

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/03/2025
NAME OF PROVIDER OR SUPPLIER  Ohio Eastern Star Hlth Care Ctr The		STREET ADDRESS, CITY, STATE, ZIP CODE  1451 Gambier Road Mount Vernon, OH 43050	

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 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34298</p> <p>Based on interviews, record review, and review of the facility assessment, the facility failed to appropriately revise and implement individualized treatment and services to ensure residents, who displayed behaviors and/or were diagnosed with dementia received the appropriate treatment and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. The facility failed to appropriately address Resident #73's dementia-related behaviors. This affected one (Resident #73) of three residents reviewed for dementia. The facility census was 71.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #73 was admitted on [DATE] and expired on [DATE] with diagnoses that included vascular dementia, anxiety disorder, depression, and dysphagia.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had moderately impaired cognitive skills. The MDS also revealed Resident #73 had verbal behaviors directed towards others.</p> <p>Review of the physician orders revealed Resident #73 was ordered Ativan (antianxiety) 0.5 milligram (mg) tablet by mouth every six hours as needed and Ativan, Benadryl, Haldol (ABH) gel (for agitation) 0.5 milliliter (ml) topically as needed every six hours from [DATE] to [DATE]. Review of the medication administration record (MAR) revealed Resident #73 had been administered ABH gel on [DATE] at 7:57 P.M. and it was somewhat effective. A progress note dated [DATE] at 12:27 A.M. revealed Resident #73 was yelling at staff and making rude comments. Resident #73 was also arguing with and touching other residents. This caused increased agitation among the other residents. Review of the MAR revealed Resident #73 was not administered as needed Ativan.</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 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the Facility Assessment updated on [DATE] revealed the facility accepted and provided care for mental and behavioral health residents with psychosis, impaired cognition, mental disorder depression, bipolar disorder, schizophrenia, anxiety disorder, behavior that needs interventions, and Behavioral and Psychological Symptoms of Dementia (BPSD). This included common diagnoses of Alzheimer's disease and non-Alzheimer's dementia. The number/average or range of residents over the past year with behavioral health needs was two. Those with physical behavioral symptoms directed towards others was one and those with verbal behavioral symptoms directed towards others was two. The assessment revealed education about dementia care included providing care for a person living with dementia that focused holistically on the needs of the resident living with dementia as well as the other residents in the nursing home annually and orientation. Education for caring for a person with Alzheimer's or other dementia by supporting residents through the implementation of individualized approaches to care (including direct care and activities) directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities was ongoing and completed annually.</p> <p>Review of the MAR revealed Resident #73 was administered Ativan 0.5 mg as needed on [DATE] at 11:53 A. M. The Ativan was somewhat effective. A progress note dated [DATE] at 2:42 P.M. revealed Resident #73 went into another resident's room but came back out into the hallway. The MAR did not reveal as needed ABH gel was administered.</p> <p>Physician orders revealed Resident #73 was ordered ABH gel 0.5 ml topically every six hours as needed from [DATE] until [DATE]. A progress note dated [DATE] at 10:54 A.M. revealed Resident #73 followed an activities staff member into another resident's room. The nurse was able to redirect Resident #73 out of the room. The MAR revealed Resident #73 was administered as needed ABH gel on [DATE] at 11:34 A.M. The as needed ABH gel was effective.</p> <p>A plan of care dated [DATE] revealed Resident #73 demonstrated behaviors such as yelling at staff, attempting to hit staff, slamming her door, and attempting to go out the doors. Interventions included intervening or providing redirection, providing calming activities and one on one as needed.</p> <p>A progress note dated [DATE] at 6:39 P.M. Resident #73 followed the nurse into another resident's room. Resident #73 was able to be redirected. A progress note dated [DATE] at 3:42 P.M. revealed Resident #73 went into another resident's room and shut the door. The nurse went in and found Resident #73 attempting to open the closet door in the other resident's room. Resident # 73 eventually walked out of the other resident's room. Resident #73 went into other resident rooms at 3:56 P.M. and 4:00 P.M. Staff were able to get Resident #73 to return to her own room.