STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365880	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Coshocton	100 South Whitewoman Street Coshocton, OH 43812

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medial record, review of the facility investigation, interview with the staff, and facility policy review the facility failed to ensure Resident #58 was administered the correct medication. This affected one resident (#58) of three residents reviewed for medication errors. The facility census was 54. Findings include: Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses include cellulitis of the left upper limb, urinary tract infection, cognitive communication deficit, dysphagia, hypertension, dementia, atherosclerotic heart disease, chronic kidney disease, and atrial fibrillation with pacemaker. She was discharged against medical advice on 06/23/24. Further review of the medical record revealed Resident #58 was allergic to caffeine, chocolate flavoring, codeine sulfate, and meclizine. There was no Minimum Data Set information available. Review of the vital signs for Resident #58 revealed on 06/12/24 her baseline vital signs were blood pressure 130/68, respirations 16, heart rate 72, and oxygen saturation level 96 percent on room air. Review of the progress note dated 06/13/24 at 9:40 A.M. revealed at 8:28 A.M. the nurse reported a medication error. The medication error occurred at approximately 7:37 A.M. The nurse on the floor notified the family. The Nurse Practitioner (NP) was contacted with orders to give Narcan as needed if respirations were lower than 10 per minute and does not improve with arousal, and if the Narcan was given to send the resident to the emergency room . Do vital signs every 30 minutes until 1:00 P.M., then every hour until 5:00 P.M., then every two hours until 1:00 A.M. then every four hours until 1:00 P.M. then discontinue, one liter of normal saline running at 75 milliliters an hour until completed one bag, hepatic and kidney function test to be drawn on 6/14/24, then again on 6/17/24, and monitor for respiratory distress (shallow respirations, rapid breathing, fast heart rate). The pharmacy was called and updated on the medication error and additional side effects facility needed to monitor for. This nurse relayed orders given from NP, and per the pharmacy, the orders were appropriate. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365880	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Coshocton	100 South Whitewoman Street Coshocton, OH 43812

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the post incident vital signs on 06/13/24 at 10:10 A.M. revealed the vital signs for Resident #58 were, blood pressure 135/68 respiration 18, heart rate 85, and oxygen saturation level 91 percent on room air. Review of the facility event report dated 06/13/24 at 6:20 P.M. revealed at 8:28 A.M. Resident #58 was given another resident's medication. The post event assessment revealed Resident #58 was lethargic/drowsy. She received new orders to give Narcan as needed if respirations are lower than 10 per minute and does not improve with arousal, and if the Narcan was given to send the resident to the emergency room . Do vital signs every 30 minutes until 1:00 P.M., then every hour until 5:00 P.M., then every two hours until 1:00 A.M. then every four hours until 1:00 P.M. then discontinue, one liter of normal saline running at 75 milliliters an hour until completed one bag, hepatic and kidney function test to be drawn on 6/14/24, then again on 6/17/24, and monitor for respiratory distress (shallow respirations, rapid breathing, fast heart rate). She was administered mycophenolate 500 milligrams (mg) (organ rejection medication), Cyclosporine 50 mg (organ rejection medication), Famotidine 10 mg (heartburn medication), Ativan 0.5 mg (antianxiety medication), Magnesium oxide 400 mg (supplement), Morphine 60 mg (narcotic pain medication), Nystatin 100,000 units swish and swallow (antifungal), and Prednisone 5 mg one (steroid) in error. Review of the facility investigation revealed on 06/13/24 at approximately 8:28 A.M. revealed Nurse #100 reported she gave the wrong medication to Resident #58 at 7:37 A.M. The medications were reviewed by the NP, and she ordered to give Narcan as needed if respirations are lower than 10 per minute and does not improve with arousal, and if the Narcan was given to send the resident to the emergency room . Do vital signs every 30 minutes until 1:00 P.M., then every hour until 5:00 P.M., then every two hours until 1:00 A.M. then every four hours until 1:00 P.M. then discontinue, one liter of normal saline running at 75 milliliters an hour until completed one bag, hepatic and kidney function test to be drawn on 6/14/24, then again on 6/17/24, and monitor for respiratory distress (shallow respirations, rapid breathing, fast heart rate). The family was updated on the medication error. After thorough investigation the root cause was determined to be Nurse #100 did not practice the six rights to medication administration. Review of the progress note dated 06/15/24 at 10:50 A.M. revealed Resident #58 (only assessment documented on incident) continues to be lethargic but responsive with no respiratory distress noted. Her vital signs continue to be monitored. Review of the June 2023 physician's orders revealed Resident #58 had orders to give Narcan as needed if respirations are lower than 10 per minute and do not improve with arousal, and if the Narcan was given to send the resident to the emergency room . Do vital signs every 30 minutes until 1:00 P.M., then every hour until 5:00 P.M., then every two hours until 1:00 A.M. then every four hours until 1:00 P.M. then discontinue, one liter of normal saline running at 75 milliliters an hour until completed one bag, hepatic and kidney function test to be drawn on 6/14/24, then again on 6/17/24, and monitor for respiratory distress (shallow respirations, rapid breathing, fast heart rate) dated 06/13/24. Review of the June 2023 medication administration records (MAR) revealed Resident #58 never had to be administered the Narcan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365880	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Coshocton	100 South Whitewoman Street Coshocton, OH 43812

