STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365714	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Leonard Hcc	8100 Clyo Road Centerville, OH 45458

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to administer medications as ordered to be free from errors not five (5) percent (%) or greater. There were two medication errors observed out of 27 opportunities for a medication error rate of 7.41%, This affected two (#66 and #71) of two residents observed during medication administration. The facility census was 110. Findings Included: 1. Review of Resident #71's medical record revealed the resident was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease and osteoporosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 was cognitively intact. Review of a physician order dated 04/25/25 revealed Resident #71 was ordered supplemental calcium 600 milligrams (mg) to be given once daily. Observation on 05/28/25 at 6:40 A.M. with Licensed Practical Nurse (LPN) #270 revealed the nurse was administering medication to Resident #71. At the time of the observation, calcium 600 mg was not available in the medication cart. Interview on 05/28/25 at 7:00 A.M. with LPN #270 verified she did not have calcium 600 mg available for Resident #71 and stated it was a special order and needed to be ordered. Interview on 05/28/25 at 7:39 A.M. with the Director of Nursing (DON) confirmed calcium 600 mg was not available in the facility. The DON stated the facility only had calcium 600 mg with vitamin D3 available. 2. Review of Resident #66's medical record revealed an admission date of 10/01/23. Diagnoses included Parkinson's disease and chronic obstructive disease. Review of the MDS assessment dated [DATE] revealed Resident #66 had intact cognition. Review of a physician order dated 10/11/24 revealed Resident #66 had an order for budesonide-formoterol fumarate inhalation aerosol 160-4.5 micrograms per actuation (mcg/act) with instructions to give two puffs inhaled orally two times a day related to chronic obstructive pulmonary disease. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/28/25 at 7:50 A.M. with LPN #398 revealed the nurse was preparing medications for Resident #66 and did not have budesonide-formoterol fumarate available in the medication cart to administer to Resident #66. Interview on 05/28/25 at 8:02 A.M. with LPN #398 verified Resident #66 did not have budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act available in the medication cart to administer to the resident. Interview on 05/28/25 at 8:10 A.M. with the DON stated the facility had a medication dispensing machine that only carried narcotic medications and the facility did not carry aerosols in stock. The DON stated all aerosol medications needed to be specially ordered. Review of the facility medication administration policy, dated 12/20/24, revealed the 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. This deficiency represents non-compliance investigated under Complaint Number OH00164611.

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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 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** Based on medical record review, staff interview, review of electronic mail (email) documents, and facility policy review, the facility failed to ensure residents were free from significant medication errors. This affected two (#112 and #113) of four residents reviewed for medications. The facility census was 110. Findings Included: 1. Review of Resident #112's medical record revealed an admission date of 04/16/25. Diagnoses included depression, hyperkalemia, fluid overload, thrombocytopenia, peripheral vascular disease, protein-calorie malnutrition, chronic obstructive pulmonary disease, acute diastolic heart failure, and congestive heart failure. The resident was discharged on 04/24/25. Review of Resident #112's physician orders revealed an order dated 04/20/25 for the diuretic furosemide 20 milligrams (mg) with instructions to take two tablets by mouth once a day for hypertension. This order was discontinued on 04/24/25. Review of Resident #112's physician orders revealed an order dated 04/21/25 for furosemide 60 mg once a day for edema and was discontinued on discontinue on 04/24/25. Review of Resident #112's medication administration record (MAR) for April 2025 revealed Resident #112 was administered furosemide 20 mg two tablets on 04/22/25 and 04/23/25 and also received furosemide 60 mg on 04/22/25 and 04/23/25. Interview on 05/28/25 at 3:00 P.M. with Director of Nursing Assisted Living ([NAME]) #693 stated the previous DON at the facility was who handled all investigations but [NAME] #693 had been working with her. [NAME] #693 verified Resident #112's order for furosemide 20 mg two tablets daily was not discontinued before starting the new order of furosemide 60 mg and the medications should not have been given together. 2. Review of Resident #113's medical record revealed the resident was admitted on [DATE]. Diagnoses included type two diabetes, autistic disorder, symbolic dysfunctions, and paranoid schizophrenia. Resident #113 was alert with periods of confusion. The resident was discharged on 05/12/25. Review of Resident #113's physician orders revealed an order dated 04/30/25 for the medication to treat high blood pressure and fluid retention hydrochlorothiazide 50 mg by mouth three times a day. The order was discontinued on 05/05/25. Review of Resident #113's physician orders revealed an order dated 05/05/25 for the blood pressure medication hydralazine 50 mg by mouth three times a day. Review of Resident #113's nursing progress note dated 05/05/25, written by Licensed Practical Nurse (LPN) #301, revealed Medical Director (MD) #350 ordered to discontinue hydrochlorothiazide 50 mg due to a decrease in weight and start hydralazine 50 mg three times a day. