STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366118	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elms Retirement Village Inc	136 S Main St Wellington, OH 44090

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on observation, record review, and interview, the facility failed to ensure the physician was notified of unavailable medications. This affected two residents (#29 and #51) of three residents reviewed for notification. The facility census was 50. Finding include: 1. Review of the medical record for Resident #51 revealed an admitted [DATE] at 11:30 P.M. with diagnoses including osteomyelitis, multiple sclerosis, neuropathy, nicotine dependence. The resident was discharged on [DATE]. Review of the Medication Administration Record (MAR) revealed an order for oxycodone 10 milligram (mg) was signed as administered on 10/09/24 at 8:00 A.M. and 12:00 P.M. There were no other medications administered. The MAR indicated missing doses for the following. Cefazolin intravenous (IV) antibiotic two doses, Duloxetine (antidepressant) one dose, Robaxin (muscle relaxer) three doses, midodrine (use to increase blood pressure) two doses, oxycodone (for pain) three doses, Metamucil one dose, Miralax one dose, prednisone (steroid) one dose, dulera inhaler used for asthma one dose, and magnesium two doses. Review of the progress note revealed no evidence the physician was notified of the missing doses of medications. Interview on 11/13/24 at 9:24 A.M. with the Director of Nursing (DON) stated it is not the facility's protocol to notify the physician of missing doses of antibiotics or medications with new residents. Medications are administered upon delivery. The DON stated the physicians are aware of the procedure. Interview with the Nurse Practitioner (NP) #280 revealed she completed an initial visit with Resident #51 in the morning on 10/09/24 and was unaware that the resident did not receive any of his medications. NP #280 stated she received no notifications and finds this concerning. 2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including diverticulosis, basal cell carcinoma, spinal stenosis, osteoarthritis, and atrial fibrillation. (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
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set assessment dated [DATE] revealed the resident had impaired cognition and was dependent on showers, transfers, and toileting. Review of the care plan dated 10/09/24 revealed a plan for alteration in cardiac output, arrhythmia and cardiorespiratory distress, atrial fibrillation and pacemaker. Interventions included monitor vital signs, weights and assess for shortness of breath and edema. Review of the physician order dated 11/05/24 revealed an order for torsemide 20 mg once daily in the morning for edema starting on 11/06/24. In addition, an order stating new medication will be initiated upon pharmacy delivery Observation of medication administration on 11/06/24 at 9:34 A.M. with Medication Technician (MT) #206 preparing morning medications for Resident #29 revealed MT #206 began searching for torsemide however it was not in the medication cart. MT #206 administered the medications except the torsemide to Resident #29. MT #206 asked Registered Nurse (RN) #206 to see if torsemide was in the pyxis (a computer mediation dispensing system). RN #211 stated she will check the pyxis and if the medication was unavailable, she would call the pharmacy and notify the physician. Review of the Medication Administration Record (MAR) for November 2024 revealed on 11/06/24 torsemide was signed off with a code five indicating to see the nurses notes. Review of the progress note dated 11/06/24 at 12:38 P.M. written by RN #211 stated the pharmacy was called to inquire about the delivery status of Resident #29's torsemide. The medication would be sent out in the next drop off. The medication was unavailable in the pyxis system. There was no evidence the physician was notified the medication was unavailable. Interview on 11/12/24 at 12:45 P.M. with Registered Nurse (RN) (hospice) #278 revealed on 11/05/24 at 1:30 P.M. she assessed Resident #29 for edema. RN #278 contacted the hospice physician to order torsemide. RN #278 stated she was not notified Resident #29 did not receive her torsemide as scheduled on 11/06/24. Interview on 11/12/24 at 1:53 P.M. with the Director of Nursing (DON) stated the resident had an order for new medications will be initiated upon pharmacy delivery. Due to the order the physician did not need to be notified. Review of the facility policy titled, Notification of change in resident condition, revised January 2022 stated the facility will ensure that resident and physician are notified of any incident involving the resident, significant change in the resident's condition and new physician orders.