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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366024	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sycamore Run Nursing and Rehab Ctr	6180 State Route 83 N Millersburg, OH 44654

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and medication manufacturer guideline review the facility failed to provide respiratory care following inhaled respiratory medication as administered. This deficient practice affected two residents (Resident #3 and #11) out of three residents reviewed for respiratory medication administration. The facility census was 90. 1.Review of Resident #11's medical record revealed admission date 02/27/26 with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease (COPD), emphysema, and heart disease.Review of Resident #11's physician orders revealed an order dated 03/04/26 for respiratory medication Ellipta 62.5 micrograms (MCG) per actuation Aerosol Powder, breath activated 1 puff inhale orally one time a day related to Emphysema, Rinse mouth with water after using.Review of Resident #11's admission Minimum Data Set (MDS) dated [DATE] revealed Resident #11had intact cognition with a Brief Interview Mental Status (BIMS) score of 15 out a possible 15 and required assistance from staff to complete Activities of Daily Living (ADL) tasks.Observation on 04/30/26 at 7:00 A.M. revealed Licensed Practical Nurse (LPN) #422 administered Resident #11's inhalation medication Ellipta 62.5 micrograms (MCG) per actuation inhaler. Following completion of the inhaled medication, LPN #422 did not prompt Resident #11 to rinse his mouth with water.Interview on 04/30/26 at 7:03 A.M. with LPN #422 confirmed Resident #11 did not rinse his mouth following the administration of inhaled medication Ellipta 62.5 micrograms (MCG) per actuation inhaler.2. Review of Resident #3's medical record revealed admission date 02/01/05 with diagnoses including but not limited Chronic Obstructive Pulmonary Disease (COPD), high blood pressure, and anxiety.Review of Resident #3's physician orders revealed an order dated 07/15/25 for respiratory medication Breo Ellipta Inhalation Aerosol Powder Breath Activated 100-25 micrograms (MCG) per actuation (Fluticasone Furoate-Vilanterol) 1 puff inhale orally one time a day related to COPD. Rinse mouth after use with water, do not swallow.Review of Resident #3's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had impaired cognition with a Brief Interview Mental Status (BIMS) score of five out of possible 15 and required staff assistance to complete Activities of Daily Living (ADL) tasks.Review of Resident #3's Medication Administration Record (MAR) dated 04/01/26 to 04/30/26 revealed the order for Breo Ellipta Inhalation Aerosol Powder Breath Activated 100-25 micrograms (MCG) per actuation (Fluticasone Furoate-Vilanterol) 1 puff inhale orally one time a day related to COPD. Rinse mouth after use with water, do not swallow. Observation on 04/30/26 at 7:32 A.M. revealed Licensed Practical Nurse (LPN) #422 administered Resident #3's inhalation medication Breo Ellipta Aerosol Powder Breath Activated inhaler. Following completion of the inhaled medication, LPN #422 did not prompt Resident #3 to rinse his mouth with water and spit out the water into a cup.Interview on 04/30/26 at 7:35 A.M. with LPN #422 confirmed Resident #3 did not rinse his mouth with water and spit the water into a cup following the administration of inhalation medication Breo Ellipta Aerosol Powder Breath Activated inhaler per physician order.Review of the manufacturer guidelines for Breo Ellipta Inhaler Administration undated revealed after inhalation, the patient should rinse their mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis (thrush).

