Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER: Widows Home of Dayton		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 South Findlay Street Dayton, OH 45403	

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** 46613 Based on medical record review, staff and resident interviews, and policy review, the facility failed to ensure a medication was available for administration as ordered. This affected one (#51) resident out of the three residents reviewed for medications available from pharmacy for administration. The facility census was 62. Findings include: Review of the medical record for Resident #51 revealed an admitted [DATE] with medical diagnoses of acquired absence of left below knee amputation (BKA), peripheral vascular disease, diabetes mellitus, and hypertension. Review of the medical record for Resident #51 revealed an admission Minimum Data Set (MDS) assessment, dated 08/21/24, which indicated Resident #51 was cognitively intact and required substantial/maximum staff assistance with toilet hygiene and transfers and partial/moderate staff assistance with bathing and bed mobility. Review of the medical record for Resident #51 a physician order dated 09/12/24 for Percocet 5-325 milligram (mg) give one tablet by mouth every four hours for pain. Review of the medical record for Resident #51 revealed the October 2024 Medication Administration Record (MAR) which did not have documentation to support Resident #51 received Percocet as ordered on 10/12/24, 10/13/24, 10/18/24, and 10/28/24. Review of Resident #51's December 2024 MAR revealed no documentation to support Resident #51 received Percocet as ordered on 12/04/24. Review of the medical record for Resident #51 revealed a nurses' note dated 10/18/24 at 12:46 P.M. with stated the nurse spoke with the pharmacy and per the representative the Percocet would be delivered in the evening. Review of Resident #51's nurses' note dated 10/19/24 at 12:03 A.M. stated Resident #51 was out of Percocet. The note stated the nurse contacted the pharmacy to get authorization to pull the medication from the Pyxis system, but the nurse did not have access to the Pyxis. The note continued to state the nurse contacted the on-call supervisor who stated she did not have access to the Pyxis system either. Review of the medical record for Resident #51 revealed a nurses' note dated 12/04/24 at 10:47 P.M. which stated Percocet was not given because the medication was not available in the medication cart and the medication was reordered. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Widows Home of Dayton	50 South Findlay Street Dayton, OH 45403

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	Interview on 12/04/24 at 11:38 A.M. with Resident #51 confirmed he does not receive his pain medication at times because the medication was not available at the time of administration. Interview on 12/05/24 at 9:40 A.M. with Regional Clinical Nurse (RCN) #170 confirmed the medical record for Resident #51 did not contain documentation to support Resident #51 received his Percocet as ordered on 10/12/24, 10/13/24, 10/18/24, 10/28/24, and 12/04/24. Review of the facility policy titled, Administering Medications, stated medications shall be administered in a safe and timely manner, as prescribed. The policy stated medications must be administered in accordance with the orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number OH00159826.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER Widows Home of Dayton		STREET ADDRESS, CITY, STATE, ZIP CODE 50 South Findlay Street Dayton, OH 45403	

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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** 46613 Based on medical record review, staff interview, and policy review, the facility failed to ensure a resident was free from significant medication error. This affected one (#32) resident out of the three residents reviewed for medication administration. The facility census was 62. Findings include: Review of the medical record for Resident #32 revealed an admitted [DATE] with medical diagnoses of myocardial infarction, cerebral infarctions, diabetes mellitus with neuropathy, spinal stenosis and congestive heart failure. Review of the medical record for Resident #32 revealed a quarterly Minimum Data Set (MDS) assessment, dated 09/24/24, which indicated Resident #32 was cognitively intact and required supervision with toilet hygiene, showers, bed mobility, and transfers. Review of the medical record for Resident #32 revealed a physician order dated 05/12/24 for Insulin Glargine 100 units per milliliter (ml), administer eight units subcutaneous (SQ) daily, an order dated 06/-2/24 for Insulin Lispro 100 units per ml, administer five units SQ before meals daily, and an order dated 11/06/24 for Zoloft 175 milligram (mg) one tablet by mouth daily. Review of the medical record for Resident #32 revealed the November 2024 Medication Administration Record (MAR) did not contain documentation to support Resident #32 was administered Insulin Glargine as ordered on 11/05/24, 11/14/24, 11/15/24, 11/18/24 through 11/21/24. Further review of the November MAR revealed no documentation to support Resident #32 was administered Zoloft as ordered on 11/14/24, 11/25/24, 11/18/24 through 11/21/24 or Insulin Lispro as ordered on 11/05/24, 11/14/24, 11/15/24, 11/18/24 through 11/21/24, or 11/24/24. Interview on 12/04/24 at 2:45 P.M. with Regional Clinical Nurse (RCN) #170 confirmed the medical record for Resident #32 did not contain documentation to support the staff administered Resident #32's Insulin Glargine, Insulin Lispro and Zoloft as ordered in November 2024. RCN #170 confirmed Resident #32 did not experience any negative effects from medications not being administered as ordered. Review of the facility policy titled, Administering Medications, stated medications shall be administered in a safe and timely manner, as prescribed. The policy stated medications must be administered in accordance with the orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number OH00159826.