STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365717	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Convalarium at Indian Run	6430 Post Rd Dublin, OH 43016

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, review of the facility policy, and staff interview, the facility failed to ensure physician ordered laboratory services for a resident were completed in a timely manner. This affected one (Resident #10) of three residents reviewed for laboratory services. The facility census was 88. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, diabetes Mellitus (DM) and dementia. Review of the Minimum Data Set (MDS) assessment completed 07/18/24 revealed Resident #10 had a memory problem and had a diagnosis of DM. Review of Resident #10's physician orders dated 07/18/24 revealed hemoglobin A1C (HbA1c) (a blood test that measures average blood sugar levels over the past two to three months) and basal metabolic panel (BMP) (checks the body's fluid balance and levels of electrolytes) every six months on the second Wednesday in August and January due to a diagnosis of DM. Review of the physician notes dated 07/18/24 revealed a new order received from certified nurse practitioner for BMP and HbA1c every six months starting in August. The physician note completed 08/09/24 revealed the labs were not completed that were ordered on last visit, will re-order today. Review of the medication administration record (MAR) for Resident #10 revealed a BMP, Complete Blood Count (CBC), and Thyroid Stimulating Hormone (TSH) were ordered and completed on 08/12/24. However, review of laboratory results revealed there were were no labs drawn on 08/12/24 and the BMP and HbA1C was never drawn from 07/18/24 to 09/11/24. Interview on 09/12/24 at 10:02 AM with the Administrator and Director of Nursing (DON) confirmed Resident #10's physician orders for BMP and HbA1C to be drawn on 07/18/24 and 08/09/24 but were never drawn from 07/18/24 to 09/11/24. The Administrator and DON confirmed the CBC and TSH labs were not completed too. The Administrator and DON stated the laboratory company was not sent out to obtain Resident #10's labs. Review of the facilities Physician Orders policy dated 06/09/22 revealed the nurse that takes the physician order will be responsible for executing the order. The nurse should contact laboratory services to execute the order. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365717	A. Building B. Wing	09/12/2024

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Convalarium at Indian Run	6430 Post Rd Dublin, OH 43016

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This was an incidental finding discovered during the course of the complaint investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49039 Based on observation, review of the facility policy, and staff interview, the facility failed to complete hand hygiene during medication administration to residents in enhanced barrier precautions. This affected two (Resident #24 and #70) of four residents observed for medication administration. The facility census was 88. Findings include: Observation on 09/12/24 at 12:07 P.M. with Licensed Practical Nurse (LPN) #999 revealed prior to preparing medication for Resident #70, hand hygiene was not performed, and gloves were not worn. LPN #999 began preparing Resident #70's medication, directly from the medication card into the medication cup. LPN #999 then returned the medication card to the cart, locked it, and entered Resident #70's room, which had an enhanced barrier sign posted on the door. Resident #70 needed moderate assistance with medication administration, including spoon-feeding the medication with applesauce. Resident #70 took medications without difficulty. Upon exiting, hand hygiene was not performed by LPN #999. Observation on 09/12/24 at 12:15 P.M. with LPN #999 revealed after administering Resident #70's medication, hand hygiene was not performed. LPN #999 unlocked the medication cart and started preparing medications for Resident #24. LPN #999 poured Tylenol from a shared facility bottle into the medication cup and then retrieved a medication card from the medication cart and popped it into the cup. LPN #999 returned the medication card to the cart, locked it, and entered Resident #24's room, which had an enhanced barrier precautions sign posted on the door. LPN #999 gave Resident #24 his medication, which he took without issues. After completing the task, LPN #999 discarded the medication cup in the trash, exited the room without performing hand hygiene, and returned to the medication cart. Interview on 09/12/24 at 12:20 P.M. with LPN #999 confirmed that hand hygiene was not performed as required before and after preparing Resident #70 and #24's medications. Review of the Enhanced Barrier Precautions signage from United States Department of Health and Human Services, undated, revealed everyone must clean their hands, including before entering and when leaving the room. Review of the facilities Infection Control- Isolation/Precautions policy dated 08/2024 revealed staff must perform hand hygiene before and after contact with the resident and after contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident's room. This was an incidental finding discovered during the course of the complaint investigation.