

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Convallarium at Indian Run		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37100</p> <p>Based on medical record review and staff interview, the facility failed to follow resident code status orders. This affected one (Resident #90) of one resident reviewed for code status. Also, the facility failed to follow physician orders regarding resident weight status. This affected one (Resident #44) of five residents reviewed for nutritional orders. The census was 79.</p> <p>Findings include:</p> <p>1. Resident #90 was admitted to the facility on [DATE]. Her diagnoses were congestive heart failure, muscle weakness, chronic respiratory failure, acute pulmonary edema, asthma, morbid obesity, atrial fibrillation, hypertension, anxiety disorder, insomnia, depression, hypothyroidism, osteoarthritis, and obstructive sleep apnea.</p> <p>Review of her Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact.</p> <p>Review of Resident #90's physician orders and code status form found she had a code status of Do Not Resuscitate (DNR) Comfort Care Arrest (CCA).</p> <p>Review of Resident #90's progress notes dated [DATE] revealed staff entered her room at approximately 11:10 P.M. and found there was no response from the resident when staff called out. A carotid pulse was found when checked, but Resident #90 was still unresponsive. At that time, staff started Cardiopulmonary Resuscitation (CPR), until the paramedics arrived, then it was discovered that the patient had a DNR-CCA order. CPR was ceased at that point and Resident #90 expired.</p> <p>Interview with Registered Nurse (RN) #139 and RN #141 on [DATE] at 9:25 A.M. and 9:33 A.M. confirmed they are to check code status before performing CPR. They can find code status in the electronic record and they have a hard copy at the nurse's station too.</p> <p>Interview with the Director of Nursing (DON) on [DATE] at 9:42 A.M. and 9:48 A.M. confirmed CPR was performed on Resident #90, who had a code status of DNR-CCA.</p> <p>51068</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50008</p> <p>Based on resident medical record review, interviews with staff, and review of facility policy, the facility failed to provide proper wound monitoring for Resident #61. This affected one resident (#61) out of five residents reviewed for wound care. The facility census was 79 residents.</p> <p>Findings include:</p> <p>Resident #61 was admitted on [DATE] with diagnoses that included chronic respiratory failure, protein calorie malnutrition, paraplegia, disease of spinal cord, tracheostomy, and person injured in a motor vehicle accident.</p> <p>Review of Resident #61's Minimum Data Set (MDS) assessment dated [DATE] revealed that resident had four stage four pressure ulcers, all of which were present upon admission to the facility.</p> <p>Review of Resident #61's medical record revealed the resident was seen by the wound care nurse and wound nurse practitioner on 09/18/24 and measurements of his wounds were recorded. On 09/24/24, Resident #61 had a brief hospitalization and he was readmitted to the facility on [DATE]. On 09/25/24, Resident #61's wounds were not measured. The wound nurse attempted to see Resident #61 on 10/02/24, but he was unable to be seen, as he was out to an appointment. On 10/04/24, Resident #61 had a brief hospitalization and he was readmitted to the facility on [DATE]. On the clinical nursing assessment dated [DATE], it was noted the resident had multiple skin issues with treatments completed, but wounds were not measured. On 10/09/24, Resident #61's weekly wound assessment stated, See the hospital wound care notes. Measurements and area taken from these notes. On 10/16/24, Resident #61's wounds were visualized, measured, and recorded by the wound care nurse. The resident did not suffer any adverse outcome from the lack of wound monitoring, but had the potential to suffer an adverse outcome after not having a wound specialist visualize his wounds in the facility for twenty-eight days.</p> <p>An interview with Registered Nurse (RN) #142 on 11/26/24 at 10:31 A.M. confirmed that neither she nor the wound nurse practitioner saw Resident #61's wounds from the time frame between 09/18/24 and 10/16/24.</p> <p>An interview with the Director of Nursing (DON) on 11/27/24 at 1:31 PM revealed that she would expect a resident with pressure ulcers to be assessed and monitored by the wound nurse or wound specialist on a weekly basis. Interview with the DON confirmed that the wounds were not measured upon readmission on 09/25/24 and 10/05/24.</p> <p>Review of a facility policy titled, Pressure Injury Risk Assessment last reviewed on 08/2023 revealed that a complete head to toe skin check would be completed by a licensed nurse upon admission and readmission.