| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365530 | A. Building<br>B. Wing | 10/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Delhi Post-Acute | 5999 Bender Road<br>Cincinnati, OH 45233 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492<br><br>Based on medical record review, observations, resident and staff interviews, and policy review, the facility failed to timely obtain and implement hospital recommendations for positive airway pressure devices, and the facility failed to have physician orders for positive airway pressure devices. This affected one (Resident #72) of three residents reviewed for positive airway pressure devices. The facility census was 101.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #72 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD) and diastolic heart failure. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #72 had moderately impaired cognition, had no behaviors, and did not reject care.<br><br>Review of the care plan dated 08/05/24 revealed Resident #72 was at risk for complications with the respiratory system due to multiple diagnoses. Resident #72 was noted to adjust her oxygen settings on her own. Interventions included assess/report signs of hypoxia, incentive spirometer as ordered, oxygen therapy as ordered, and remind resident not to adjust her oxygen settings as needed.<br><br>Resident #72 discharged to the hospital on 09/03/24 and returned to the facility on [DATE].<br><br>Review of the hospital discharge summary dated 09/05/24 revealed Resident #72 presented to the Emergency Department (ED) with shortness of breath, increased confusion, and taking off her oxygen per nursing facility on 09/03/24 and was admitted with COPD exacerbation, acute on chronic respiratory failure with hypercapnia and hypoxia, and acute metabolic encephalopathy. Resident #72 was treated with steroids, bronchodilators, and bilevel positive airway pressure (BiPAP), and showed significant improvement, and was back to her baseline at the time of discharge. Resident #72 was weaned to her baseline oxygen of three liters per minute and was recommended to continue using BiPAP while sleeping at the facility. There were no specifications noted on the discharge summary for BiPAP settings.<br><br>Review of the medical record revealed no progress noted regarding follow-up with the hospital for clarification for BiPAP settings after return to the facility on [DATE]. There were no active or completed physician orders for the use BiPAP for Resident #72. Resident #72 discharged to the hospital on 09/17/24.<br><br>(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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the hospital paperwork dated 09/17/24 revealed Resident #72 presented to the ED with a complaint of altered mental status (AMS). It was strongly suggested the altered mental status was secondary to medication. While Resident #72 would most likely benefit from BiPAP, it was highly unlikely she would use BiPAP. Since she did not present with acute hypercapnia nor need BiPAP during this admission, recommendations included to hold off on BiPAP after discharge.<br><br>There were no active or completed physician orders for the use BiPAP for Resident #72.<br><br>During an interview on 10/01/24 at 2:38 P.M., Registered Nurse (RN) #226 verified Resident #72 had no records for BiPAP in her electronic medical record. RN #226 stated she knew Resident #72 looked in the medical record and verified Resident #72 did not have an order in the chart for BiPAP and the resident had a BiPAP machine in her room.<br><br>During an interview and observation on 10/01/24 at 2:57 P.M., Resident #72 was observed sitting up in bed with a BiPAP machine on a cart at bedside. Resident #72 stated the machine had been ordered around the beginning of September, date not specified. The resident stated the device originally sat in her room about four to five nights, unused, because none of the staff knew how to apply it. An unidentified nurse set up the device, explained how to use it, and the resident stated she both applied and turned on the device herself at bedtime.<br><br>During an interview on 10/01/24 at 3:57 P.M., the Director of Nursing (DON) stated she called their supplier last week (09/27/24) in response to family concerns that Resident #72 was not getting her BiPAP. The DON stated Respiratory Therapy (RT) was supposed to come assess the resident first before the machine was delivered to the resident. The DON stated Resident#72 had not been assessed by RT, and the DON was not sure why the BiPAP machine had been delivered to her room. The DON verified Resident #72 used the machine without physician orders. The DON did not know how the machine had been delivered without an order.<br><br>Observation and interview on 10/02/24 at 10:19 A.M. revealed Resident #73 was seated upright in bed with BiPAP mask on face and machine running. Licensed Practical Nurse (LPN) #154 was standing at bedside with resident adjusting straps to facemask for BiPAP machine. LPN #154 stated Resident #72 had an order for BiPAP to be used at bedtime and as needed (PRN). The nurse stated she walked into the room and Resident #72 was putting on the mask because she said she wanted to take a nap. The nurse stated she had just turned the machine on and was adjusting the straps when this surveyor walked into the room. The nurse verified there was an error message on the machine and removed the mask. LPN # 154 stated she did not know what the settings were supposed to be and stated she had to check the order. LPN # 154 verified Resident #73 did not have an order on file for the BiPAP machine and stated she would have to call the provider for settings before she could apply the mask to the resident. LPN #154 stated she did not know how long Resident #73 had the device. LPN # 154 stated she had just returned from a two-week vacation and believed Resident #72 had the device before she left.<br><br>Review of the facility document titled CPAP/BiPAP Support, dated 03/2015, revealed prior to using positive air pressure devices, nurses should check the medical record for baseline oxygen saturation levels, review the physician's order to determine oxygen concentration, flow, and Positive End-Expiratory Pressure (PEEP) settings for the machine.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00158245. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492<br><br>Based on medical record review, staff interview, and policy review, the facility failed to provide medications as ordered. This affected one (Resident #72) of five residents reviewed for medication administration. The facility census was 101.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #72 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety disorder, and major depressive disorder.<br><br>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #72 had moderately impaired cognition and did not reject care.<br><br>Review of the care plan dated 08/05/24 revealed Resident #72 was at risk for pain or discomfort due to shingles neuropathy, chronic back pain, and right fourth and fifth toe fractures. Interventions included to administer medications as ordered, assess pain every shift and as indicated, and notify physician of unmanageable/intolerable pain.<br><br>Review of Resident #72's physician orders dated August 2024 revealed an order for Lyrica (generic is pregabalin) oral capsule 75 milligrams (mg) - Give one capsule by mouth three times a day for pain.<br><br>Review of the Medication Administration Record (MAR) dated August 2024 revealed Resident #72 did not receive doses of Lyrica 75 mg on 08/12/24 (three doses), 08/13/24 (three doses), and 08/17/24 (three doses).<br><br>Review of the progress notes dated 08/12/24, 08/13/24, and 08/17/24 revealed Lyrica (Pregabalin) 75 mg was not available to be administered.<br><br>During an interview on 10/01/24 at 2:38 P.M., Registered Nurse (RN) #226 verified Resident #72 did not receive nine doses of Lyrica as ordered on 08/12/24, 08/13/24, and 08/17/24 because the facility did not have medication and the medication was unavailable in the emergency supply.<br><br>Review of the policy titled Administering Medications dated 04/2019 revealed medications were administered in a safe and timely manner and within one hour of their prescribed time.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00158245. |