STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365668	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Memorial Home	272 Benedict Ave Norwalk, OH 44857

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on medical record review, review of room and board rates, and staff interview, the facility failed to ensure Skilled Nursing Facility Advanced Beneficiary Notices (SNF ABNs) contained all required and accurate information. This affected two (#51 and #112) of three residents reviewed for beneficiary notices. The facility census was 66. Findings Include: 1. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including dementia, disorientation, and skin cancer. Review of the SNF ABN provided to Resident #51 on 12/26/23, prior to the discontinuation of skilled services on 12/29/23, revealed the notice contained no information regarding what skilled services were being discontinued and noted the estimated cost per day of the service as $235.00 per day. Review of the facility's current room and board rates revealed a semi-private room had a cost of $240.00 which included no skilled services. The SNF ABN provided to Resident #51 had no cost estimate for the skilled services in addition to room and board fees. 2. Review of the medical record revealed Resident #112 was admitted to the facility on [DATE] with diagnoses including aphasia, epilepsy, and major depressive disorder. Review of the SNF ABN provided to Resident #112 on 05/28/24, prior to the discontinuation of skilled services on 05/30/24, revealed the notice contained no information regarding what skilled services were being discontinued and noted the estimated cost per day of the service as $240.00 per day. Review of the facility's current room and board rates revealed a semi-private room had a cost of $240.00 which included no skilled services. The SNF ABN provided to Resident #112 had no cost estimate for the skilled services in addition to room and board fees. Interview with the Administrator verified the SNF ABNs provided to Resident #51 and Resident #112 did not contain all required and accurate information in an interview on 08/14/24 at 3:00 P.M.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 38091 Based on review of personnel files, staff interview, and review of the facility abuse policy, the facility failed to develop and implement policies and procedures to include screening of all employees against the State of Ohio Nurse Aide Registry to identify if an employee had a finding concerning abuse. This had the potential to affected all 66 residents residing in the facility. The census was 66. Findings Include: Review of the personnel files for the Director of Nursing (DON), Licensed Practical Nurse (LPN) #249, LPN #273, and Dietary Aide (DA) #280 revealed no evidence they were screened prior to employment using the State of Ohio Nurse Aide Registry. The identification of findings would be necessary to determine if any employee had actions identified that would validate allegations of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of their property. Interview with Human Resource Director (HRD) #300 on 08/15/24 at 9:00 A.M. verified there was no evidence that the DON, LPN #249, LPN #273, and DA #280 were screened using the State of Ohio Nurse Aide Registry. HRD #300 further noted she was unaware of the requirement to use the Nurse Aide Registry for screening beyond state tested nurse aides (STNAs). Review of the policy titled, Resident Rights - Misappropriation and Reporting, dated 05/01/24 revealed, all individuals applying for employment at (the facility) are screened through an interview process which includes questions about convictions, a thorough check of references and contact with the State Nurses Aide Registry or other appropriate licensing board. Individuals who have been found guilty of abuse, neglect or mistreatment of another individual or have been convicted of fraud, theft or other acts of property misappropriation will not be hired.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49793 Based on medical record review, review of resident census information, email correspondence with the local Ombudsman, and staff interview, the facility failed to ensure the state Ombudsman's office was notified of resident discharge or transfer from the facility as required. This affected two (#30 and #60) of two residents reviewed for hospitalization . The facility census was 66. Findings include 1. Review of the medical record revealed Resident #30 was admitted to the facility with an initial admitted [DATE] and re-admitted [DATE]. Diagnoses included Parkinson's disorder, dementia with mood disturbance and anxiety, and type II diabetes mellitus. Review of nursing progress notes and resident census records revealed Resident #30 was transported to a local hospital on 10/09/23, 01/08/24, and 02/20/24. Review of both the electronic and paper medical records revealed no evidence the state Ombudsman was notified of Resident #30's transfers to the hospital. 2. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE] with diagnoses that included syncope and collapse, muscle weakness, and atrial fibrillation. Review of nursing progress notes and resident census records revealed Resident #60 was transported to a local hospital on 05/17/24 and did not return to the facility. Review of both the electronic and paper medical records revealed no evidence the state Ombudsman was notified of Resident #30's transfers to the hospital. Review of an email from Local Ombudsman (LO) #555 on 08/13/24 at 9:56 A.M. revealed no record of the facility emailing/notifying the state Ombudsman's office of Resident #30 or Resident #60's discharge or transfers. In an interview on 08/14/24 at 10:55 A.M. with the Administrator verified the facility did not notify the state Ombudsman of Resident #30's transfers and Resident #60's discharge to the hospital. The Administrator also revealed due to an incorrect email address to the Ombudsman provider by a former employee during transition out of the facility, the facility had sent resident transfer and discharges notices to an incorrect email address for approximately six months. 38091