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review and interview the facility failed to ensure on going monitoring of resident status. This affected one (Resident #51) of three reviewed for quality of care. The facility census was 50. Finding include: Review of the medical record for Resident #51 revealed an admitted [DATE] at 11:30 P.M. with diagnoses including osteomyelitis, a bone infection, of the vertebra of the sacral and sacrococcygeal region, the tailbone, multiple sclerosis, neuropathy, nicotine dependence. The resident was discharged on [DATE] at approximately 8:00 P.M. The resident did not receive any medications from the pharmacy prior to discharge. Review of the Medication Administration Record (MAR) revealed oxycodone 10 milligram (mg) was signed as administered on 10/09/24 at 8:00 A.M. and 12:00 P.M. there were no other medications administered. The MAR indicated missed medications of: Cefazolin intravenous (IV) antibiotic two doses, Duloxetine (antidepressant) one dose, Robaxin (muscle relaxer) three doses, midodrine (used to treats low blood pressure), two doses, oxycodone (pain) three doses, Metamucil one dose, Miralax one dose, prednisone (steroid) one dose, dulera inhaler used for asthma one dose, and magnesium two doses. Review of assessments revealed an admission assessment was completed at on 10/08/24 at 11:30 P.M. There were no additional assessments completed on 10/09/24. Review of the vital tab revealed one set of vital monitoring including a blood pressure, temperature, pain and respiratory status. There was no other monitoring documented. Review of Nurse Practitioner (NP) dated 10/09/24 revealed the patient was admitted to the emergency roiagnom on [DATE] with sacral pressure ulcer, suspected osteomyelitis, and urinary tract infection. The patients stay was complicated by hypotension requiring blood pressure medications. The patient was stabilized and referred to a skilled nursing facility for rehab and IV antibiotics. Interview on 11/13/24 at 8:52 A.M. with Registered Nurse (RN) #211 stated she worked day shift on 10/09/24 and the skilled assessments are completed on night shift. RN #211 stated that she did not monitor Resident #51 for signs and symptoms of infections or for blood pressure due to not receiving his medications from the pharmacy. Interview on 11/13/24 at 9:24 A.M. with Director of Nursing (DON) stated Resident #51 vitals were within normal limits at 3:00 A.M. and there would be no reason to monitor blood pressure or assess for signs and symptoms of infection due to not receiving medications. The DON stated skilled assessment is completed once a day on night shift. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 12:04 P.M. with the Nurse Practitioner (NP) #280 stated she completed an initial visit with Resident #51 in the morning on 10/09/24 and was unaware that the resident did not receive any of his medications. NP #280 stated she was not notified of the missing doses of cefazolin and midodrine and found it very concerning that the resident was not being monitored and assessed. This deficiency represents non-compliance investigated under Complaint Number OH00158867.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on observation, record review, and interview, the facility failed to ensure medications were available for administration. This affected two residents (Resident #29 and Resident #51) of three reviewed for medication administration. The facility census was 50. Finding include: 1. Review of the medical record for Resident #51 revealed an admitted [DATE] at 11:30 P.M. with diagnoses including osteomyelitis, multiple sclerosis, neuropathy, nicotine dependence. The resident was discharged on [DATE]. Review of the admission medication orders revealed the following: Cefazolin 2000 milligrams (mg) infused morning, noon and evening, duloxetine (antidepressant) 20 mg daily, hydroxyzine (antihistamine) 25 mg daily, Robaxin (muscle relaxant) 750 mg four times daily, midodrine (used for hypotension) 20 mg three times daily, oxycodone 10 mg every four hours as needed for pain, trazodone 150 mg at night for sleep, Metamucil daily, MiraLAX daily, prednisone (steroid) 10 mg, trazodone 150 mg used for sleep at night, dulera inhaler twice daily used for asthma, and magnesium chloride 64 mg twice daily an supplement. Review of the Medication Administration Record (MAR) revealed oxycodone 10 mg was signed as administered on 10/09/24 at 8:00 A.M. and 12:00 P.M. there were no other medications administered. The MAR indicated missing doses for the following: Cefazolin intravenous (IV) two doses, Duloxetine one dose, Robaxin three doses, midodrine two doses, oxycodone three doses, Metamucil one dose, Miralax one dose, prednisone one dose, dulera inhaler one dose, magnesium two doses. Review of the Pharmacy delivery receipt dated 10/09/24 revealed there was no delivery time indicated. The following medications were delivered. Cefazolin, Robaxin, Duloxetine, hydroxyzine, midorine, Fluticasone nasal spray, Dulera inhaler, prednisone, magnesium,and trazodone. Interview on 11/06/24 at 11:45 A.M. with Registered Nurse (RN) #212 stated she worked the day shift on 10/09/24 and called the pharmacy twice to pull oxycodone from the facility's supply and to get an arrival time for Resident #51's medications. RN #212 stated she worked to 7:00 A.M. to 7:00 P.M. and Resident #51's medications were not delivered to the facility. Interview on 11/06/24 at 2:54 P.M. with Licensed Practical Nurse (LPN) #268 stated she worked the night shift 10/09/24 from 7:00 P.M. to 7:00 A.M. and was assigned to Resident #51. Between 7:30 P.M. and 8:30 P.M. she went in to check on Resident #51. LPN #268 stated Resident #51's husband was upset that Resident #51 did not receive her medications from the pharmacy. Resident #51's husband called emergency medical services due to the facility was not taking care of his wife. Interview 11/06/24 at 4:23 P.M. with LPN #218 stated she admitted Resident #51 on 10/08/29 at 11:30 P.M. and submitted the medication orders to the pharmacy. LPN #218 stated she called pharmacy and was informed the team will review the medications in the morning and the medications will be sent out second delivery and should arrive approximately 6:00 P.M. on 10/09/24. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/12/24 at 12:04 P.M. with the Pharmacist #279 stated the prednisone, midodrine, and oxycodone were available in the pyxis dispensing system (a computer mediation dispensing system). The cefazolin, Duloxetine, hydroxyzine, Robaxin, midodrine, trazodone, prednisone, trazodone, Dulera inhaler, magnesium and oxycodone were delivered to the facility between 6:45 P.M. and 8:30 P.M. Pharmacist #279 stated there were no stat orders on any of the medications including the antibiotic that indicated a timely need. Interview on 11/13/24 at 9:24 P.M. with the Director of Nursing (DON) stated the pharmacy is located in Cincinnati. The facility receives deliveries from the pharmacy between 5:00 A.M. and 7:00 A.M. and from 5:00 P.M. to 7:00 P.M. The DON stated Resident #51 was admitted after the cut off time and therefore medications were scheduled for the second delivery the next day between 5:00 P.M. and 7:00 P.M. The DON verified Resident #51 was admitted around 10:30 P.M. on 10/08/24 and did not receive his medication until 10/09/24 between 6:45 P.M. and 8:00 P.M. twenty hours after admittance. 2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including diverticulosis, basal cell carcinoma, spinal stenosis, osteoarthritis, and atrial fibrillation. Review of the Minimum Data Set assessment dated [DATE] revealed the resident had impaired cognition and was dependent on showers, transfers, and toileting. Review of the care plan dated 10/09/24 revealed a plan for alteration in cardiac output, arrhythmia and cardiorespiratory distress, atrial fibrillation and pacemaker. Interventions included monitor vital signs, weights, and assess for shortness of breath and edema. Review of the physician order for November 2024 revealed an order dated 11/05/24 at 6:33 P.M. for torsemide 20 mg once daily in the morning for edema starting on 11/06/24. Observation of medication administration on 11/06/24 at 9:34 A.M. with Medication Technician (MT) #206 gathering morning medications for Resident #29 revealed she prepared aspirin hydralazine, metoprolol, and prostat. MT #206 began searching for torsemide however it was not in the medication cart. MT #206 administered all the medications except the torsemide to Resident #29. MT #206 asked RN #211 to see if torsemide was in the pyxis. RN #211 stated she will check the pyxis and if the medication was unavailable, she would call the pharmacy and notify the physician. Review of the Medication Administration Record for November 2024 revealed on 11/06/24 upon rise the torsemide was signed off with a code five indicating to see the nurses notes. Review of the progress note revealed dated 11/06/24 at 12:38 P.M. written by RN #211 stated the pharmacy was called to inquire about the delivery status of Resident #29's torsemide. The medication will be sent out in the next drop off. The medication was unavailable in the pyxis system. Interview on 11/06/24 at 5:25 P.M. with RN #248 verified that Resident #29 torsemide was not administered and the pharmacy had not shipped the torsemide. Review of the pharmacy delivery receipt dated 10/06/24 at 6:09 P.M. revealed the torsemide was delivered to the facility. (continued on next page)

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	366118	A. Building B. Wing	11/13/2024

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/12/24 at 12:04 P.M. with the Pharmacist #279 verified the order torsemide order missed the cut off time of 5:00 P.M. on 11/05/24 and was not delivered until 6:09 P.M. on 11/06/24. Review of the the facility's pharmacy contract undated stated the pharmacy agrees to deliver to the facility any prescriptions and supplies daily six days a week with an additional delivery if an emergency arises, except for circumstances and conditions beyond its control. This deficiency represents non-compliance investigated under Complaint Number OH00158867.