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review the facility failed to ensure medications were labeled and stored securely. This deficient practice affected one resident (Resident #42) out of 10 residents reviewed for medication administration. The facility census was 90.Findings Include:Review of Resident #42's medical record revealed admission date 04/14/26 with diagnoses including but not limited to type two Diabetes, vascular dementia, and Congestive Heart Failure (CHF).Review of Resident #42's admission Minimum Data Set (MDS) dated [DATE] revealed Resident #42 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of four out of possible 15 and required assistance from staff to complete Activities of Daily Living (ADL) tasks.Review of Resident #42's physician orders revealed an order for an insulin order Humalog Kwik-Pen 100 units per milliliter (ML) inject subcutaneously with meals related to type two Diabetes. Update physician or Nurse Practitioner for Blood Sugar less than 70 or greater than 400. Use per sliding scale 0-150 equals (=) 3 units; 151-200 = 4 units; 201-250 = 5 units; 251- 400 = 6 units. (therapeutic interchange (TI) for Novolog insulin) and an insulin order for Lantus Solo-Star 100unit per ML inject 26 units daily at bedtime related to type two Diabetes.An observation on 04/30/26 at 7:55 A.M. revealed Licensed Practical Nurse (LPN) #363 administered Resident #42's morning medications and sliding scale insulin. In the top drawer of the medication cart were a Novolog Insulin pen and a Lantus Insulin pen. There was no label on either insulin pen to indicate Resident #42's insulin orders and name.An interview on 04/30/26 at 8:00 A.M. with LPN #363 confirmed Resident #42's Novolog and Lantus Insulin pens were not labeled reflecting Resident #42's insulin orders and name. LPN #363 stated Resident #42 was the only resident on the unit that required insulin administration, and everyone knows those are Resident #42's insulin pens.Review of the facility's policy titled, Medication Storage dated 07/23/19 revealed pharmacy dispenses medications in packaging/containers that meet regulatory requirements. Medications shall be kept and stored in these packages/containers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review the facility failed to follow infection control procedures related to medication administration This deficient practice affected one resident (Resident #42) of 10 residents reviewed for medication administration. The facility census was 90. Findings include:Findings Include:Review of Resident #42's medical record revealed admission date 04/14/26 with diagnoses including but not limited to type two Diabetes, vascular dementia, and Congestive Heart Failure (CHF).Review of Resident #42's admission Minimum Data Set (MDS) dated [DATE] revealed Resident #42 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of four out of possible 15 and required assistance from staff to complete Activities of Daily Living (ADL) tasks.Review of Resident #42's physician orders revealed an order for an insulin order Humalog Kwik-Pen 100 units per milliliter (ML) inject subcutaneously with meals related to type two Diabetes. Update MD/NP for Blood Sugar less than 70 or greater than 400. Use per sliding scale 0-150 equals (=) 3 units; 151-200 = 4 units; 201-250 = 5 units; 251- 400 = 6 units. (therapeutic interchange (TI) for Novolog insulin) and an order dated 04/28/26 for antianxiety medication Ativan Oral Tablet 0.5 milligram (MG) (Lorazepam) Give 1 tablet by mouth every 4 hours related to severe agitation related to vascular dementia, administer every 4 hours while awakeAn observation on 04/30/26 at 7:55 A.M. revealed Licensed Practical Nurse (LPN) #363 prepared Resident #42's antianxiety medication Ativan 0.5 MG. LPN #363 removed the Ativan tablet from the medication card, placed into a medication cup and then poured the tablet into the pill cutter. LPN #363 then used an ungloved hand to position the tablet in the center of the pill cutter. LPN #363 cut the tablet in half and poured one half of the tablet into the medication cup. LPN #363 then prepared Resident #42's Humalog Insulin for blood sugar reading of 240 per glucometer which required 5 units of insulin per sliding scale orders. LPN #363 sanitized her hands and cleansed Resident #42's right lower abdomen with an alcohol pad. LPN #363 administered Resident #42's insulin and wiped the area with an alcohol pad. LPN #363 did not don gloves prior to administering Resident #42's insulin as ordered.An interview on 04/30/26 at 8:00 A.M. with LPN #363 confirmed Resident #42's antianxiety medication was repositioned in the pill cutter with an ungloved hand and LPN #363 did not don gloves prior to administering Resident #42's Humalog insulin to the right lower abdomen. LPN #363 stated gloves should have been worn during medication preparation and during insulin administration, but she didn't put gloves on at the time.Review of the facility's policy titled, Injectable Medications dated 06/21/17 revealed step #11apply gloves prior to injecting medication.