STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366223	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Notre Dame Health Center	699 East Columbia Avenue Cincinnati, OH 45215

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40141 Based on interview, medical record review, and facility policy review, the facility failed to submit a new Level I Pre-admission screening and resident review (PASARR) when required for one (#4) of one sampled resident reviewed for PASARRs. The census was 39. Findings included: Review of an admission record revealed the facility admitted Resident #4 on 03/30/22. According to the admission record, the resident had a medical history that included diagnoses of anxiety disorder (onset 09/16/22), dementia (onset 10/01/22), major depressive disorder (onset 09/21/23), and delusional disorders (onset 11/06/24). Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 08/07/24, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS assessment revealed the resident had active diagnoses to include anxiety disorder, depression, and psychotic disorder. Review of Resident #4's medical record revealed no evidence to indicate a level I PASARR screening was completed after the resident received new mental illness diagnoses. During an interview on 11/13/24 at 10:51 A.M., Social Worker (SW) #250 indicated she was responsible for resident PASARRs and indicated a resident review was done if there was a significant change or if a mental health diagnosis was added. SW #250 stated the resident review was for updates on the PASARR identification screening form. SW #250 indicated if the resident obtained a new mental health diagnosis, then a new resident review was completed at that time. SW #250 stated she completed a resident review for Resident #4 on 11/12/24 because the resident's prior PASARR did not have the resident's current mental illness diagnoses on it. SW #250 indicated the dates the resident obtained the mental health diagnoses were on the chart on the medical diagnoses list. SW #250 indicated the PASARR should have been resubmitted when the resident was diagnosed with the mental health diagnoses. During an interview on 11/13/24 at 12:27 P.M., the Director of Nursing (DON) indicated SW #250 was responsible for the PASARR process. The DON indicated she did not know much about the PASARR protocols, but if there was a regulation then she expected it to be followed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 12:56 P.M., the Administrator indicated SW #250 was responsible for the resident PASARRs. The Administrator stated she expected for a Level I PASARR to be submitted when a resident obtained a new mental illness diagnosis. Review of a facility policy titled, PAS/RR [PASARR] Behavioral Health Services, revised 08/2024, indicated, the Social Worker or her designee will initiate a PAS/RR in the [name] system when a [resident] is being admitted to the facility from the community; when a [resident] is admitted to the facility from another facility and this document was not sent in with other transfer documents, or when a [resident] has a significant change in condition (either improvement or decline) and has indications of serious mental illness.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 31524 Based on interviews, medical record review, and facility policy review, the facility failed to follow vital sign parameters when administering blood pressure medications for two (#25 and #33) of five sampled residents reviewed for unnecessary medications. The census was 39. Findings included: 1. Review of an admission record indicated the facility admitted Resident #25 on 09/18/23. According to the admission record, the resident had a medical history that included diagnoses of congestive heart failure, hypertension (HTN), and atrial fibrillation. Review of a significant change in status Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 08/07/24, revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Review of Resident #25's care plan included a focus area, revised 08/01/24, that indicated the resident was at risk for complications related to adverse effects of medications used to treat chronic heart failure and HTN as well as changes in blood pressure. Interventions directed staff to administer medications and to check vital signs per the physician's order and to watch for complications related to a blood pressure below the parameters set by the physician. Review of Resident #25's order summary report which contained active orders as of 11/12/24, revealed an order dated 07/08/24 for metoprolol tartrate (an antihypertensive medication) oral tablet 25 milligrams (mg), give one tablet by mouth two times a day for HTN, with instructions to hold if the systolic blood pressure SBP was less than 110 millimeters of mercury (mmHg) or if the diastolic blood pressure (DBP) was less than 60 mmHg. Review of Resident #25's medication administration record (MAR) for the timeframe of 10/01/24 to 10/31/24, revealed evidence to indicate staff administered