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A progress note dated [DATE] at 4:50 P.M. revealed the nurse called Viaquest (company that specializes in the mental and behavioral health treatment for residents at nursing facilities) and left a message. Resident #73's daughter was notified Resident #73 was attacking staff, kicking doors, attempting to leave the unit, and entering other residents' rooms. At 5:02 P.M. Resident #73's daughter arrived at the facility. A progress note dated [DATE] at 5:11 P.M. revealed a Certified Nurse Practitioner (CNP) from Viaquest called and left a message with new orders for Haloperidol Lactate (to treat acute agitation) two milligrams (mg) twice a day for 14 days and Haloperidol Decanoate (long-acting form of Haloperidol) 50 mg for four weeks with a dose to be administered immediately. At 5:16 P.M. another CNP from Viaquest called and suggested a pink slip (emergency hospitalization for a mentally ill individual who may be a harm to themselves or others) would be faxed to the facility. Review of the MAR revealed as needed ABH gel was not applied on [DATE] until 5:26 P.M. and was somewhat effective. A progress note dated [DATE] at 5:40 P.M. revealed Resident #73's daughter reported Resident #73 was in a calmer state and was sitting in recliner. Resident #73's daughter stated she was returning to work and could be called if anything else was needed. Resident #73 received the Haloperidol one ml injection prior at 5:45 P.M. prior to Resident #73's daughter leaving.</p> <p>Review of the Ohio Department of Mental Health and Addiction Services Application for Emergency Admission form (DMHAS-0025) dated [DATE] at 5:28 P.M. revealed the name of the psychiatric hospital was left blank. The form was marked Resident #73 represented a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness. The form was also marked that Resident #73 represented a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community. Resident #73 would benefit from treatment in a hospital for mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or self. The Statement of Belief on the form instructed that the belief for why hospitalization was necessary had to be documented. The Statement of Belief was signed by Viaquest CNP and revealed Resident #73 had recurrent aggression amongst staff. Resident #73 was physically aggressive and attacking staff (kicking, scratching, punching, etc.). Resident #73 was unable to be consoled or redirected by staff. It is the provider's recommendation that Resident #73 be sent out for further evaluation and treatment.</p> <p>The next progress note dated [DATE] at 1:00 P.M. revealed Licensed Practical Nurse (LPN) #100 and the Director of Nursing (DON) pulled Resident #73's daughter aside and advised the daughter of the plan to send Resident #73 to the emergency department for a psychological evaluation and admission to psychiatric hospital to get treatment. Resident #73 would need urine analysis and blood work to rule out anything acute before the psychiatric hospital would admit Resident #73. It was explained that Resident #73 was a danger to staff and other residents. The paperwork including a pink slip, orders, code status, and face sheet was given to Resident #73's daughter. On [DATE] at 1:30 P.M. Resident #73 left the facility with the daughter to go to the emergency department for psychiatric evaluation.</p> <p>A progress note dated [DATE] at 9:50 P.M. revealed Resident #73 returned to the facility due to not meeting the criteria for admission to a psychiatric hospital.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on [DATE] at 2:44 P.M. LPN #101 revealed she was working day shift on [DATE] and [DATE]. LPN #101 verified she had obtained a pink slip for Resident #73 on [DATE] because Resident #73 was combative and attacking the staff. Resident #73 went into other resident rooms and would kick at other residents if they walked past her. (Review of the medical record revealed no documentation of Resident #73 being aggressive towards other residents). LPN #101 stated Resident #73 would not take as needed medication, so it was not administered. LPN #101 verified as needed medication was administered on [DATE] when Resident #73's daughter came to the facility. LPN #101 stated her shift ended at 6:00 P.M. on [DATE] and she did not know if Resident #73 continued to have behaviors that evening. LPN #101 also stated she could not recall if Resident #73 had behaviors the morning of [DATE] prior to being sent to the hospital for evaluation. LPN #101 stated there was a delay in sending Resident #73 to the hospital because the facility needed to find a psychiatric hospital that would take Resident #73. LPN #101 verified they were unfamiliar with how a pink slip worked.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160152.</p>		