STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365933	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Buckeye Terrace Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 140 N State Street Westerville, OH 43081	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, review of the facility assessment, hospital record review, review of police reports, review of facility policies, and interviews, the facility failed to identify potential risks/hazards for residents with a substance use disorder, develop and implement comprehensive and individualized care plans and provide adequate supervision to prevent unintentional/intentional drug overdoses for residents in the facility. This resulted in Immediate Jeopardy and actual harm/death on [DATE] when Resident #1 overdosed by shooting opioid medications in his peripherally inserted central catheter (PICC) line after he obtained a syringe from the trash bin on the facility medication cart. Resident #1 had a history of intravenous illicit substance abuse prior to admission and had an intravenous line while at the facility. The Immediate Jeopardy and potential for actual harm/death continued on [DATE] when Resident #2 was found unresponsive in his room from a drug overdose. The resident was transferred to the emergency room with altered mental status and unresponsiveness due to an intentional opiate overdose. The toxicology report revealed Resident #2 had overdosed on opiates (prescribed) and Fentanyl (not prescribed). This affected two residents (#1 and #2) of three residents reviewed for substance use disorder. The facility identified 26 residents with a history of substance use disorder. The facility census was 63. On [DATE] at 5:05 P.M., the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Clinical Services (RDCS) #104, and Regional Clinical Director #114 were notified Immediate Jeopardy began on [DATE] when Resident #1, who had been admitted to the facility with a PICC line for intravenous antibiotic and who had been receiving opioid medication daily, was found unresponsive on the bathroom floor due to a drug overdose. The resident subsequently passed away as a result of the overdose. On [DATE], there was a plastic jar with 24 various pills found in Resident #1's nightstand drawer, three used syringes with pink residue, and an unopened syringe. In addition, on [DATE] Resident #2 who had a history of substance abuse disorder was found unresponsive in room from an intentional drug overdose. The resident had obtained medications from a former resident and had stored the medications in his room for several days prior to the incident. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following interventions: On [DATE] at 12:30 P.M. Licensed Practical Nurse (LPN) #100 called emergency medical services (EMS) for possible drug overdose for Resident #1. Police arrived shortly after EMS. (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: 365933	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER: Buckeye Terrace Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 140 N State Street Westerville, OH 43081	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 12:34 P.M., LPN #100 notified Assistant Director of Nursing (ADON) #102 that Resident #1 was being sent out for possible drug overdose. At 12:46 P.M., the LNHA was notified of Resident #1's possible drug overdose. On [DATE] at 3:00 P.M., the facility began their investigation into Resident #1's possible drug overdose. The LNHA spoke to the hospital and obtained an official police report. The LNHA interviewed Resident #67 (roommate of Resident #1) and Resident #29 about any information related to Resident #1's overdose. Resident #67 stated they were not aware of Resident #1 having any visitors. Resident #29 stated Former Resident #3 had drugs delivered in food items brought in from the outside. On [DATE] at 5:30 P.M., LNHA reviewed video footage of the front reception camera from [DATE] at 12:00 A.M. to 2:00 P.M. for any packages being delivered to the facility. This was completed due to information received from an interview with Resident #29. No evidence was observed on camera footage of any packages being delivered. On [DATE] at 2:00 P.M., the DON provided education on the new process changes to five registered nurses (RNs) and twelve LPNS on the following system changes: effective Immediately, all syringes will only be disposed of in a sharp container including all needles syringes and mouth sweeps will be performed on all resident's post medication administration. Any agency nurses would be educated by the DON prior to the start of their shift on the above system changes if needed. On [DATE] at 2:15 P.M., physician orders were written by the DON for all residents to have mouth sweeps after administration of medication. These were to appear on the medication administration record (MAR) for the nurses to sign and validate that this task was performed. On [DATE] at 8:30 A.M., the DON completed writing physician orders for all residents to say, Crush medications if suspected 'cheeking' medications (concealing a medication in the mouth i.e. between the teeth and the cheek, to avoid swallowing it). On [DATE], an audit was initiated by the DON for the disposal of syringes into the appropriate sharp container and not in the medication trash bin on the side of the medication cart. This audit would be completed by the DON/Designee three times per week for two weeks then two times a week for two weeks and then weekly for eight weeks. Results of the audits to be reviewed in monthly QA for further need of monitoring and/or enhancement. On [DATE], an audit was initiated by the DON for mouth sweeps to ensure a mouth sweep was performed post medication administration. The DON/Designee would complete this audit three times a week for two weeks, then twice a week for two weeks, and then weekly for eight weeks. Results would be reviewed in monthly QA for further need of monitoring and or enhancement. On [DATE] and [DATE] the facility reviewed the care plans for all the residents to identify any resident who had a history of substance abuse were identified and to make sure those identified as having a history of substance abuse had an appropriate care plan in place (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckeye Terrace Rehabilitation and Nursing Center	140 N State Street Westerville, OH 43081

