STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365598	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of West Carrollton The	115 Elmwood Circle West Carrollton, OH 45449

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on medical record review and staff interview, the facility failed to ensure a residents medications were accurately transcribed upon a residents admission resulting in omission of medications and medication errors. This affected one (#217) out of four residents reviewed for medication administration. Facility census was 76. Findings include: Review of the medical record for Resident #217 revealed and admitted [DATE], discharge date of [DATE]. Diagnosis included encounter for surgical aftercare following surgery on the nervous system, spinal stenosis, site unspecified, other reduced mobility, and muscle weakness (generalized). Review of the discharge return not anticipated Minimum Data Set (MDS) assessment, dated 03/29/24 revealed Resident #217 was cognitively intact, and required partial assistance with toilet hygiene, bathing, dressing, bed mobility, and transfers. Further review of Resident #217's record including admission orders and medication administration record (MAR) revealed the following medication omissions: Atenolol 25 milligram (mg) (beta blocker for high blood pressure) was omitted from 03/25/24 through 03/28/24 and Lidocaine Patch EX (for nerve pain) was omitted from 03/25/24 through 03/28/24. There was a medication transcription error/omission for Buprenorphine HCl-Naloxone HCl Sublingual Tablet Sublingual 8-2 mg (Buprenorphine HCl-Naloxone HCl Dihydrate)-give 1. 5 oral strips sublingually two times a day for (pain), original order was Buprenorphine HCl-Naloxone HCl Sublingual Tablet Sublingual 8-2 mg (Buprenorphine HCl-Naloxone HCl Dihydrate)-give 1/2 oral strip sublingually two times a day for (pain) was not received from a pharmacy from 03/24/24 through 03/26/24, when the medication was discontinued. There was a medication error when order for Alendronate Sodium Oral Tablet 70 mg (Alendronate Sodium)-give 1 tablet by mouth one time a day every 7 day(s), Friday mornings, (for Osteoporosis) was entered into the electronic medication record (EMR) without Friday in the order, resulting in the medication being administered to early on Monday, 03/25/24. Review of the nurse practitioner's (NP) progress note, dated 03/26/24 revealed Resident #217 was clinically stable, has a history of drug use and takes suboxone daily which has not been given since her admission to the facility, plan was: continue current management per orders. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365598	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of West Carrollton The	115 Elmwood Circle West Carrollton, OH 45449

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders dated 03/24/24 Alendronate 70 mg every 7 days, Friday morning was started on 03/25/24. Atenolol 25 mg daily was started on 03/29/24, Buprenorphine 8 mg/naloxone 2 mg sublingual (SL) film place under tongue every 12 hours, 1/2 strip was transcribed as give 1.5 strips and was documented as given on 03/26/24. Lidocaine Patch EX apply topically daily as needed was started on 03/29/24. Review of the nursing progress note dated 03/26/24 at 9:35 A.M. for Resident #217 revealed new orders received to discontinue Senna 8.6 2 tabs twice daily, start senna 8.6-2 tablets every 12 hours as needed (PRN), discontinue Buprenorphine HCl-Naloxone HCl Sublingual Tablet Sublingual 8-2 mg (Buprenorphine HCl-Naloxone HCl Dihydrate)-give 1.5 oral strips sublingually two times a day for pain. Resident #217 made aware and voiced understanding. Review of the nursing progress note dated 03/28/24 at 10:44 A.M. for Resident #217 revealed Certified Nurse Practitioner (CNP) #301 ordered Lidocaine Patch 4% externally, apply in the morning and remove in the evening, Miralax changed to as needed, Oxycodone discontinue date changed to indefinite, Diazepam discontinued. Resident #217 and family aware of the changes Review of the MAR dated March 2024 revealed Resident #217 received Alendronate Sodium 70 mg for diagnosis of osteoporosis on Monday, 03/25/24 (however, the Alendronate was ordered to be administered on Fridays), Atenolol 25 mg for blood pressure on 03/29/24, Buprenorphine HCL-Naloxone HCL Sublingual 8-2 mg 1.5 oral strips sublingually on 03/26/24 for pain, and Lidocaine External Patch 4% on 03/29/24 for pain. Review of medication reconciliation physician's order report from referring facility upon Resident #217's admission, dated 03/24/24, revealed Alendronate 70 mg every seven days on Friday mornings, Atenolol 25 mg daily, Buprenorphine 8 mg/naloxone 2 mg sublingual film place under tongue every 12 hours 1/2 strip two times daily, HM Lidocaine Patch EX apply topically daily as needed. Interview on 04/23/24 at 10:25 A.M. with Licensed Practical Nurse (LPN) #222 confirmed she signed off that Resident #217 received Buprenorphine HCL-Naloxone HCL Sublingual Tablet Sublingual 8-2 mg - Give 1.5 oral strips sublingually on 03/26/24 at 8:00 A.M. but admits she should not have signed off that she gave the medication because it was not available and that she did not give it. Interview with LPN #222 confirmed the actual dose that should have been ordered was Buprenorphine HCL-Naloxone HCL Sublingual Tablet Sublingual 8-2 mg-give 1/2 strip oral strips sublingually twice daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365598	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of West Carrollton The	115 Elmwood Circle West Carrollton, OH 45449

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/23/24 at 11:46 A.M. with LPN/Unit Manager #187 confirmed orders received on 03/24/24, date of admission, for Resident #217 for Atenolol 25 mg tablet, take one by mouth daily was not transcribed on admission per orders received, Buprenorphine 8 mg/naloxone 2 mg SL film was transcribed incorrectly upon admission, Alendronate 70 mg tab - take one by mouth every Friday was ordered without the every Friday in the order and was administered early on Monday, 03/25/24 and Lidocaine Patch EX order received as Lidocaine Patch EX apply topically as needed was not transcribed or clarified on admission. A Lidocaine External Patch 4% was ordered on 03/28/24 and administered on 03/29/24. Interview with LPN/Unit Manager #187 also confirmed the Buprenorphine 8 mg / naloxone 2 mg SL film, place under tongue every 12 hours, 1. 5 strips shows it was administered on 03/26/24 at 8:00 A.M. but LPN/Unit Manager #187 states it was not given due to Resident #217 is on Oxycodone and the two shouldn't be taken together. Interview with LPN/Unit Manager #187 also confirmed there was not an order saying to hold Buprenorphine 8 mg/naloxone 2 mg SL film if Oxycodone is given. Interview with LPN/Unit Manager #187 also confirmed Buprenorphine 8 mg/naloxone 2 mg SL film was never received from the pharmacy to administer. Interview on 04/23/24 at 12:31 P.M. with the Administrator confirmed she did reach out to the local Suboxone Clinic prior to Resident #217's admission and the provider had planned on coming to see the resident, but admission was delay and there was no follow up on admission and the clinic personnel did not make it into the facility to see Resident #217. Interview on 04/23/24 at 12:50 P.M. with Registered Nurse, Regional Clinical Coordinator #206 revealed if a resident is being admitted on Suboxone, the facility will reach out the local Suboxone clinic to ensure the resident is seen and can continue the medications as needed. This deficiency represents non-compliance investigated under Complaint Number OH00152864.