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49793 Based on observation, staff interview, and policy review, the facility failed to ensure posted nursing staff information was posted daily as required. This had the potential to affect all 66 residents. The facility census was 66. Findings include: Upon entrance to the facility for an annual survey on 08/12/24 at 8:05 A.M., observation of the posted nursing staffing information for staff directly responsible for resident care was noted to be dated 08/09/24. On 08/12/24 at 8:08 AM, interview with Licensed Practical Nurse (LPN) #263 verified the posted nursing staffing information for staff directly responsible for resident care was dated 08/09/24 and was not up to date. Review of the policy titled, Nursing-Posting Direct Care Daily Staffing Numbers, dated 08/01/24, revealed within two (2) hours of the beginning of each shift, the number of Licensed Nurses (Registered Nurses and LPNs) and the number of unlicensed nursing personnel (state tested nurse aides) directly responsible for residents care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, staff interview, medical record review, and review of hospital provider documentation, the facility failed to timely implement behavioral health services upon return from an emergency department (ED) visit for suicidal ideations. This affected one (#46) of three residents reviewed for behaviors. The facility census was 66. Findings include: Review of the medical record for Resident #46 revealed an admitted [DATE]. Medical diagnoses included left femur fracture, depression, and anxiety. Review of Resident #46's Minimum Data Set (MDS) 3.0 admission assessment, dated 07/10/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. Resident #46 was not recorded to have any hallucinations, delusions, behaviors or rejection of care. Review of Resident #46's physicians orders, dated 07/05/24, revealed the resident had orders for buspirone (an anti-anxiety medication) 15 milligrams (mg) three times daily routine, duloxetine (an antidepressant medication) 120 mg once daily in the morning, and trazodone (an antidepressant medication which can also treat insomnia) 150 mg once daily at bedtime. Review of Resident #46's care plan, dated 07/08/24, revealed the resident used antidepressant medication. Listed interventions included to give antidepressant medications as ordered by the physician and to monitor and document side effects and effectiveness. An additional care plan focus identified the resident also used anti-anxiety medication. Listed interventions included to give anti-anxiety medication as ordered by the physician, monitor and document side effects and effectiveness, and to monitor for behaviors and notify the physician as needed. An additional care plan focus, initiated on 08/13/24 and revised on 08/15/24, identified the resident had a potential psychosocial well-being problem related to home environment. Resident #46 had a recent emergency room (ER) visit related to suicidal ideations. The resident returned with orders for follow up counseling. Listed interventions included to consult with pastoral care, social services, and psychiatric services as needed and to monitor and document the resident's usual response to problems. Review of Resident #46's electronic and paper medical record revealed no target behaviors, behavioral approaches, or routine side effect or behavioral monitoring had been implemented for the resident. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #46's interdisciplinary progress notes revealed a note dated 07/23/24 which described the resident as slightly tearful and recorded her as making a statement of rather be in heaven with Jesus than to be in so much pain. A note dated 07/27/24 identified the resident had an increase in pain and anxiety during the shift, and had been crying out in pain asking Jesus to end it. The note identified the provider had been notified and provided new orders to manage the resident's pain and anxiety. Review of notes dated 07/30/24 revealed therapy staff reported to nursing that Resident #46 made several comments during their session referring to wanting to kill herself. When assessed the resident stated she wanted to go home and swallow a bottle of pills so I can die and go home. Social services and the provider were notified. An additional nursing note identified the resident as extremely restless, who stated several times she wanted to go home so I can take a bottle of pills to be with the Lord, and, I just want to die, I'm tired of all this. Subsequent notes dated 07/30/24 revealed social services