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at approximately 5:30 A.M. Resident #2 was noted to be unresponsive by LPN #130. Resident #2's pulse was 55 and oxygen saturation was 66. LPN #130 applied oxygen to Resident #2 per non-rebreather and then called 911. At approximately 5:33 A.M., LPN #130 administered two doses of Narcan (a medication to treat narcotic overdose in an emergency) prior to Emergency Medical Services (EMS) arrival. On [DATE] at approximately 5:40 A.M., Resident #2 was arousing but not yet oriented. Police arrived on the scene and searched Resident #2's room. No medications were found in Resident #2's room. On [DATE] at approximately 5:45 A.M., EMS made the decision to transport Resident #2 to the ED. Resident #2 told the ED staff they he crushed his pain medication that morning and snorted it. On [DATE] at 6:00 A.M., the DON verified with LPN #130 the last time Resident #2 had received a dose of his medication was on [DATE] at 12:00 A.M. and the medication was crushed as physician ordered. On [DATE] at 1:45 P.M. , DON drove to the hospital and interviewed Resident #2 about details of the potential drug overdose. Resident #2's statement consisted of the following information: Resident #2 stated that he had gotten the medication from a former resident a while ago. Resident #2 stated he could not remember the name of the former resident. On [DATE] at 3:00 P.M. Facility Department Heads completed a full house sweep of 18 resident's rooms; residents who were on the facility substance use disorder (SUD) program per the contract agreement. No illegal substances were found in this sweep of residents' rooms. These 18 residents had signed a contract allowing staff to conduct room searches because they were identified at high risk. On [DATE] at 3:00 P.M., the facility department heads conducted a room sweep for 24 residents not on the SUD program who gave permission for the room sweep when asked. No illegal substances were found. On [DATE] at 3:00 P.M., an emergency Quality Assessment and Performance Improvement (QAPI) meeting was held with facility department heads and Medical Director #500 to discuss Resident #2's overdose and the facility's plan of correction and steps taken toward an abatement plan. On [DATE], the DON completed education to the facility nurses for policy review of medication storage and for no medication/substance to be kept in the resident's rooms. Five RN's,12 LPNS, and 19 State tested Nursing Assistants (STNAs) were educated on [DATE]. All assigned agency nurses would be educated by the DON prior to the start of their shift on the facility medication storage policy and no medications/substances to be unsecured in resident rooms. On [DATE], the LHNA completed in person education for all 53 residents residing in the facility on this date related to the facility policy for medication storage in the facility and there were to be no medications/substances in resident rooms. On [DATE], the facility initiated random room audits to check for unsecured medications/substances five times a week times for two weeks, then three times a week for two weeks, then times a week for two weeks, and then weekly for six weeks. Results would be reviewed in monthly QA for further need of monitoring and/or enhancement. This audit will be performed by the DON/Designee. On [DATE] at 9:30 A.M., 1:20 P.M. to 1:45 P.M., and 4:00 P.M., onsite surveyor observations revealed the nurses disposed of syringes and needles in the sharp' container. There were no syringes observed in the medication trash bins. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Buckeye Terrace Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 140 N State Street Westerville, OH 43081	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 10:26 A.M. and 2:56 P.M., surveyors noted there were no medications observed in Resident #2's room. On [DATE], surveyor review of Resident #2 and #3's medication administration records (MAR) revealed nursing was completing mouth sweeps after medication administration. On [DATE], surveyor review of the facility's audits for medication sweeps post medication administration, the disposal of syringes into the appropriate sharp container, and checks for unsecured medications/substances revealed no negative findings from the audits completed through this time. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility continued in their process of implementing corrective actions and monitoring to ensure on-going compliance. Findings include: Review of the facility assessment dated [DATE] revealed there were 15 residents with active or current substance use disorders for the first quarter of 2023 and zero behavioral health needs. The assessment reflected the facility managed the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identified, and implemented interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post-traumatic stress disorder, other psychiatric diagnoses, and intellectual or developmental disabilities. 