

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Colonial Nursing Center of Rockford		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Buckeye Street Rockford, OH 45882	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review, review of facility investigation report, resident and staff interviews, and policy review, the facility failed to ensure medications were consumed at the time of administration. This affected one (#08) out of three residents reviewed for medication administration. The facility census was 25.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #08 revealed an admitted [DATE] with medical diagnoses of acquired left below the knee amputation (BKA), chronic obstructive pulmonary disease, congestive heart failure, obsessive-compulsive disorder (OCD), major depression, and peripheral vascular disease.</p> <p>Review of the medical record for Resident #08 revealed an admission Minimum Data Set (MDS) assessment, dated 07/29/24, which indicated Resident #08 was cognitively intact and required substantial/maximum staff assistance with toilet hygiene and bathing, supervision with transfers and set-up assistance with eating and bed mobility. The MDS indicated Resident #08 received antidepressant, anticoagulant, antibiotic, and opioid medications.</p> <p>Review of the medical record for Resident #08 revealed physician orders dated 07/24/24 for acetaminophen 650 milligram (mg) one tablet by mouth every four hours as needed, 07/25/24 for cholecalciferol (vitamin D3) 1000 units one tablet by mouth daily and oxycodone-acetaminophen (Percocet) 5-325 mg one tablet by mouth every four hours as needed, 07/26/24 for Colace (stool softener) 100 mg one tablet by mouth two times per day, and 08/15/24 for gabapentin 100 mg one tablet by mouth every evening. Review of Resident #08's medical record revealed there was no physician order, assessment or care plan allowing the resident to self administer medications.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Colonial Nursing Center of Rockford		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Buckeye Street Rockford, OH 45882	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record for Resident #08 revealed a nurse progress note dated 08/24/24 at 4:41 A.M. written by Licensed Practical Nurse (LPN) #75 which stated the nurse gave Resident #08 his morning medications, watched the resident take medications and left the room. The note stated a State tested Nursing Assistant (STNA) went into Resident #08's room to empty his catheter and saw Resident #08 putting medications into his pillowcase. The note stated LPN #75 and Director of Nursing (DON) went into Resident #08's room and asked where he placed his medications. Resident #08 denied having the medications. The note stated LPN #75 checked in Resident #75's pillowcase and found a medication cup in a glove with two gabapentin tablets, one acetaminophen tablet, two stool softener tablets, four Vitamin D3 tablets, and ten Percocet tablets. The note continued to state the LPN educated Resident #08 on severe misuse of medications and how important it was to have his medications on him and to take them with compliance.</p> <p>Review of the facility investigation report, dated 08/24/24, stated Resident #08 was noted to hoard medications. The report stated Resident #08 was removed from the room by the floor nurse and DON. The report stated medications found were counted and destroyed. The investigation report stated Resident #08 was educated and the confirmed he took the medications but stated he didn't know why and wouldn't do it again. The report stated the facility notified the Administrator, Assisted Living waiver program representative, Resident #08's physician and representative of the incident. The report continued to state Resident #08 was alert and oriented to person, place, time, and situation and have no negative effects of the incident.</p> <p>Interview on 09/25/24 at 8:50 A.M. with Resident #08 confirmed he had previously kept medications in his mouth and would put in his pillowcase. Resident #08 stated he no longer kept his medications after the staff spoke to him about it.</p> <p>Interview on 09/25/24 at 8:57 A.M. with LPN #75 confirmed she was the nurse who administered medications to Resident #08 on 08/24/24. LPN #75 stated she observed Resident #08 consume his medications and left the room. LPN #75 stated she was notified by the STNA that Resident #08 had medications in his pillowcase. LPN #75 confirmed Resident #08 had medication in his pillowcase, and some were half dissolved. LPN #75 confirmed Resident #08 informed her he would pocket the medication in his cheek and then put in his pillowcase.</p> <p>Interview on 09/25/24 at 9:31 A.M. with DON confirmed Resident #08 had medications found in his pillowcase on 08/24/24. DON confirmed Resident #08 was educated on not keeping medications in his cheeks. DON stated Resident #08 has not had an incident of pocketing medications in his cheek since 08/24/24.</p> <p>Review of the facility policy titled, Medication Administration, revised 07/01/24, stated medications are administered by licensed nurse, or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The policy stated the nurse was to observe resident consumption of medication.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157430.</p>		