet, give one tablet by mouth daily for diabetes. Ordered 07/30/22.</p> <p>-Vitamin D oral tablet, give 2000 units by mouth daily for Vitamin D deficiency.</p> <p>-House protein supplement, give 30 milliliters (ml) by mouth two times a day for wound healing. Ordered 01/26/23.</p> <p>Observation on 08/28/24 at 9:12 A.M. of LPN #147 pulling medication for Resident #42 revealed this nurse was noted to pop each medication out of the medication card or medication bottle, place the medication directly into her hand and then place the medication into a medication cup for administration.</p> <p>Interview on 08/28/24 at 9:14 A.M. with LPN #147 confirmed she had touched each medication tablet or capsule prior to placing the medication into a cup for administration without wearing gloves. LPN #147 verified per facility policy she should wear gloves when handling medication but always forgets.</p> <p>Review of the facility policy titled Medication Administration-General Guidelines, revision date of 01/2018 revealed 2) Hand washing and Hand Sanitization: The person administering medication adheres to good hand hygiene, before beginning a medication pass, prior to handling any medications, after coming into direct contact with a resident.</p> <p>Review of the facility policy titled Hand Hygiene,; revision date of 06/06/2023 revealed Alcohol-Based Hand Rub (ABHR) is to be used before donning gloves, after removing gloves.</p> <p>This was an incidental finding identified during investigation for Complaint Number OH00155915.</p>		