1. Review of the Resident #1's closed medical record revealed hospital records dated [DATE] noted Resident #1 had history of intravenous drug use with lasted reported use two weeks prior. Resident #1 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis of vertebra, chronic obstructive pulmonary disease, opioid dependence, and anxiety disorder. Review of the plan of care dated [DATE] revealed Resident #1 had a PICC line. Interventions included to change the dressing to PICC site as ordered every seven days, flush both ports every shift and after each administration of antibiotic with 10 milliliters (ml) of normal saline, monitor for signs and symptoms of infection including redness, swelling, temperature, and report any abnormal finding to the physician. Record review revealed there were no interventions initiated to address the resident's history of intravenous drug use. A plan of care dated [DATE] revealed Resident #1 had a substance abuse disorder. No interventions were listed on the plan of care. Review of the five-day Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1's Brief Interview for Mental Status (BIMS) score was 14 which indicated Resident #1 was cognitively intact. The assessment noted Resident #1 was independent with activities of daily living (ADL). Review of Resident #1's medication orders for [DATE] revealed medications included Gabapentin (nerve pain medication) 800 milligram (mg) three times a day, Naloxone (to treat narcotic overdose) liquid one spray to alternating nostrils as needed every two to five minutes until paramedics arrived, and Oxycodone (opiate) 20 mg every four hours as needed for moderate pain. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckeye Terrace Rehabilitation and Nursing Center	140 N State Street Westerville, OH 43081

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Medication Administration Record (MAR) for [DATE] revealed Resident #1 received 71 doses of Oxycodone from [DATE] to [DATE]. Resident #1 was administered Oxycodone on [DATE] at 3:00 A.M., 7:47 A.M. and 11:53 A.M. Review of the general progress note dated [DATE] at 12:20 P.M. authored by LPN #100 revealed LPN #100 was called to Resident #1's room by another resident. LPN #100 found Resident #1 on the floor. Resident #1 was lying on his right-side thrashing back and forth. LPN #100 saw Resident #1 had a syringe in his hand. LPN #100 had another nurse obtain Narcan. Resident #1 received Narcan nasally and 911 was called. Resident #1 continued to thrash around, and vitals were not able to be obtained. Resident #1 had a laceration to the left eye that was unable to be assessed due to Resident #1's condition. An ambulance arrived and carried Resident #1 downstairs on a stretcher. Review of the emergency department (ED) notes dated [DATE] revealed Resident #1 was found unresponsive with a syringe in his hand. Upon arrival at the ED, Resident #1 was pulseless and cardiopulmonary resuscitation (CPR) was initiated. Return of spontaneous circulation (ROSC) was achieved twice and Resident #1 was under a total of approximately ten minutes. Cardiac arrest was likely due to drug overdose. Resident #1 had a history of Fentanyl and heroin abuse. Opiate and Oxycodone were detected in Resident #1's drug screen. Review of the police case report dated [DATE] at 12:33 P.M. revealed Resident #1 was found in his bathroom unresponsive. Staff provided the syringe Resident #1 had in his hand. A needle was not attached, and the syringe was empty. The officer searched the immediate area around Resident #1's bed and found no drugs or paraphernalia. Resident #1's roommate reported he was not aware of Resident #1 having any visitors. The police case report revealed on [DATE], an officer met with Assistant Director of Nursing (ADON) #102. ADON #102 reported Resident #1's room was being cleaned out by Head of Housekeeping #103 when a plastic jar with various pills was found in the nightstand drawer. Head of Housekeeping #103 also found three used syringes with pink residue and an unopened syringe. Head of Housekeeping #103 placed the items in a bag and turned them over to ADON #102. ADON #102 stated Resident #1 had been using his PICC line to inject himself with Oxycodone and other unknown drugs. Resident #1 was prescribed Oxycodone but not intravenously. The officer took possession of the pills and syringes. Most of the pills did not have any kind of markings on them. The pills, syringes, and body camera footage were entered into evidence. The 24 pills seized included one round orange pill marked with 022 tentatively identified as Cyclobenzaprine (muscle relaxant), one round orange capsule marked with 214 and tentatively identified as Gabapentin, one round green pill with no markings, one black round pill with no markings, three round scored white pills with no markings, one half round white pill with no markings, one brown round pill with no markings, 15 small white round pills with no markings, three used syringes with pink residue, one unopened syringe, and small plastic jar with a white lid. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 10:53 A.M. with Regional Director of Clinic Services (RDCS) #104 revealed the facility identified Resident #1 was taking used syringes out of the medication trash containers on the side of the medication carts. RDCS #104 stated Resident #1 had told other residents that was where he was getting the syringes. Resident #1 was ordered to receive medications by mouth. The nurses were not doing a mouth sweep after the administration of medications. Partially disintegrated pills were found when Resident #1's room was being cleaned. The police were notified, and the pills were turned over to the police. RDCS #104 stated tape with a serial number/code could be used to indicate if a PICC line had been accessed by someone other than a nurse. There were also locked caps for IV access lines. RDCS #104 stated the tamper tape and locked caps were only used when there was suspicion of tampering with the intravenous access. RDCS verified no antitampering interventions had been placed on Resident #1's PICC line. RDCS #104 stated mouth sweeps were now being done on all residents, and medications were crushed if there was suspicion of a resident hiding medication in their mouth instead of swallowing the medication. All used syringes were now to be placed in sharp containers and unused syringes were to be secured with access to nurses only. RDCS #104 revealed residents on the SUD program had supervised visitations. These visits could be supervised in the lobby by the receptionist or in the hallways by nurses or any staff that were within eyesight. Packages for those on the SUD program were checked by receptionist, but the facility did not check any food that was ordered and brought to the facility. RDCS #104 stated Resident #1 had not exhibited any suspicious behaviors prior to overdose. Since Resident #1 did not exhibit any suspicious behaviors while residing at the facility, there was no increased supervision levels in place. Interview on [DATE] at 12:37 P.M. with SUD Counselor #400 revealed the program provided group sessions Monday through Friday. Residents on the program followed the building rules of no leave of absence without approval and supervision with visitors. Resident #1 attended group nine hours a week. Interview on [DATE] at 2:01 P.M. with LPN #100 revealed she was the first nurse to get to Resident #1. LPN #100 stated a syringe was discovered in Resident #1's hand and it appeared Resident #1 had overdosed. Emergency personnel were called. LPN #100 stated education had been provided to discard syringes in sharp containers and check resident's mouths after administering medications after Resident #1 overdosed. Interview on [DATE] at 2:05 P.M. with Medical Director #500 revealed the facility tried to make things as safe as possible. Medical Director #500 stated there were no specific instructions for residents with intravenous access who had a history of intravenous drug use. A new intervention had been put in place to crush medications for residents as needed when there were concerns of not swallowing medications when administered. Interview on [DATE] at 3:49 P.M. with the DON verified a comprehensive and individualized plan of care had not been developed or initiated for Resident #1 related to his substance abuse disorder prior to his overdose and death in the facility. 2. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, stimulant abuse, and multiple fractures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the plan of care dated [DATE] revealed Resident #2 had a substance abuse disorder with a history of stimulant abuse. Interventions included monitoring Resident #2 for signs and symptoms of intoxication, monitoring for overdose, and report any symptoms of intoxication to the Administrator, DON, and physician. Resident #2 was not allowed a leave-of-absence without a supervised person, all packages must be searched, and visits to be supervised. Review of the MDS assessment dated [DATE] revealed Resident #2 had a BIMS score of 13 which indicated Resident #2 was cognitively intact. The MDS revealed no concerns with Resident #2's mood or behavior. Review of the physician orders revealed Resident #2 was ordered Norco (opiate) ,d+[DATE] mg every six hours at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M. On [DATE], a new order was received for Resident #2's medications to be crushed. On [DATE], Resident #2 received Norco ,d+[DATE] mg on [DATE] at 11:30 P.M. Resident #2 did not have a physician order for Fentanyl (synthetic opioid for severe pain). Review of the police case report revealed on [DATE] at 5:49 A.M., Resident #2 overdosed on prescribed medication by taking an extra dose without the nurse's knowledge. Medics administered Narcan and transported Resident #2 to the hospital. Two officers looked around Resident #2's room and did not see any indicators of drug use or any drug related paraphernalia in plain view. An officer went to the hospital and Resident #2 stated he did not take a pill that was administered by the nurse. Resident #2 stated on [DATE] around 2:00 A.M. he crushed and snorted the extra dose of medication without anyone knowing. The nurse found Resident #2 unresponsive when entering the room to administer medication scheduled for 6:00 A.M. A general progress note dated [DATE] at 6:11 A.M. revealed Resident #2 was found unresponsive. Resident #2 had a pulse rate of 55 beats per minute and oxygen saturation of 60-percent. Resident #2 was not able to state name, place, or time. Resident #2 was administered oxygen via a non-rebreather. Resident #2 was transported to the hospital. The hospital summary dated [DATE] revealed Resident #2 had a past medical history of paranoid schizophrenia, substance abuse, and blood clots. Resident #2 presented to