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34745</p> <p>Based on observations, staff interview, and review of the facility policy, the facility failed to ensure medications were not left at bedside. This affected one resident (#55) of one resident observed for medications left at bedside. The census was 79.</p> <p>Findings include:</p> <p>Review of medical record for Resident #55 revealed an admitted [DATE]. The resident was admitted with diagnosis of acute and chronic respiratory failure.</p> <p>Observation on 11/27/24 at 8:50 A.M. upon entering Resident #55's room, revealed the resident was asleep with bipap upon his face. The nightstand beside the bed had a pill cup with eight tablets of medications. There was not a nurse in the room at this time. There was a certified nurse aide who came into the room with his breakfast tray and the resident removed the bipap then grabbed at the pill cup to take them. The resident stated they were the pills from the night time. This surveyor asked the resident to wait until the nurse could come to the room to verify the medications.</p> <p>Interview with Licensed Practical Nurse (LPN) #187 on 11/27/24 verified the medications were left on the resident's nightstand from the night shift nurse. The medications were from the 6:00 A.M. medication pass.</p> <p>Review of the undated medication storage policy revealed medication will be stored in a manner the integrity of the product ensures the safety of the residents.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34745</p> <p>Based on observation, staff interview, and review of the facility policy, the facility failed to prevent a medication error rate of less than five percent. There were two medication errors out of 25 opportunities, resulting in an eight percent error rate. This affected one (Resident #20) of six residents observed for medication administration. The census was 79.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #20 was admitted on [DATE].</p> <p>Review of the physician orders dated 07/17/24 for Resident # 20 revealed an order for Tylenol 325 milligrams (mg), give two tablets every six hours for general discomfort and an order dated 09/30/24 for Morphine Sulfate oral solution 20 mg per 5 milliliters (ml) to give 0.5 mg by mouth four times a day and to give 0.5 ml by mouth every two hours for pain and short of breath.</p> <p>Observation of Licensed Practical Nurse (LPN) #119 on 11/26/24 at 2:15 P.M. revealed LPN #119 prepared medications for Resident # 20 which included Tylenol 500 mg, two tablets and Morphine solution 20 ml per 5 ml, 0.75 mg liquid. The pills were crushed and placed in applesauce. The syringe contained 0.75 mg of Morphine and Tylenol was given by mouth.</p> <p>Interview with LPN #119 on 11/26/24 at 2:15 P.M. explained the resident receives 0.5 mg of Morphine as a routine medications and 0.25 mg which is as needed (PRN) to equal 0.75 ml of Morphine for pain and was written by hospice.</p> <p>Interview with LPN #119 on 11/26/24 at 2:35 P.M. verified the medications which were given; Tylenol 500 mg, two tablets, and Morphine solution 20 ml per 5 ml, to equal 0.75 mg liquid were not the correct medication dose as ordered by the physician. The LPN #119 stated the order must have been changed from what the resident previously was receiving.</p> <p>Review of the facility's policy, Medications Dispensing, undated, revealed all medications will be prepared and administered in a manner consistent with the general requirements outlined in this policy, including medication inspection to confirm the medication name and dose are correct.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068</b></p> <p>Based on record review, staff interview, resident interview, and policy review, the facility failed to prevent significant medication errors. This affected two (Resident's #44 and #23) of five residents reviewed for medication administration. The facility census was 79.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #44 revealed an admitted [DATE] and a re-entry admitted [DATE]. Medical diagnoses include chronic obstructive pulmonary disease (COPD), morbid obesity due to excess calories, type two diabetes mellitus with diabetic polyneuropathy, and unspecified protein-calorie malnutrition.</p> <p>Review of Resident #44's Minimum Data Set (MDS) 3.0 assessment revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.</p> <p>Review of the physician orders for Resident #44 revealed an order for insulin glargine solostar subcutaneous solution pen-injector 100 unit, inject 45 units subcutaneously two times a day related to type two diabetes melluitus with diabetic polyneuropathy with a start date of 09/24/24.</p> <p>Review of the medication administration report (MAR) revealed Resident #44's insulin was not provided on 10/02/24, 10/08/24, 10/12/24, 10/22/24, 11/04/24, and 11/10/24.