

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Garden Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3536 Washington Ave Cincinnati, OH 45229	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</b></p> <p>Based on medical record review, staff interview, and review of the facility policy, the facility failed to report an allegation of misappropriation of resident funds to the Ohio Department of Health (ODH.) This affected one (Resident #33) of three residents reviewed for misappropriation. The facility census was 47 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), traumatic compartment syndrome of left lower extremity, and major depressive disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #33 dated 07/06/24 revealed the resident had intact cognition and required supervision with activities of daily living (ADLs.)</p> <p>Review of the progress note for Resident #33 dated 09/01/24 timed at 4:03 P.M. per Licensed Practical Nurse (LPN) #20 revealed Resident #33 reported he had two hundred dollars in his room, and someone had stolen it. LPN #20 documented Resident #33's allegation of misappropriation of money would be reported to administration.</p> <p>Review of the facility Self-Reported Incidents (SRIs) dated 08/31/24 to 09/19/24 revealed the facility did not complete an SRI regarding Resident #33's allegation of misappropriation of money.</p> <p>Interview on 09/19/24 at 10:10 A.M. with the Director of Nursing (DON) confirmed the facility should have completed an SRI regarding Resident #33's allegation of stolen money made to staff on 09/01/24. The DON confirmed the Assistant Director of Nursing (ADON) was not available for interview.</p> <p>Interview on 09/19/24 at 10:58 A.M. with the Administrator confirmed the staff reported Resident #33 had made an allegation of missing money, but the facility did not report the allegation to ODH via an SRI.</p> <p>Interview on 09/19/24 at 11:12 A.M. with LPN #20 confirmed a staff member reported that Resident #33 alleged on 08/31/24 or 09/01/24 that someone had stolen two hundred dollars from him. LPN #20 further confirmed she reported the allegation to the Administrator and the ADON on 08/31/24 or 09/01/24.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated April 2021 revealed residents had the right to be free from misappropriation of resident property. Staff should investigate and report allegations of misappropriation within timeframes required by federal regulations.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00157751.</p>		

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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>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</b></p> <p>Based on medical record review, observation, interview, review of manufacturer's guidelines, and review of the facility policy, the facility failed to ensure medication error rates below five percent (%). This affected three (Residents #21, #26, and #27) of three reviewed for medication administration. The medication error rate was 11.1 % based on 36 medication opportunities and four observed errors. The facility census was 47 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #21 revealed an admitted [DATE] diagnoses including bipolar disorder, congestive heart failure (CHF), and type two diabetes mellitus.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #21 dated 07/09/24 revealed the resident had moderate cognitive impairment and required setup with activities of daily living (ADLs.)</p> <p>Review of the physician's orders for Resident #21 revealed an order dated 08/09/24 for Lantus insulin inject 10 units subcutaneously two times a day for diabetes management and an order dated 09/06/24 for loratadine 10 milligrams (mg) one tablet by mouth one time a day for allergies.</p> <p>Observation on 09/18/24 at 8:57 A.M. revealed loratadine was not available for administration.</p> <p>Observation on 09/18/24 at 8:59 A.M. revealed LPN #20 did not prime the Lantus insulin pen with two units prior to administering 10 units of insulin to Resident #21.</p> <p>Interview on 09/18/24 at 9:01 A.M. with LPN #20 confirmed she did not administer loratadine to Resident #21 because it was unavailable. LPN #20 also verified she did not prime the insulin pen with two units of insulin prior to administration.</p> <p>Review of the manufacturer's instructions for Lantus insulin pens dated 06/12/24 revealed the insulin pen should be primed before each use. This should be done to remove any bubbles, to ensure that the pen is working properly, and that the device can administer the dose of insulin required.</p> <p>2. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, chronic kidney disease, depression, and anxiety disorder.</p> <p>Review of the MDS assessment for Resident #26 dated 07/16/24 revealed the resident had moderate cognitive impairment and required setup with ADLs.</p> <p>Review of the physician's orders for Resident #26 revealed an order dated 09/29/23 for amiodarone 200 mg give one tablet by mouth in the morning for antiarrhythmic.</p> <p>Observation on 09/18/24 at 8:41 A.M amiodarone was not available for administration.</p> <p>Interview on 09/18/24 at 8:43 A.M. with LPN #20 verified she did not administer amiodarone to Resident #26 to because it was unavailable.</p> <p>(continued on next page)</p>		

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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>3. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including emphysema, and generalized anxiety disorder.</p> <p>Review of the MDS assessment for Resident #27 dated 07/05/24 revealed the resident had intact cognition required setup and assistance with ADLs.</p> <p>Review of the physician's orders for Resident #27 revealed an order dated 06/05/24 for Claritin capsule 10 mg give one capsule by mouth one time a day for allergies.</p> <p>Observation on 09/18/24 at 8:30 A.M. revealed Claritin was not available for administration.</p> <p>Interview on 09/18/24 at 8:33 A.M. with LPN #20 confirmed she did not administer Claritin 10 mg to Resident #27 because it was unavailable.</p> <p>Review of the facility policy titled Administering Medications dated April 2019 revealed medications were to be administered in a safe and timely manner, and as prescribed. Medications were administered in accordance with prescriber orders, including any required time frame.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00157751.</p>		