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on observation, record review, and interview, the facility failed to ensure the residents were free of significant medication errors. This affected two residents (Resident #29 and Resident #51) of three reviewed for medication administration. The facility census was 50. Finding include: 1. Review of the medical record for Resident #51 revealed an admitted [DATE] with diagnoses including osteomyelitis, multiple sclerosis, and neuropathy. The resident was discharged on [DATE]. Review of the October 2024 physician orders revealed an order for Cefazolin intravenous (IV) infusion, an antibiotic three times daily for osteomyelitis and an order for midodrine used to increase blood pressure, three times daily. Review of the Medication Administration Record (MAR) for October 2024 revealed on 10/09/24, two doses of Cefazolin IV were signed off as not available upon rise and at lunchtime. On 10/09/24, two doses of midodrine were signed off as not available prior to breakfast and prior to lunch. Review of Nurse Practitioner (NP) note dated 10/09/24 revealed the patient was admitted to the emergency roiagnom on [DATE] with sacral pressure ulcer, suspected osteomyelitis and urinary tract infection. The patient's stay was complicated by hypotension requiring blood pressure medications. The patient was stabilized and referred to a skilled nursing facility for rehab and IV antibiotics. Interview on 11/13/24 at 8:05 A.M. with Resident #51's husband stated his wife had not received any antibiotics from the pharmacy and they were at the facility for 20 hours. Resident #51's husband stated he needed to take care of his wife therefore he called emergency medical services (EMS). Resident #51 was admitted to the hospital for four weeks with a diagnosis of a wound infection and osteomyelitis. Interview on 11/13/24 at 9:24 A.M. with the Director of Nursing (DON) stated Resident #51 was admitted late on 10/08/24 and missed the pharmacy cut off time and therefore received the medications the next day around 7:30 to 8:00 P.M. The DON stated infectious disease will just make up the missed doses on the back end of treatment. Medications are administered upon delivery. The DON stated due to pharmacy having two delivery times a day she could not get the antibiotics and medications any earlier. Interview on 11/13/24 at 12:04 P.M. with the Nurse Practitioner (NP) #280 stated she did an initial visit with Resident #51 in the morning on 10/09/24 and was unaware that the resident did not receive any medications. NP #280 stated she found the missing doses of cefazolin and midodrine very concerning. 2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including diverticulosis, basal cell carcinoma, spinal stenosis, osteoarthritis, and atrial fibrillation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set, dated dated dated [DATE] revealed the resident had impaired cognition and was dependent on showers, transfers, and toileting. Review of the care plan dated 10/09/24 revealed a plan for alteration in cardiac output, arrhythmia and cardiorespiratory distress, atrial fibrillation and pacemaker. Interventions included monitor vital signs, weights and assess for shortness of breath and edema. Review of the Hospice Case Manager notes by Registered Nurse (RN) #278 on 11/05/24 revealed Resident #29 had a 2.4 pound increase in weight. The resident had two plus pitting in both legs, a fluid buildup that leads to swelling. The severity of edema is assessed by grading scale of one to four with four being the worst. There was an new order for torsemide 20 milligram daily for edema. Review of the physician orders for November 2024 revealed an order dated 11/05/24 at 6:33 P.M. for torsemide 20 mg once daily in the morning for edema starting on 11/06/24. Observation of medication administration on 11/06/24 at 9:34 A.M. with Medication Technician (MT) #206 preparing morning medications for Resident #29. MT #206 began searching torsemide however it was not in the medication cart. MT #206 administered the medications except the torsemide to Resident #29. MT #206 asked Register Nurse (RN) #211 to see if torsemide was in the pyxis a computer mediation dispensing system. RN #211 stated she will check the pyxis (a computerized medication dispensary system) and if the medication was unavailable, she would call the pharmacy and notify the physician. Review of the Medication Administration Record for November 2024 revealed on 11/06/24, torsemide was signed off with a code five, indicating to see the nurses notes. Review of the progress note dated 11/06/24 at 12:38 P.M. written by RN #211 stated the pharmacy was called to inquire about the delivery status of Resident #29's torsemide. The medication will be sent out in the next drop off. The medication was unavailable in the pyxis system. Interview on 11/12/24 at 12:45 P.M. with Registered Nurse (RN) #278, the hospice case manager, revealed on 11/05/24 at 1:30 P.M. she assessed Resident #29 for edema and added a new order torsemide. RN #278 was not notified the Resident #29 did not receive her torsemide as scheduled on 11/06/24. The pharmacy is slow on delivering medications to the facility. Interview on 11/12/24 at 3:33 P.M. with the Pharmacist #279 verified the order torsemide order missed the cut off time of 5:00 P.M. on 11/05/24 and was not delivered until 6:09 P.M. on 11/06/24. Interview on 11/12/24 at 1:53 P.M. with the Director of Nursing (DON) stated Resident #29 had an order for new medication which would be initiated upon pharmacy delivery. The DON stated the torsemide was delivered at 6:09 P.M. on 11/06/24. It was not appropriate to administer the medication when it was delivered therefore it was administered the morning on 11/07/24. The DON stated Resident #29's legs were big prior, and it was not a new condition. This deficiency represents non-compliance investigated under Complaint Number OH00158867.