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #113's MAR for May 2025 revealed Resident #113 received hydrochlorothiazide 50 mg on 05/01/25, 05/02/25, 05/03/25, and 05/04/25 three times a day at 9:00 A.M., 2:00 P.M., and 9:00 P.M. Further review of the May 2025 MAR revealed Resident #113's hydralazine 50 mg was started on 05/05/25 at 12:00 P.M. and hydrochlorothiazide was discontinued. Review of an email dated 05/28/25 at 12:43 P.M. by [NAME] #693 revealed confirmation Resident #113's provider originally ordered hydralazine 50 mg three times a day to be administered, but an order initiated by a nurse for the resident to receive hydrochlorothiazide 50 mg three times a day instead. The prescribing provider and the resident's family were promptly notified and no adverse effects were observed. Resident #113 remained stable with vital signs within normal range. Interview on 05/28/25 at 3:00 P.M. with [NAME] #693 stated a nurse put in the incorrect medication (hydrochlorothiazide 50 mg) in Resident #113's physician orders on 04/30/25 and the order was supposed to be for hydralazine 50 mg. [NAME] #693 confirmed this was a medication error because the wrong medication was initiated and administered to Resident #113. [NAME] #693 stated the nurse that placed the incorrect medication in Resident #113's record as an order was provided education. Interview on 05/28/25 at 5:00 P.M. with the Director of Nursing (DON) stated she expected her nurses to make sure they check the five rights of medication administration to prevent medication errors and provides education right away on any medication errors at the facility. Review of the facility medication administration policy, dated 12/20/24, revealed 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. This deficiency represents non-compliance investigated under Complaint Number OH00164611.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of laboratory results, review of a facsimile (fax) document, staff interview, and review of a facility policy, the facility failed to notify the physician of critical laboratory values in a timely manner. This affected one (#112) of three residents reviewed for laboratory services. The facility census was 110. Findings Included: Review of Resident #112's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included depression, hyperkalemia, fluid overload, thrombocytopenia, peripheral vascular disease, protein-calorie malnutrition, chronic obstructive pulmonary disease, acute diastolic heart failure, and congestive heart failure. The resident was discharged on 04/24/25. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #112 had intact cognition, required setup for meals, and required substantial maximal assistance for bathing, personal hygiene, dressing the lower body, and placing shoes on and off the feet. Review of a physician order dated 04/03/25 revealed Resident #112 had an order for laboratory values to be completed including a complete blood count (CBC) and basic metabolic panel (BMP) one time only related to hyperkalemia. Review of a plan of care dated 04/08/25 revealed Resident #112 had impaired cardiac output related to acute diastolic congestive heart failure, hypertension, heart disease, and coronary angioplasty status. Interventions included to monitor for shortness of breath, sudden weight gain, take medications as ordered, and laboratory work will be drawn as ordered and the physician notified of abnormal laboratory values. Review of laboratory results dated [DATE] revealed Resident #112 had CBC and BMP laboratory values that revealed a sodium level of 132 milliequivalents per liter (mEq/L) (normal range was 136 to 145 mEq/L), chloride was 82 mEq/L (normal range was 98 to 110 mEq/L), carbon dioxide was 37 micromoles per mole (µ[NAME]/[NAME]) (normal range was 21 to 33 µ[NAME]/[NAME]), blood urea nitrogen (BUN) was 31 milligrams per deciliter (mg/dL) (normal range was 6-25), platelets were 137 microliters (mcL) (normal range was 150 to 450 mcL), monocytes were 13.7 percent (%) (normal range was 2.0 to 12.0%), and potassium was 4.9 mEq/L (normal range was 3.5 to 5.3 mEq/L). Review of a physician order dated 04/18/25 revealed Resident #112 had an order for Digoxin 125 microgram (mcg) one time a day for systolic heart failure and was discontinued on 04/24/25. Review of a physician order dated 04/21/25 revealed Resident #112 had an order for BMP, CBC, and Digoxin level laboratory values with orders to obtain laboratory levels one time only for abnormal laboratory values for two days. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the laboratory results dated [DATE] revealed Resident #112 had a BMP, CBC, and a Digoxin level with a collection time of 1:21 P.M. and was reported at 7:04 P.M. The report was provided to the facility at 7:04 P.M. of the following critical laboratory values: Digoxin level of 3.50 nanograms per milliliter (ng/mL) (normal level was 0.8 to 2.0 ng/mL), BUN of 107 mg/dL, chloride of 82 mEq/L, and potassium was 7.0 mEq/L. Review of the laboratory document titled, Fax Report History, for Resident #112 revealed dates and times of laboratory result for BMP, CBC, and Digoxin level reporting. On 04/23/25, there were failed fax transmissions at the times of 3:37 P.M., 4:04 P.M., and 7:02 P.M. On 04/24/25, failed fax transmission times of 1:02 A.M. and at 2:23 A.M. were noted. The facility ultimately received the fax transmission on 04/24/25 at 5:43 A.M. Interview on 05/28/25 at 3:15 P.M. with Medical Director (MD) #350 stated the laboratory company never reported the laboratory values for Resident #112 to the facility by fax and he did not receive notification of the critical laboratory values obtained on 04/23/25 from the laboratory company. Interview on 05/29/25 at 7:05 P.M. with Licensed Practical Nurse (LPN) #263 stated she never received the laboratory values by fax or telephone of Resident #112's critical laboratory values until the laboratory called her on 04/24/25 at 5:43 A.M. LPN #263 verified she never told the on-call physician about Resident #112's critical laboratory values until the resident was not longer in the facility. LPN #263 stated she would have called the on-call physician if the critical laboratory values were reported to the facility. Review of the facility policy titled, Physician, Physician Assistant, Nurse Practitioner, or Clinical Specialist Lab Notification, dated 02/2023, revealed it was the policy of the facility to timely notify the physician, physician assistant, nurse practitioner, or clinical nurse specialists of lab results. This deficiency represents an incidental finding investigated under Master Complaint OH00165855.