assessed the resident and recommended she be seen at the ER for evaluation and placement. The provider was notified and agreed. The resident's spouse was notified and the resident was recorded as being transferred to theER on [DATE] at approximately 1:15 P. M. A subsequent note dated 07/30/24 at 7:08 P.M. revealed Resident #46 returned from the ER with no new orders. Nursing staff will follow up with counseling for the resident and continue 15-minute checks. The resident voiced no questions or concerns and was observed to be smiling. A note dated 08/02/24 recorded the resident as being tearful at bedtime, and made negative statements while asking staff to, Pray for me tonight. Review of Resident #46's ED provider note, dated 07/30/24, revealed the resident arrived from the facility for suicidal ideations. Resident #46 stated she had a plan to take a bunch of pills and stated she wanted to end it all. The note indicated Resident #46 stated she started to have suicidal ideation but denied a plan to the ER provider. The note indicated that prior to arrival to the ED, she reported she wanted to commit suicide as her pain was too much for her to handle and she was unable to live a normal life. The note indicated the resident's laboratory results and examination were unremarkable, and a mental health professional recommended the patient be discharged back to her rehabilitation facility with an outpatient safety plan. The note indicated that return to ED precautions were reviewed with the patient at length. The plan included a consultation to mental health and listed a provider for the resident to follow up with within three days. Review of Resident #46's paper medical record revealed the only psychiatric notes contained in the record was a Crisis Management Plan, dated 07/30/24, from a local mental health entity. The plan identified triggers, breathing exercises, and support persons. The note indicated a representative from the mental health provider would be reaching out to get Resident #46 back on track with treatment as she missed her last appointments with psychiatry and counseling. Review of Resident #46's paper and electronic medical contained no evidence that the resident had seen a counselor, psychiatrist, or attending provider since her return to the facility. An interview on 08/14/24 at 2:44 P.M. with the Administrator revealed the facility typically did not take residents who have behavioral needs, and they will typically go to another local facility. He believed the facility nursing staff documents behaviors in the progress notes as they arise. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/14/24 at 3:41 P.M. with Registered Nurse (RN) #217 revealed Resident #46 was intermittently confused, but believed her issues were more psychiatric related. RN #217 was familiar with the resident's recent statements of wanting to end her life and subsequent ER visit. RN #217 indicated the resident was placed on 15-minute checks for 24 hours except for when she was in the ER, and her call light cord was temporarily removed from her room and replaced with a bell. RN #217 stated no other changes had been made to her medication regimen. An interview on 08/15/24 at 9:36 A.M. with Assistant Director of Nursing (ADON) #229 revealed the facility had no written policy for behavior monitoring. The facility's practice was if any behaviors were observed, nursing staff would document in the progress notes, but there was nothing prompting staff to monitor or record the presence or absence of behaviors. ADON #229 stated the facility did not have an in-house psychiatrist, but there was a local counseling center across the street that was utilized and the in-house nurse practitioner was present in the building four days a week. An interview on 08/15/24 at 9:53 A.M. with the Director of Nursing (DON) revealed the facility's practice was to chart behaviors by exception, but verified the facility needed a better system to prompt nursing staff to record the absence or presence of behaviors. A follow-up interview on 08/15/24 at 12:52 P.M. with the DON and ADON #229 revealed the facility did not have a policy which addressed suicidal ideations. The procedure for suicidal ideations was to notify the provider, obtain an order to send to the resident to the ER, and from there the acute care hospital had a practice for suicidal ideations. If it was determined the resident was suitable to return, recommendations would be implemented upon the resident's return. The DON stated the counselor Resident #46 saw in theER on [DATE] deemed her non-suicidal and suitable to return to the facility with an outpatient safety plan. Resident #46's ER provider progress note and the resident's Crisis Management Plan was reviewed with the DON. The DON verified the resident had an appointment scheduled with a counselor for 08/16/24, but that appointment had not been initiated or scheduled by facility staff until 08/14/24. The DON additionally confirmed Resident #46 had not been seen by the facility's Medical Director, nurse practitioner, or a psychiatrist since her return from the 07/30/24 ED visit. A telephone interview on 08/15/24 at 2:15 P.M. with Medical Director (MD) #290 revealed he was familiar with Resident #46 and of her ED visit on 07/30/24 for suicidal ideations. MD #290 reported the resident had a psychiatric history, with an inpatient psychiatric stay in