metoprolol tartrate to the resident when the resident had a DBP of 56 mmHg on 10/18/24, 57 mmHg on 10/24/24, and 58 mmHg on 10/26/24. Review of Resident #25's MAR for the timeframe of 11/01/24 to 11/30/24, revealed evidence to indicate staff administered metoprolol tartrate to the resident when the resident had a DBP of 54 mmHg on 11/04/24. During an interview on 11/12/24 at 2:50 P.M., Licensed Practical Nurse (LPN) #1 stated if vital sign parameters were included in a medication order, she checked the resident's vital sign prior to administering a medication and held the medication if the resident's blood pressure did not meet the criteria to administer the medication. LPN #1 stated she administered Resident #25's metoprolol tartrate on 10/24/24 because the resident's SBP was within an acceptable range even though the DBP was not. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 9:11 A.M., LPN #2 stated when she administered blood pressure medications with parameters, she checked the resident's blood pressure, and if the reading was below the parameter set by the physician to hold the medication, she did not administer the medication. LPN #2 stated on 11/04/24 she administered Resident #25's metoprolol even though the resident's DBP was below the specified parameter. Per LPN #2, the purpose of including a blood pressure parameter in a medication order that lowered a resident's blood pressure was to make sure the resident's blood pressure did not get too low to where the resident became symptomatic of low blood pressure. 40141 2. Review of an admission record indicated the facility admitted Resident #33 on 04/25/23. According to the admission record, the resident had a medical history that included a diagnosis of HTN. Review of a quarterly MDS assessment, with an ARD of 10/23/24, revealed Resident #33 had a BIMS score of zero, which indicated the resident had severe cognitive impairment. Review of Resident #33's order summary report, that contained active orders as of 11/12/24, contained an order dated 03/06/24, for metoprolol succinate extended release (antihypertensive) 25 mg to administer 12.5 mg by mouth one time a day, with instructions to hold if the resident's SBP was less than 120 mmHg and/or the heart rate was less than 60 beats per minute. Review of Resident #33's MAR for the timeframe 10/01/24 to 10/31/24, revealed documentation that indicated staff administered metoprolol succinate 12.5 mg when the resident's SBP was less than 120 mmHg on 10/11/24, 10/28/24, and 10/30/24. Review of Resident #33's MAR for the timeframe 11/01/24 to 11/30/24, revealed documentation that indicated staff administered metoprolol succinate 12.5 mg when the resident's SBP was less than 120 mmHg on 11/02/24. During an interview on 11/13/24 at 9:11 A.M., LPN #2 stated if the vital signs were under the parameter, then she would hold the medication and document in the progress note that the medication was withheld. LPN #2 indicated it was on the nurse to catch it if the blood pressure was outside of the parameters. LPN #2 reviewed Resident #33's MAR for 10/11/24 and 10/30/24 then indicated she signed the metoprolol succinate 12.5 mg as administered so the medication would have been administered. LPN #2 stated the purpose of the parameter was so the blood pressure did not go too low and the resident become symptomatic of low blood pressure. During an interview on 11/13/24 at 9:44 A.M., Pharmacist #375 stated the purpose of including a parameter with a blood pressure medication order was to ensure a resident's blood pressure stayed within the range the physician felt was safe for the resident. Pharmacist #375 stated metoprolol tartrate acted to lower the blood pressure, and if it was administered when a resident's blood pressure was already low, it could cause tiredness, dizziness, and other unwanted adverse effects. During an interview on 11/13/24 at 11:38 A.M., Physician #300 stated the purpose of including parameters with medications such as metoprolol tartrate that lowered blood pressure was to prevent lowering a resident's blood pressure further to prevent any adverse effects. Per Physician #300, if a resident's blood pressure reading was already low, administering that medication could lower it further, which could cause adverse effects on a resident's desired blood pressure or heart rate. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 12:28 P.M., the Director of Nursing (DON) stated she expected the nurses to hold a medication if the resident's vital signs were outside the parameters outlined in the physician's order. During an interview on 11/13/24 at 12:56 P.M., the Administrator stated she expected nursing staff to follow the policies for following parameters under the guidance of the DON. Review of a facility policy titled, Administering Medication, revised 05/2024, indicated, medications shall be administered in a safe and timely manner, and as prescribed. The policy specified medications must be administered in accordance with the orders, including any required time frame.