</p> <p>Review of the vitals tab revealed Resident #44's blood sugars were taken on the dates her insulin was not provided. The following sugars were noted on the missing dates: 10/02/24 259 at 8:53 A.M., 10/08/24 156 at 7:51 A.M., 10/12/24 212 at 10:15 A.M., 10/22/24 302 at 7:50 A.M., 11/04/24 225 at 8:00 A.M., and 11/10/24 297 at 8:49 A.M.</p> <p>Review of the progress notes for Resident #44 revealed there were no notes indicating why Resident #44 missed her insulin on those dates.</p> <p>Interview on 11/26/24 at 2:23 P.M. with the Director of Nursing (DON) verified that any missed doses of insulin should have been documented in the progress notes including why the does was missed.</p> <p>Interview on 1126/24 at 3:52 P.M. with the DON verified that there was no documentation of why the insulin was not administered on the missing dates.</p> <p>41266</p> <p>2. Review of the medical record for Resident #23 revealed an admitted on 06/06/23. Medical diagnoses included type two diabetes mellitus without complications, morbid obesity, long term use of insulin, unspecified mood (affective) disorder, and delusional disorders.</p> <p>Review of the current physician orders revealed Resident #23 had an order for Levemir insulin with instructions to inject 29 units subcutaneously at bedtime for diabetes dated 07/25/23.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan revised 06/13/24 revealed Resident #23 had potential for unmanaged blood glucose levels and for complications related to type two diabetes mellitus, insulin dependency, and morbid obesity. Interventions included administer medications as ordered.</p> <p>Review of the Medication Administration Record (MAR) dated September 2024 revealed Resident #23 did not receive Levemir insulin on 09/01/24. There was a code of 9 (other-see notes) entered.</p> <p>Review of the Medication Administration Record (MAR) dated November 2024 revealed Resident #54 did not receive Levemir insulin on 11/11/24. There was a code of 9 (other-see notes) entered.</p> <p>Review of the progress notes and electronic MAR (e-MAR) notes revealed there were not any notes entered to explain why Resident #54 did not receive insulin injections on 09/01/24 or 11/11/24.</p> <p>Interview on 11/25/24 at 10:22 A.M. with Resident #54 revealed she did not always receive insulin at night as ordered. The resident reported she did not receive Levemir injection approximately one to two weeks ago because the agency nurse stated there was not any Levemir insulin in stock at the facility. Resident #54 denied having any negative outcomes from the missed dose of insulin.</p> <p>Interview on 11/27/24 at 9:00 A.M. with the Director of Nursing (DON) confirmed Resident #54 did not receive ordered doses of Levemir insulin on 09/01/24 or 11/11/24. The DON confirmed there was no evidence in the medical record to explain why the insulin doses were not received.</p> <p>Review of the facility policy, Medication Dispensing System, undated, revealed the policy stated, medications are administered in a timely fashion as specified by policy. After Medication Administration: document necessary medication administration/treatment information (e.g., when medications are administered, medication injection site, refused medications and reason, prn medications, etc.) on appropriate forms.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50008</p> <p>Based on observations, staff interviews, and review of facility policies and procedures, the facility failed to maintain sanitary food storage and preparation conditions. This had the potential to affect 55 residents who ate food prepared from the facility. The facility census was 79.</p> <p>Findings include:</p> <p>Observation of the kitchen walk in refrigerator on 11/25/24 at 8:38 A.M. revealed that a container that appeared to contain de-stemmed grapes, a container that appeared to contain shredded lettuce and a container that contained a small diced yellow fruit were unlabeled and undated on the refrigerator shelves.</p> <p>Interview on 11/25/24 at 8:38 A.M. with Dietary Manager #235 confirmed that three containers of food in the walk in refrigerator were unlabeled and undated. Dietary Manager #235 was unable to verify when the food items were initially opened.</p> <p>Observation on 11/25/24 at 8:43 A.M. revealed that there was approximately one inch thick of ice and snow like frost build up on the bottom left freezer when the walk in freezer door was opened. There were boxes of food with ice and frost on them. The door frame was observed to have ice build up on the door frame near the seal.</p> <p>Interview on 11/25/24 at 8:43 A.M. with Dietary Manager #235 confirmed that there was visible ice and snow build up on food products in the walk in freezer and ice build up on the freezer door frame.