the Summer of 2023, and identified the resident as being established with psychiatry and counseling prior to admission to the facility. MD #290 additionally confirmed he had not seen Resident #46 to re-evaluate her since she returned back to the facility following the ER visit on 07/30/24. An interview on 08/15/24 at 4:00 P.M. with the Administrator revealed he recalled hearing of the situation with Resident #46's ED visit related to suicidal ideations but was not present in the facility. The Administrator verified the facility missed an opportunity with arranging Resident #46's services upon her return to the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on medical record review, staff interview, review of the Food and Drug Administration (FDA) Black Box Warning information, and policy review, the facility failed to ensure psychotropic medications were administered to address appropriate conditions that reflect resident current health conditions and failed to ensure the residents were adequately monitored while receiving psychotropic medications. This affected four (#17, #46, #47, and #51) of five residents reviewed for unnecessary medications. The facility census was 66. Findings include: 1. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia in other diseases classified elsewhere elsewhere with psychotic disturbance, and anxiety disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident # 17 was severely cognitively impaired and required extensive assistance of one staff person for completing her activities of daily living (ADLs). Review of the mood and behaviors sections of the assessment revealed no coded instances of hallucinations, delusions, behaviors, or rejection of care. Review of the admission physician orders for Resident #17 revealed the resident was prescribed Seroquel (antipsychotic medication that treats and manages behaviors associated several mental health disorders including bipolar and schizophrenia) 25 milligrams (mg) in the morning. The indication/diagnosis for the use of Seroquel was noted to be restlessness. Review of the care plan dated 06/19/24 revealed Resident #17 was at risk for medical concerns related to psychotropic drug use. Review of interventions revealed the facility will monitor/record/report to the medical doctor as need, side effects and adverse reactions of psychoactive medications including unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, and behavior symptoms not usual to the person. Review of the monthly pharmacy review recommendation from the facility's contracted pharmacist dated 07/10/24 revealed Resident #17 continued to received the quetiapine (generic name for Seroquel) 50 mg by mouth at bed time, but was unable to find a corresponding diagnosis in the diagnosis list in the electronic medical record. The pharmacist continued to recommend assisting the nursing staff and note the diagnosis to associate with use of the antipsychotic. Further review revealed the physician responded with an order to add a diagnosis of Alzheimer's disease, unspecified, to the order for Seroquel . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Black Box Warning (informational message alerting the facility of potential consequences of administering the medication issued by the FDA) for Seroquel in the facility's electronic medical record system that appeared at each administration of the medication revealed Seroquel was associated with increased mortality in elderly patients with dementia related psychosis and elderly patients with dementia related psychosis treated with an antipsychotic drugs are at an increased risk of death. Seroquel was not approved for the treatment of patients with dementia related psychosis. Further review of the warning noted individuals taking Seroquel should be monitored closely for clinical worsening and suicidal thoughts and behaviors. Review of the nursing progress notes, assessment,s and other items in the electronic and paper medical records revealed no evidence of any behaviors or behaviors monitoring taking place as noted in the care plan or as recommended in the FDA Black Box Warning information sheet to indicate Resident #17's continued use of Seroquel as ordered. A telephone interview on 08/15/24 at 10:09 A.M. with Consultant Pharmacist (CP) #294 revealed as part of her monthly pharmacy review, she reviews all high risk medications, which include antipsychotic medications. CP #294 stated sometimes providers are using off-label diagnoses for antipsychotic medication and the facility providers usually explain their rationale for the medication's use. CP #294 was unaware of any stated rationale from Resident #17's Seroquel use other than standard off label use through out numerous facilities she contracts with. 2. Review of the medical record for Resident #46 revealed an admitted [DATE]. Medical diagnoses included left femur fracture, depression, and anxiety. Review of Resident #46's MDS 3.0 admission assessment, dated 07/10/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. Resident #46 was not recorded to have any hallucinations, delusions, behaviors or rejection of care. Review of Resident #46's physicians orders, dated 07/05/24, revealed the resident had orders for buspirone (an anti-anxiety medication) 15 mg three times daily routine, duloxetine (an antidepressant medication) 120 mg once daily in the morning, and trazodone (an