the ED on [DATE] with altered mental status and unresponsiveness due to intentional opiate overdose. Resident #2 received Narcan multiple times and recovered. Resident #2's urine toxicology was positive for opiates and fentanyl. Resident #2 reported he had snorted Norco (opioid) the morning of [DATE]. Interview on [DATE] at 10:26 A.M. with Resident #2 revealed drugs taken at the time of overdose had been obtained from a former resident. Resident #2 stated he could not recall the former resident's name. Resident #2 stated if he had a visitor, he had to go to the front lobby so the visit could be supervised. Subsequent interview on [DATE] at 2:56 P.M. revealed he was unsure why nursing crushed his medications starting in [DATE] and stated he did not request his medications to be crushed. Interview on [DATE] at 10:59 A.M. with the LNHA revealed after Resident #2 overdosed, all resident rooms were searched for any drugs or drug paraphernalia. The LNHA stated some over-the-counter medications and lighters were found. No drugs or drug paraphernalia were discovered. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 12:37 P.M. with SUD Counselor #400 revealed the program provided group sessions Monday through Friday. Residents on the program followed the building rules of no leave of absence without approval and supervision with visitors. Resident #2 had not been part of the program until returning from the hospital on [DATE]. Interview on [DATE] at 2:01 P.M. with LPN #100 revealed Resident #2 had an order for medications to be crushed prior to overdose. Interview on [DATE] at 2:05 P.M. with Medical Director #500 revealed the facility tried to make things as safe as possible. A new intervention had been put in place to crush medications for residents as needed when there were concerns of not swallowing medications when administered. Interview on [DATE] at 11:30 A.M. with RDCS #104 verified Resident #2 did not have a diagnosis of substance abuse, but a plan of care dated [DATE] was in place for substance abuse disorder. RDCS #104 verified Resident #2 was not on the SUD program prior to the overdose on [DATE]. RDCS #104 verified Resident #2 had requested medications to be crushed prior to overdose and nurses reported they crushed Resident #2's medications. Review of the facility undated Medication Storage policy and procedure revealed all drugs and biologicals would be stored in locked compartments. Only authorized personnel would have access to the keys to locked compartments. Review of the facility undated Resident Self-Administration of Medication policy revealed bedside medication storage was permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. For bedside storage to occur the manner of storage prevents access by other residents and medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage. This deficiency represents non-compliance investigated under Complaint Number OH00153228 and Complaint Number OH00153109.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49039 Based on observations, record review, and family, resident, and staff interview, the facility failed to timely repair a resident's sink and ensure it was functional for the resident's use. This affected one (Resident #27) of three residents reviewed for functional sinks in resident rooms. The facility census was 63. Findings include: Review of the facility's maintenance requests revealed Resident #27 had two requests placed on 02/14/24 and 03/14/24 for the room's sink stopped up and both requests were marked as closed. Interview on 04/25/24 at 9:32 A.M. with State tested Nursing Aide (STNA) #111 revealed the employee had knowledge of the clogged sink in Resident #27's room and stated it needed to be unclogged to work again. STNA #111 stated she would notify management of Resident #27's clogged sink. Interview on 04/25/24 at 9:36 A.M. with Director of Maintenance #109 confirmed knowledge of Resident #27's lack of water supply from the sink. Director of Maintenance #109 stated the sink was clogged, if water supply was turned back on, it would have to be unclogged often. Interview on 04/25/24 at 9:37 A.M. with the Director of Nursing (DON) confirmed Resident #27's water supply was not working. Interview and observation with Resident #27 and the resident's daughter on 04/25/24 at 9:40 A.M. revealed concerns with Resident #27's sink function. Resident #27 stated he has not had sink water supply since admission (03/20/24). Management was notified upon his admission and he was informed the water supply in the bathroom was shut off due to an unresolved pipe backup with his sink. Observation of Resident #27's sink revealed the water supply was turned off. Observation on 04/25/24 at 12:11 P.M. confirmed the facility had not addressed Resident #27's concerns regarding sink water supply. There was no water supply. Interview on 04/30/24 at 10:40 A.M. with Director of Maintenance #109 confirmed a request was placed on 03/14/24 for Resident #27's sink to be unclogged, the issue was resolved by shutting off the room's water supply temporarily. Resident #27's water supply was shut off from 03/14/24 to 04/29/24 with no follow up appointments scheduled with a plumber to resolve the issue. Interview on 04/30/24 at 02:46 P.M. with the Administrator revealed the Administrator had no knowledge of concerns regarding Resident #27's sink concern. The Administrator confirmed the facility did not respond timely and appropriately to the maintenance request. This deficiency represents non-compliance investigated under Complaint Number OH00153228.