</p> <p>Observation on 11/26/24 at 11:04 A.M. revealed that two ceiling vents were covered in a brown and black fuzz. The dirty ceiling vents were over a food preparation area.</p> <p>Interview on 11/26/24 at 11:04 A.M. with Dietary Manager #235 confirmed the presence of a brown and black fuzzy substance on the ceiling vents located over the food preparation area.</p> <p>Review of a 2023 policy titled, Food Storage, revealed that food will be stored in an area that is clean, dry and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. All containers or storage bags must be legible and accurately labeled and dated. Racks and other storage surfaces should be clean and protected from splashes, overhead pipes or other contaminations (ceiling sprinklers, sewer/waste disposal pipes, vents, etc.) All foods should be covered, labeled and routinely monitored to assure that foods will be consumed by their use by dates.</p> <p>\</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50008</p> <p>Based on observation, interview, medical record review, and policy review, the facility failed to ensure catheter bags were stored in a sanitary manner to prevent infection. This affected one (Resident #20) of one resident observed for catheter storage. Additionally, the facility failed to ensure Enhanced Barrier Precautions (EBP) were in place for Resident #96. This affected one (Resident #96) of one resident observed for EPB. The facility census was 79.</p> <p>Findings include:</p> <p>1. Resident #20 was admitted on [DATE] with diagnoses including Parkinsonism, neuromuscular dysfunction of bladder, personal history of malignant neoplasm of prostate, and muscle weakness.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that resident had an indwelling catheter.</p> <p>Review of Resident #20's orders dated 06/17/24 revealed that Resident #20 had scheduled catheter and foley care monitoring on every shift daily.</p> <p>Observation of Resident #20 on 11/26/24 from 6:59 A.M. until 7:16 A.M. revealed that his catheter bag was laying flat against the floor under his bed.</p> <p>Interview with Licensed Practical Nurse (LPN) #119 on 11/26/24 at 7:16 A.M. revealed that Resident #20's catheter bag was laying flat against the floor under his bed.</p> <p>Review of facility policy reviewed in August 2024 titled, Catheter Care, revealed that the catheter should be secured after catheter care is provided. The drainage tubing and bag should be checked to ensure that the catheter is draining properly.</p> <p>41266</p> <p>2. Review of the medical record for Resident #86 revealed an admitted on 08/19/24. Medical diagnoses included malignant neoplasm of larynx, dysphagia-oro-pharyngeal phase, and malignant neoplasm of head, face, and neck.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #86 had intact cognition. Resident #86 required assistance from staff to complete Activities of Daily Living (ADLs). Resident #86 had a feeding tube in place.</p> <p>Observations and interviews on 11/25/24 at 2:15 P.M., 11/26/24 at 8:38 A.M., and 11/26/24 at 3:30 P.M. revealed Resident #86 had a peg tube placed in abdominal area. Resident #86 stated staff typically wore a mask and gloves while caring for him but did not wear gowns. There was no sign on Resident #86's door or any available Personal Protective Equipment (PPE) placed near Resident #86's room. There was no evidence Resident #86 had been placed under Enhanced Barrier Precautions (EBP).</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician orders revealed there was no order for Enhanced Barrier Precautions (EBP) in place until 11/26/24, following surveyor intervention.</p> <p>Interview on 11/26/24 at 3:35 P.M. with Agency Registered Nurse (ARN) #502 confirmed Resident #86 did not have a sign placed on his door or any PPE placed by his room for EBP. ARN #502 confirmed EBP should be utilized for a resident who had any openings, like a peg tube.</p> <p>Interview on 11/26/24 at 3:38 P.M. with the Director of Nursing (DON) confirmed Resident #86 had not been placed under EBP due to having a peg tube. The DON confirmed EBP should have been initiated.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>41266</p> <p>Based on record review, review of immunization records, staff interview, and facility policy review, the facility failed to educate residents on the risks and benefits and/or offer influenza vaccinations to residents as required. This affected five (Residents #42, #44, #61, #72, and #89) of five reviewed for immunizations. The facility census was 79.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of the medical record for Resident #42 revealed an admitted on 10/29/24. Medical diagnoses included encephalopathy, acute and chronic respiratory failure with hypoxia, type II Diabetes Mellitus with hyperglycemia, and morbid obesity.