antidepressant medication which can also treat insomnia) 150 mg once daily at bedtime. Review of Resident #46's care plan, dated 07/08/24, revealed the resident used antidepressant medication. Listed interventions included to give antidepressant medications as ordered by the physician and to monitor and document side effects and effectiveness. An additional care plan entry identified the resident also used anti-anxiety medication. Listed interventions included to give anti-anxiety medication as ordered by the physician, monitor and document side effects and effectiveness, and to monitor for behaviors and notify the physician as needed. Review of Resident #46's electronic and paper medical record revealed no target behaviors, behavioral approaches, or routine side effect or behavioral monitoring had been implemented and documented for the resident. 3. Review of the medical record for Resident #47 revealed an admitted [DATE]. Medical diagnoses included dementia, depression, insomnia, and anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #47's MDS assessment, dated 07/25/24, revealed the resident had a BIMS score of 03 indicating severely impaired cognition. The resident was not recorded to have any hallucinations, delusions, behaviors, or rejection of care. Review of Resident #47's physician's orders revealed the resident had an order dated 02/08/24 for Celexa (an antidepressant medication) 10 mg once daily for anxiety/depression, an order dated 11/08/23 for Klonopin (an anti-anxiety medication) 0.25 mg once daily at bedtime for anxiety, an order dated 08/30/23 for trazodone 25 mg once daily at bedtime for sleep, and an order dated 05/14/24 for Seroquel 12.5 mg once daily for dementia. Resident #47 had a previous order dated 02/09/24 for Seroquel 25 mg 1 tablet daily for anxiety/depression that was discontinued on 05/06/24. Review of Resident #47's care plan, revised 07/25/24, revealed the resident used antidepressant medication related to insomnia and depression. Listed interventions included to give antidepressant medications as ordered by the physician and to monitor and document side effects and effectiveness. An additional care plan focus, dated 03/12/24, identified the resident also used anti-anxiety medication. Listed interventions included to give anti-anxiety medication as ordered by the physician, monitor and document side effects and effectiveness, and to monitor for behaviors and notify the physician as needed. An additional care plan focus, revised 06/12/24, identified Resident #47 used psychotropic medications. Listed interventions included to administer medications as ordered, to monitor and document for side effects and effectiveness, consult with the pharmacy and health care provider to consider dosage reduction when clinically appropriate, and if the resident refused care or demonstrated behaviors, assess for pain and treat as needed, and maintain safety and reapproach later or with a different caregiver. Review of Resident #47's progress notes between 05/06/24 and 05/14/24 revealed no recorded behaviors or rationale for why the resident's Seroquel was re-started after being previously discontinued. Progress notes reviewed from 04/01/24 to 08/12/24 revealed behaviors were only described and recorded on 07/29/24, 08/07/24 and 08/12/24. Review of Resident #47's electronic and paper medical record revealed no target behaviors, behavioral approaches, or routine side effect or behavioral monitoring had been implemented for Resident #47. 4. Review of medical record for Resident #51 revealed an admitted [DATE]. Medical diagnoses include unspecified dementia with unspecified severity and with other behavioral disturbance, hypertension, atrial fibrillation, Alzheimer's disease with late onset, and anxiety disorder. Review of Resident #51's MDS assessment dated [DATE], revealed Resident #51 had moderately impaired cognition with no signs or symptoms of behaviors and delirium. The resident demonstrated no indicators for psychosis or behavioral symptoms. The assessment indicated the resident received antipsychotic, antidepressant, and diuretic medications. Review of Resident #51's physician orders reveals the resident has an order dated 06/20/24, for Trazadone 0.5 MG one (1) tablet by mouth, give at bedtime related to unspecified dementia, unspecified severity, and with other behavioral disturbances, and orders for Risperdal (antipsychotic) 0.5 MG, dated 08/14/24, one (1) tablet by mouth give at bedtime related to unspecified dementia, unspecified severity, and with other behavioral disturbances. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #51's electronic and paper medical record revealed no documentation of target behaviors, behavioral approaches, or routine side effect or behavioral monitoring had been implemented for Resident #51. On 08/15/24 at 11:30 A.M., interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) #229 revealed the facility did not have a specific charting or documentation area designed to monitor residents' behaviors who are administered psychotropic medications and thus had no evidence of behavior/medication monitoring for Resident #17, Resident #46, Resident #47, and Resident #51. The DON stated the nursing staff document by exception meaning all standards have been met with a normal or expected response unless otherwise documented. A telephone interview on 08/15/24 at 10:09 