STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366245	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Glen Health Campus	2150 Montego Drive Springfield, OH 45503

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 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** 44080 Based on medical record review, review of hospital documentation, staff interview, nurse practitioner interview, and facility policy review, the facility failed to ensure residents received medications as ordered which resulted in a significant medication error. This affected one (#72) of three residents reviewed for medication administration. The facility census was 69. Findings Included: Review of the medical record for Resident #72 revealed an admitted d of 12/13/24. Diagnoses included displaced intertrochanteric fracture of the left femur, hemiplegia, hemiparesis following cerebral infarction affecting the left dominant side, hypertensive chronic kidney disease, tachycardia, and personal history of transient ischemic attack. The resident was discharged on [DATE]. Review of a hospital discharge summary dated 12/13/24 revealed Resident #72 was admitted to the hospital on 12/02/24 for a fracture to the left hip after suffering a fall. Resident #72 had surgery and a post open reduction and internal fixation (ORIF) with transfemoral nails. Resident #72's active problems included systemic lupus erythematosus, chronic kidney disease, transient ischemic attack, nonrheumatic aortic valve insufficiency, carotid stenosis bilateral, anti-phospholipid syndrome, tachycardia, palpitations, hypertension, intertrochanteric fracture of the left femur, and valvular heart disease. Further review revealed the resident was discharged with orders for the anticoagulant medication warfarin (Coumadin) five (5) milligrams (mg) with instructions to take one tablet by mouth for two days. It was indicated Resident #72 required 7.5 mg of warfarin. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was cognitively intact, required set up help for meals, supervision for oral care, toileting hygiene, dressing the upper body, and personal hygiene, and required partial to moderate assistance for putting on and off footwear, bathing, and dressing the lower body. Review of physician orders dated 12/26/24 revealed Resident #72 had an order for a one time dose of warfarin 7.5 mg at 1:30 P.M. Review of the December 2024 medication administration record (MAR) revealed Resident #72 only received a one time dose of warfarin 7.5 mg on 12/26/24 at 1:30 P.M. for the resident's entire stay at the facility. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 12/27/24, written by Licensed Practical Nurse (LPN) #229, revealed the indication for Resident #72 to use warfarin was a prior to history of transient ischemic attack (TIA). Interview on 03/13/25 at 2:23 P.M. with LPN #229 stated she talked to Certified Nurse Practitioner (CNP) #243, and stated the facility checked Resident #72's prothrombin time/international normalized ratio (PT/INR, a blood test that measures how long it takes blood to clot) and then notified CNP #243 of the results. LPN #229 stated CNP #243 spoke to Resident #72 and was educated to contact the provider when discharged . Interview on 03/12/25 at 2:41 P.M. with LPN #270 stated the nurse asked LPN #229 how to place Resident #72's warfarin order in the chart since the order was not normal. LPN #270 stated she never put the order in the electronic medical record because it needed clarification. LPN #270 stated the nurse on the next shift was to review the warfarin order and the nursing supervisor checked the medical records for errors. LPN #270 verified she never clarified Resident #72's warfarin order with the provider who wrote the order. LPN #270 stated the Administrator and Clinical Nurse Supervisor #229 contacted her on 12/26/24 to discuss why Resident #72's warfarin order was missed from the hospital record. Interview on 03/12/25 at 2:52 P.M. with CNP #243 stated he was aware of Resident #72's order for warfarin from the hospital documentation, but there were concerns about when to begin the medication. CNP #243 stated there was no record of him telling the nursing staff to contact the prescriber to address Resident #72's warfarin order. CNP #243 confirmed Resident #72 did not timely receive the ordered warfarin as per the hospital records. Interview on 03/12/25 at 3:20 P.M. with LPN #265 stated she never called the provider who ordered Resident #72's warfarin to verify the order. Interview on 03/12/25 at 4:10 P.M. with LPN #305 stated she worked on 12/26/24 and stated Resident #72 had asked her to check her PT/INR. LPN #305 stated Resident #72 asked to have her PT/INR checked because she was on warfarin in the past. LPN #305 stated she looked in the hospital discharge summary and found Resident #72 had an order for warfarin and she told LPN #229 right away. LPN #305 stated she never called the provider who ordered the medication for Resident #72 for clarification. Review of the facility policy titled, Guidelines for Medication Orders, dated 05/2016, revealed each resident shall be under the care of a licensed physician authorized to practice medicine in the state where care was provided and shall be seen by the physician in accordance with regulations and as resident condition warrants. A current list of orders will be maintained in the electronic clinical record of each resident. This deficiency represents non-compliance identified under Complaint Number OH00163064.