</li> </ol> <p>Review of immunization records revealed Resident #42 received the influenza (flu) immunization on 11/23/22. There was no further evidence Resident #42 had been offered the vaccination since admission. There was no evidence Resident #42 had been educated on the risks and benefits of receiving the flu vaccination.</p> <ol style="list-style-type: none"> <li>Review of the medical record for Resident #44 revealed an initial admitted on 05/13/23 and a readmitted on 09/23/24. Medical diagnoses included idiopathic aseptic necrosis of right hand, chronic obstructive pulmonary disease, type II Diabetes Mellitus with polyneuropathy, and morbid obesity.</li> </ol> <p>Review of immunization records revealed Resident #44 received the flu vaccination on 11/08/23. There was no evidence Resident #44 had been offered the flu vaccination in 2024. There was no evidence Resident #44 had been educated on the risks and benefits of receiving the flu vaccination.</p> <ol style="list-style-type: none"> <li>Review of the medical record for Resident #61 revealed an initial admitted on 09/16/22 and a readmitted on 11/19/24. Medical diagnoses included chronic respiratory failure with hypoxia, resistance to carbapenem, tracheostomy status, paraplegia, disease of spinal cord, colostomy status, pressure ulcer of right lower back stage IV, pressure ulcer of sacral region stage IV, pressure ulcer of other site stage IV, pressure ulcer of left lower back stage IV, and anal fistula.</li> </ol> <p>Review of immunization records revealed Resident #61 refused the flu vaccination. However, there was no date indicated on the Influenza Vaccine Consent Form. Resident #61's signature or a representative's signature was not present on the form. There was no evidence Resident #61 and/or the resident's representative had been educated on the risks and benefits of the flu vaccination.</p> <ol style="list-style-type: none"> <li>Review of the medical record for Resident #72 revealed an initial admitted on 03/16/23 and a readmitted on 08/09/24. Medical diagnoses included anoxic brain damage, resistance to carbapenem, protein-calorie malnutrition, epilepsy, tracheostomy status, gastrostomy status, and dependence on respirator (ventilator) status.</li> </ol> <p>Review of immunization records revealed Resident #72 received the flu vaccination on 11/08/23. There was no evidence the flu vaccination had been offered to the resident or resident representative in 2024. There was no evidence Resident #72 and/or the resident representative had been educated on the risks and benefits of the flu vaccination.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Convallarium at Indian Run		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Review of the medical record for Resident #89 revealed an admitted on 10/30/24. Medical diagnoses included encephalopathy, chronic respiratory failure, morbid obesity, and simple chronic bronchitis.</p> <p>Review of the immunization records revealed Resident #89 received the flu vaccination on 12/09/22. There was no evidence Resident #89 or the resident's representative had been offered the flu vaccination since admission. There was no evidence Resident #89 and/or the resident's representative had been educated on the risk and benefits of the flu vaccination.</p> <p>Interview on 11/27/24 at 11:23 A.M. with the Director of Nursing (DON) confirmed the above findings. The DON confirmed deficiencies with vaccinations of residents had been identified and she had planned to start obtaining consents from residents next week. The DON stated, I know we aren't where we are supposed to be with them.</p> <p>Review of the facility policy, Influenza and Pneumococcal Disease Prevention, dated 01/31/22, revealed the policy stated, residents, regardless of stay, should be offered the seasonal influenza vaccine. Influenza immunizations are offered to all residents and facility personnel according to the time period provided by the Centers for Disease Control and Prevention (CDC). Before offering the immunization, nursing facility personnel and each resident or the resident's legal representative receive education regarding the benefits and potential side effects of the immunization. Documentation that the resident and/or resident's legal representative was provided education regarding the benefits and potential side effects of the influenza and/or pneumococcal immunization, documentation of any refusals to be vaccinated, and documentation that the resident either received the influenza and/or pneumococcal immunization or did not receive it, is kept in the resident's medical record.</p>		