A.M. with Consultant Pharmacist (CP) #294 revealed as part of her monthly pharmacy reviews, she reviews all high risk medications, which include antipsychotic medications. Consultant Pharmacist #294 stated behavior monitoring is not something she had reviewed as part of her monthly reviews, nor is it anything she had recommended or used to make medication adjustment recommendations. Review of the policy titled, Psychotropic medication monitoring, dated 6/21/17, revealed each resident receiving a psychotropic agent is monitored for episodes of behavior being treated and/or manifestations(s) of the disordered thought process, adverse reactions and side effects, and appropriateness of drug selection and dosage disorder. Review of the policy titled, Policy 8.1.3 Antipsychotics, dated 06/21/17, revealed under monitoring, the facility assures that residents are being adequately monitored for efficacy and adverse consequences. When antipsychotics are used without monitoring they may be considered unnecessary medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365668	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Memorial Home	272 Benedict Ave Norwalk, OH 44857

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** 47990 Based on observation, staff interview, medical record review, review of manufacturer guidelines, and policy review, the facility failed to ensure residents were free from significant medication administration errors. This affected one (#04) of four residents observed for medication administration. The facility census was 66. Findings include: Review of the medical record for Resident #04 revealed an admitted [DATE]. Medical diagnoses included type II diabetes mellitus with diabetic chronic kidney disease and dementia. Review of Resident #04's Minimum Data Set (MDS) 3.0 annual assessment, dated 07/06/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 06 indicating severely impaired cognition. The resident was recorded to have received insulin injections daily over the seven-day assessment look back period. Review of Resident #04's care plan, revised on 08/21/23, revealed the resident had a diagnosis of diabetes mellitus and had listed interventions which included to administer medications as ordered by the doctor. Review of Resident #04's physician's orders revealed an order dated 06/25/24 for Lantus Solostar (a long-acting insulin) 13 units by subcutaneous (SQ) injection once daily in the morning. An observation on 08/13/24 at 9:00 A.M. revealed Licensed Practical Nurse (LPN) #265 prepared Resident #04's morning medications. LPN #265 prepared the routine doses of the resident's medications first, and then prepared Resident #04's insulin. LPN #265 removed Resident #04's insulin from the medication cart, and dialed the pen up to 13 units and stated that was the resident's ordered dose. LPN #265 cleansed the hub of the insulin pen with an alcohol swab and attached a new single-use subcutaneous needle. LPN #265 did not prime the needle, finished her checks against the medication administration record (MAR), and secured the medication cart. LPN #265 entered Resident #04's room and administered the insulin to the resident into his left arm per his request. A follow up interview on 08/13/24 at 9:10 A.M. with LPN #265 confirmed she did not prime the insulin pen prior to administering the injection to Resident #04. LPN #265 stated she had only been taught to prime the insulin needle when a new insulin pen was first opened, but did not believe she had to prime prior to each insulin dose administration. Interview on 08/14/24 at 7:56 A.M. with the Director of Nursing (DON) verified the nurse should have primed the insulin pen prior to medication administration. The DON stated the facility utilized an online educational resource, which stated the manufacturer's guidelines indicated prior to each dose administration, a new single-use needle should be used and each needle should be primed with two units of insulin prior to the ordered dose being prepared. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Lantus manufacturer's guidelines for use, dated 2020, revealed users are always to perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by ensuring the pen and needle work properly, and removing air bubbles. The safety test is performed by applying a new single-use needle, selecting a dose of two units by turning the dosage selector on the pen. Hold the pen with the needle pointing upwards. Tap the insulin reservoir so any air bubbles rise up towards the needle. Press the injection button all the way in, and check if insulin comes out of the needle tip. The guidelines indicate that a safety test may have to be performed several times before insulin is seen. If no insulin comes out, check for air bubbles and repeat the safety test two more times. If no insulin comes out, the insulin may be blocked, and the needle on the pen may need to be changed. If no insulin comes out after changing the needle, the insulin pen may be damaged, and do not use the insulin pen. Review of the policy, Medication Administration - Timing Guidelines and General Info, dated 12/2023, revealed medications shall be administered as ordered. Always read every word and figure in every order with meticulous care. If there is uncertainty in technique, ask a qualified person familiar with the technique or look it up in a reference book.