STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365527	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Springfield	1600 Saint Paris Pike Springfield, OH 45504

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** 46613 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of the facility incident log, staff interview, and policy review, the facility failed to ensure an intravenous (IV) medication was administered as ordered. This affected one (#31) resident out of the three residents reviewed for medication administration. The facility census was 36. Findings include: Review of the medical record for Resident #31 revealed an admitted [DATE] with medical diagnoses of anoxic brain injury, chronic respiratory failure, dependence on respirator, and persistent vegetative state. Review of the medical record revealed Resident #31 was discharged to the hospital on 05/27/24 and returned to the facility on [DATE]. Review of the medical record for Resident #31 revealed an annual Minimum Data Set (MDS) assessment, dated 04/23/24, which indicated Resident #31 was noncommunicable due to persistent vegetative state. The MDS indicated Resident #31 was dependent upon all staff for activities of daily living (ADL). Review of the medical record for Resident #31 revealed hospital discharge orders dated 06/11/24 for Avycaz (antibiotic) 2.5 grams IV every eight hours with end of treatment on 06/14/24. Review of physician orders revealed the resident had Avycaz 2.5 grams IV every eight hours for six administrations dated 06/14/24. Review of Resident #31's Medication Administration Record (MAR) revealed documentation to support Resident #31 received Avycaz as ordered until 06/16/24. (continued on next page)

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	Review of the medical record for Resident #31 revealed an Interdisciplinary Team (IDT) note on 06/14/24 at 1:53 P.M. which stated Resident #31 readmitted from the hospital on 06/11/24 with a diagnosis of chronic respiratory failure, anoxic brain damage, pseudomonas, and Klebsiella pneumonia. The note stated Resident #31 was ordered Avycaz for eight doses and one dose was given at the hospital before discharge and per Nurse Practitioner (NP) the first dose of the antibiotic could be administered at 10:00 A.M. when arrived from the pharmacy to the facility on [DATE]. The note continued to stated Resident #31 was noted to have a decrease in oxygen saturation throughout the night and pulmonologist group was notified and an order was received to increase oxygen to keep pulse oxygen saturation above 89% with oxygen at eight liters per tracheostomy mask, elevate head of bed, and order to continue Avycaz for six doses with flush orders. The note stated the guardian was notified and stat complete metabolic panel and complete blood count labs were obtained. The note stated NP stated no x-rays were needed as the facility is aware Resident #31 had pneumonia and pseudomonas and felt that facility needed to complete the antibiotic as ordered. Further review of the medical record for Resident #31 revealed no documentation to support Resident #31 demonstrated any further respiratory issues. Review of the facility incident report revealed documentation of a medication error for Resident #31 on 06/14/24. Interview on 07/19/24 at 11:20 A.M. with Director of Nursing (DON) confirmed Resident #31 returned to the facility on [DATE] from the hospital with an order for Avycaz 2.5 grams IV for eight doses to be administered for three days. DON stated on 06/14/24 it was discovered that Resident #31 had six doses of Avycaz IV medication remaining in the medication storage room. DON stated an investigation was initiated and it was determined the night shift nurse had not administered the IV medication as ordered. DON stated NP was notified and new orders were received to administer the remaining six doses of Avycaz and to obtain stat complete metabolic panel and complete blood count lab work. DON stated Resident #31 was assessed and did not sustain any negative outcomes from Avycaz not being administered as ordered. DON stated all the nursing staff were educated on medication administration, all medication carts and medication storage rooms were audited for excessive medications and an ad hoc Quality Assurance and Quality Improvement (QAPI) was conducted. DON stated the night shift nurse was terminated. Review of the facility policy titled, Medication Administration, revised 01/17/23 stated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination. As a result of the incident, the facility took the following actions to correct the deficient practice by 06/17/24: 06/14/24 DON notified Physician and Guardian of medication error. 06/14/24 Resident #31 was assessed by licensed nurse with no negative findings. 06/14/24 stat lab work was obtained from lab company. 06/14/24 DON received new order for Avycaz 2.5 gram IV to be continued every eight hours for six doses. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/14/24 Assistant Director of Nursing (ADON) audited all medication carts and IV medications in medication storage room for excessive medications or evidence of medications not administered as ordered. 06/14/24 DON provided education to all clinical staff on medication administration policy, labeling/dating of IV bags and tubing, MAR to be signed when administering medications, and call physician if medication orders need clarify. 06/14/24 DON/designee would complete IV medication administration audit five days per week for four weeks. 06/14/24 ad hoc QAPI completed. This deficiency represents non-compliance investigated under Complaint Number OH00155335.