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NAME OF PROVIDER OR SUPPLIER  Convallarium at Indian Run		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>41266</p> <p>Based on record review, review of immunization records, staff interview, and facility policy review, the facility failed to educate on the risks and benefits and/or offer COVID-19 vaccinations to residents as required. This affected five (Residents #42, #44, #61, #72, and #89) of five reviewed for immunizations. The facility census was 79.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #42 revealed an admitted on 10/29/24. Medical diagnoses included encephalopathy, acute and chronic respiratory failure with hypoxia, type II Diabetes Mellitus with hyperglycemia, and morbid obesity.</p> <p>Review of immunization records revealed Resident #42 received COVID-19 vaccinations on 03/04/21, 04/01/21, and 11/10/21. There was no evidence Resident #42 and/or the resident's representative was educated on the COVID-19 vaccination upon admission. There was no evidence the COVID-19 vaccination was offered to Resident #42 or the resident's representative upon admission.</p> <p>2. Review of the medical record for Resident #44 revealed an initial admitted on 05/13/23 and a readmitted on 09/23/24. Medical diagnoses included idiopathic aseptic necrosis of right hand, chronic obstructive pulmonary disease, type II Diabetes Mellitus with polyneuropathy, and morbid obesity.</p> <p>Review of immunization records revealed Resident #44 refused the COVID-19 booster vaccination. There was no date indicated in the medical record of when the vaccination was refused. There was no evidence in the medical record Resident #44 and/or the resident's representative received education on the risks and benefits of the vaccination in 2023 or 2024. There was no evidence Resident #44 was offered the COVID-19 vaccination in 2023 or 2024.</p> <p>3. Review of the medical record for Resident #61 revealed an initial admitted on 09/16/22 and a readmitted on 11/19/24. Medical diagnoses included chronic respiratory failure with hypoxia, resistance to carbapenem, tracheostomy status, paraplegia, disease of spinal cord, colostomy status, pressure ulcer of right lower back stage IV, pressure ulcer of sacral region stage IV, pressure ulcer of other site stage IV, pressure ulcer of left lower back stage IV, and anal fistula.</p> <p>Review of immunization records revealed Resident #61 revealed there was no evidence the resident had received any COVID-19 vaccinations. There was no evidence in the medical record Resident #61 and/or the resident's representative refused the vaccination. There was no evidence Resident #61 and/or the resident's representative had been educated on the risks and benefits of the COVID-19 vaccination. There was no evidence the COVID-19 vaccination had been offered to Resident #61 and/or the resident's representative in 2023 or 2024.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Convalarium at Indian Run		STREET ADDRESS, CITY, STATE, ZIP CODE  6430 Post Rd Dublin, OH 43016	
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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of the medical record for Resident #72 revealed an initial admitted on 03/16/23 and a readmitted on 08/09/24. Medical diagnoses included anoxic brain damage, resistance to carbapenem, protein-calorie malnutrition, epilepsy, tracheostomy status, gastrostomy status, and dependence on respirator (ventilator) status.</p> <p>Review of immunization records revealed Resident #72 refused the COVID-19 vaccine booster, however, there was no date indicated. There was no evidence in the medical record of Resident #72 and/or the resident's representative refusing the vaccination. There was no evidence in the medical record Resident #72 and/or the resident's representative was educated on the risks and benefits of the COVID-19 vaccination. There was no evidence the COVID-19 vaccination was offered to Resident #72 and/or the resident's representative in 2023 or 2024.</p> <p>5. Review of the medical record for Resident #89 revealed an admitted on 10/30/24. Medical diagnoses included encephalopathy, chronic respiratory failure, morbid obesity, and simple chronic bronchitis.</p> <p>Review of the immunization records revealed Resident #89 received COVID-19 vaccinations on 06/30/21, 12/29/21, and 12/09/22. There was no evidence in the medical record Resident #89 and/or the resident's representative had been educated on the risks and benefits of the COVID-19 vaccine since admission. There was no evidence Resident #89 and/or the resident's representative were offered the COVID-19 vaccine since admission.</p> <p>Interview on 11/27/24 at 11:23 A.M. with the Director of Nursing (DON) confirmed the above findings. The DON confirmed deficiencies with vaccinations of residents had been identified and she had planned to start obtaining consents from residents next week. The DON stated, I know we aren't where we are supposed to be with them.</p> <p>A facility policy related to COVID-19 vaccination was requested at the time of the survey, however, a policy was not provided for review.</p>		