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/29/24 at 1:10 P.M. an interview with the Director of Nursing (DON) confirmed Resident #58 received the wrong medication. She stated they did not have to give her the Narcan, and the only change in her condition was her oxygen level dropping a little. Review of the facility policy titled, Medication Discrepancies, dated 11/06/19, revealed medication discrepancies were documented and reported to the resident's attending physician. Director of Nursing, responsible party and Performance Improvement Committee. In addition to reporting discrepancies that resulted in the resident receiving an incorrect medication, medication discrepancies that have the potential for but do not actually result in the resident receiving an incorrect medication were documented and report. This deficiency represents non-compliance investigated under Complaint Number OH00154888.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365880	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Coshocton	100 South Whitewoman Street Coshocton, OH 43812

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35765 Based on observation, interview with staff, and review of the facility policy the facility failed to ensure three medication carts were locked when unattended. This had the potential to affect 12 residents (#1, #5, #18, #22, #24, #32, #33, #42, #46, #51, #55, and #56) who were cognitively impaired and independently mobile residents. The facility census was 54. Findings include: Observation of the Buckeye Unit on 06/29/24 at 7:50 A.M. revealed three medication carts (#2, #3 and #4) were sitting outside the nurse's station unlocked and unattended. On 06/29/24 at 8:05 A.M. an interview with Nurse #101 confirmed she had left the medication carts unlocked while she went to the restroom. Review of the facility policy titled, Medication Storage-Storage of Medication, dated 01/23, revealed medications and biologicals were stored properly, following manufacturers or providers pharmacy recommendations, to maintain their integrity and to support safe effective drug administrations. The medication supply would be accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. To limit access to prescription medication, only licensed nurses, pharmacy staff and those lawfully authorized to administer medications were allowed access to medication cats. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access. This deficiency was an incidental finding identified during the complaint investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365880	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Coshocton	100 South Whitewoman Street Coshocton, OH 43812

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35765 Based on observations and interview with staff the facility to ensure staff used proper hand hygiene during medication administration. This affected three residents (#25, #51, and #54) of eight residents reviewed for medication administration. The facility census was 54. Findings include: Observations of medication administration on 06/29/24 at 11:07 A.M. revealed Nurse #101 administered medication to Resident #51, left her room, went to the medication cart in the hallway, and hugged a visitor in the hallway. She went down the hall to another unit, and she stopped at a resident's room and shook hands with a resident's family member then she went out to the medication cart and started to set up medication for Resident #54 without washing her hands. She removed a capsule of gabapentin from the card with her bare hand and put it into the medication cup and started to walk towards the resident's room. She was stopped by the surveyor to administer a new capsule of gabapentin. Nurse #101 stated she did not even realize she used her hands to pop the capsule out of the medication card. She administered a new gabapentin to Resident #54. She left the room of Resident #54 and went back out into the hallway to the medication cart and proceeded to set up medication for Resident #25 without washing her hands. She administered the medication to Resident #25 and went back out into the hallway and then went into the restroom by the nurse's station and washed her hands. On 06/29/24 at 11:41 A.M. an interview with Nurse #101 confirmed she had not washed her hands while administering medications to Residents #25, #51 and #54. This deficiency was an incidental finding identified during the complaint investigation.