

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/02/2025
NAME OF PROVIDER OR SUPPLIER  Elms Retirement Village Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the medical record, review of the facility investigation, interview with the staff, and review of facility policy and procedure, the facility failed to ensure the legal representative, physician and Resident #50 were notified of a medication error for Resident #50. This affected one resident (Resident #50) of three reviewed for medication errors.</p> <p>Findings included:</p> <p>Review of the medical record revealed Resident #50 was admitted to the facility on [DATE]. Diagnoses included quadriplegia, stage four sacral wound, stage four right buttock wound, osteomyelitis, severe protein calorie malnutrition, anxiety disorder, depression, and cachexia. She had a Power of Attorney (POA) and was discharged home on [DATE].</p> <p>Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #50 had intact cognition. She received scheduled pain medications, as needed pain medications, and non-medication interventions for pain.</p> <p>Review of the physician's orders revealed Resident #50 had an order dated 11/21/24 for Dilaudid (pain medication) 4 milligrams (mg) with instructions to administer one tablet four times daily (at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M.) for chronic pain.</p> <p>Review of Resident #50's Medication Administration Record (MAR) revealed the resident was administered Dilaudid 4 mg on 02/24/25 at 12:00 A.M. and 6:00 A.M. by the same nurse.</p> <p>Review of Resident #50's narcotic count sheets revealed Agency Licensed Practical Nurse (LPN) #100 signed out that she administered one Dilaudid 4 mg tablet 02/23/25 (indicating the morning between 02/23/25 and 02/24/25) at 12:00 A.M. and one tablet again on 02/24/25 at 6:00 A.M.</p> <p>Review of the Medication Incident Report dated 02/24/25 revealed Agency LPN #100 gave Resident #50 the wrong strength of Dilaudid. She administered two additional tablets of Dilaudid 4 mg (four extra milligrams at 12:00 A.M. and four extra milligrams at 6:00 A.M. to equal an extra total of 8 mg's administered by Agency LPN #100). It noted the error occurred, but there was no harm to the resident, the nurse received written counseling and all nurses were educated regarding narcotics and the medication administration policy. Agency LPN #100 received an Employee Performance Conference regarding the five rights of medications administration (right resident, right dose, right time, tight route, and right medication), signed by the nurse on 02/24/25.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress notes from 02/24/25 to 02/27/25 revealed no documented evidence that Resident #50's physician, her legal representative, or the resident herself, were notified of a medication error.</p> <p>On 05/02/25 at 12:30 P.M. an interview with the Director of Nursing (DON) revealed Agency LPN #100 gave twice the dosage of Dilaudid to Resident #50 on 02/24/25 at 12:00 A.M. and 6:00 A.M. She stated they found the error when the nurses were counting the narcotic medication at shift change. She stated she called the physician and let him know of the incident when she found out about it, however she never documented she notified him. She verified there was no documentation of the incident, or the physician, resident, or representative being notified of the incident in the medical record.</p> <p>Review of the facility policy titled, Medication Errors, dated May 2013 revealed the residents attending physician and family should be notified at the time of the medication error, with documentation in the resident's medical record.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164269.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the medical record, review of the facility investigation, interview with the staff, and review of facility policy and procedure, the facility failed to ensure Resident #50 was free of significant medication errors. This affected one resident (Resident #50) of three reviewed for medication errors.</p> <p>Findings included:</p> <p>Review of the medical record revealed Resident #50 was admitted to the facility on [DATE]. Diagnoses included quadriplegia, stage four sacral wound, stage four right buttock wound, osteomyelitis, severe protein calorie malnutrition, anxiety disorder, depression, and cachexia. She had a Power of Attorney (POA) and was discharged home on [DATE].</p> <p>Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #50 had intact cognition. She received scheduled pain medications, as needed pain medications, and non-medication interventions for pain.</p> <p>Review of the physician's orders revealed Resident #50 had an order dated 11/21/24 for Dilaudid (pain medication) 4 milligrams (mg) with instructions to administer one tablet four times daily (at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M.) for chronic pain.</p> <p>Review of Resident #50's Medication Administration Record (MAR) revealed the resident was administered Dilaudid 4 mg on 02/24/25 at 12:00 A.M. and 6:00 A.M. by the same nurse.</p> <p>Review of Resident #50's narcotic count sheets revealed Agency Licensed Practical Nurse (LPN) #100 signed out that she administered one Dilaudid 4 mg tablet 02/23/25 (indicating 02/24/25) at 12:00 A.M. and one tablet again on 02/24/25 at 6:00 A.M.</p> <p>Review of the Medication Incident Report dated 02/24/25 revealed Agency LPN #100 gave Resident #50 the wrong strength of Dilaudid. She administered two additional tablets of Dilaudid 4 mg (four extra milligrams at 12:00 A.M. and four extra milligrams at 6:00 A.M. to equal an extra total of 8 mg's administered by Agency LPN #100). It noted the error occurred, but there was no harm to the resident, the nurse received written counseling and all nurses were educated regarding narcotics and the medication administration policy. Agency LPN #100 received an Employee Performance Conference regarding the five rights of medications administration (right resident, right dose, right time, right route, and right medication), signed by the nurse on 02/24/25.</p> <p>Review of the progress notes from 02/24/25 to 02/27/25 revealed no documented evidence of the medication error.</p> <p>On 05/02/25 at 12:30 P.M. an interview with the Director of Nursing (DON) revealed Agency LPN #100 gave twice the dosage of Dilaudid to Resident #50 on 02/24/25 at 12:00 A.M. and 6:00 A.M. She stated they found the error when the nurses were counting the narcotic medication at shift change. She stated she called the physician and let him know of the incident when she found out about it, however she never documented she notified him.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Medication Errors, dated May 2013 revealed the purpose was to ensure all medication errors were appropriately documented and tracked to ensure safe and accurate medication administration to the residents, and to enable meeting the training needs of the staff.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164269.</p>		