Printed: 09/27/2024
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
	366155	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Albany Care Center	5691 Thompson Road Columbus, OH 43230

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 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** 47990 Based on medical record review, resident interview, staff interview, review of facility documents, and review of the facility policy review the facility failed to administer medications as ordered by the physician. This affected one (Resident #80) of three residents reviewed for medication administration. The facility census was 60 residents. Findings include: Review of the closed medical record for Resident #80 revealed an admitted [DATE] with diagnoses including aftercare following joint replacement surgery, hypertension, heart failure, and depression with a discharge date of [DATE] at 11:20 P.M. Review of the Minimum Data Set (MDS) assessment for Resident #80 dated 06/20/24 revealed the resident was cognitively intact. Review of the admitting physician's orders for Resident #80 dated 06/20/24 revealed orders for the following medications: Eliquis at 9:00 A.M. and 9:00 P.M., Arthrotec at 9:00 A.M., aspirin at 9:00 A.M., Wellbutrin at 9:00 A.M., calcium carbonate-vitamin D at 9:00 A.M., carvedilol at 9:00 A.M. and 5:00 P.M., cetirizine at 9:00 A.M., docusate sodium at 9:00 A.M. duloxetine at 9:00 A.M., furosemide at 9:00 A.M., levothyroxine at 6:00 A.M., losartan at 9:00 A.M., methadone at 9:00 A.M. and 9:00 P.M., Myrbetriq at 9:00 A.M. oxybutynin at 9:00 A.M., topiramate at 9:00 A.M. and 9:00 P.M., Ursodiol at 9:00 A.M. and 9:00 P.M. Review of the interdisciplinary progress note for Resident #80 dated 06/20/24 revealed the resident was concerned regarding her medications and told staff she was leaving against medical advice (AMA.) Resident #80 contacted her husband and left the faciity on [DATE] at 11:30 P.M. Review of the Medication Administration Record (MAR) for Resident #80 dated June 2024 revealed the resident did not receive her routine morning or evening medications on 06/20/24. The chart code 07 was entered in the MAR which indicated the progress notes would include an explanation of why the medications were not administered. (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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER New Albany Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5691 Thompson Road Columbus, OH 43230	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes for Resident #80 dated 06/20/24 revealed they did not include documentation to indicate why the resident's medications were not administered. There was no notation of notification to the pharmacy or to the prescriber to indicate the resident had missed doses of routine medications. Review of the discharge AMA form for Resident #80 dated 06/21/24 timed at 12:06 A.M. revealed the resident voiced desire to leave the facility AMA on 06/20/24 and intended to go home with support. Further review of the form revealed Resident #80 declined to discuss reasons for leaving and declined assistance with discharge planning. Interview on 07/12/24 at 8:05 A.M. with Licensed Practical Nurse (LPN) #160 confirmed there was sometimes a delay in getting newly admitted resident's medications timely, and it depended on timely transcription of resident admission orders into the facility's electronic health record. LPN #160 confirmed the facility had an emergency supply of medications which contained many common medications which staff could retrieve while awaiting the routine pharmacy delivery. Interview on 07/12/24 at 10:06 A.M. with Resident #80 confirmed she was admitted to the facility in the evening of 06/19/24 at approximately 7:15 P.M. and discharged on [DATE] at approximately 11:30 P.M. Resident #80 confirmed she did not receive her routine medications in the evening of her admission to the facility on [DATE] nor did she receive routine medications on 06/20/24 in the morning or the evening. Resident #80 confirmed she received as needed pain medication but left the facility AMA because she did not receive her routine medications. Interview on 07/12/24 at 2:17 PM with the DON confirmed Resident #80's MAR reflected the resident's routine morning and evening medications for 06/20/24 were not administered. The DON confirmed the report for facility's the automated medication system emergency supply did not show any routine medications removed for Resident #80 on 06/20/24. The DON further confirmed the facility had many of Resident #80's medications on hand in the emergency supply and could have administered the medications to the resident. Interview on 07/12/24 at 2:55 with LPN #140 confirmed she did not administer Resident #80's routine medications because they had not been delivered by the pharmacy. LPN #140 further confirmed she should have removed the available routine medications from the emergency supply and administered them to the resident. LPN #140 confirmed she recorded the chart code in the MAR to indicate the medications were not administered and to see the progress notes, but the nurse confirmed she did not document a rationale in the notes for not administering the medications. Review of the availability list for the facility's automated medication dispensing machine undated revealed the facility had doses available of the following medications: oxybutynin, carvedilol, Eliquis, duloxetine, furosemide, levothyroxine, and losartan. Review of the policy titled Medication Administration dated 08/07/23 revealed medications should be safely and accurately prepared and administered according to physician order. If a pharmacy supplied medication was not available, the nurse should refer to the pharmacy policy and procedures related to emergency pharmacy delivery and emergency supply kit usage. This deficiency represents noncompliance investigated under OH00155221.