

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2024
NAME OF PROVIDER OR SUPPLIER  Indianspring of Oakley		STREET ADDRESS, CITY, STATE, ZIP CODE  4900 Babson Place Cincinnati, OH 45227	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40471</p> <p>Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to ensure medications were stored in a safe and secure manner. This affected one (#4) of four residents observed for medications. The facility census was 98.</p> <p>Findings include:</p> <p>Record review for Resident #4 revealed an admitted [DATE] with diagnoses including atrial fibrillation, history of transient ischemic attack, and cerebral infarction.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively intact.</p> <p>Review of Resident #4's physician's orders revealed the resident was ordered the cholesterol medication atorvastatin 10 milligrams (mg) by mouth at bedtime, the supplement cyanocobalamin 1000 micrograms (mcg) by mouth daily, the blood pressure medication amlodipine besylate 10 mg by mouth daily, and the combination blood pressure medication hydrochlorothiazide and lisinopril 12.5 mg-20 mg by mouth daily on 04/03/24. On 04/16/24, Resident #4 was ordered the supplement Stress B-zinc one oral tablet daily, on 05/13/24 was ordered the anticoagulant apixaban 2.5 mg by mouth twice daily, and on 05/29/24 was ordered the blood pressure medication metoprolol succinate extended release (ER) 100 mg by mouth daily.</p> <p>Observation and interview on 06/03/24 at 11:35 A.M. with Resident #1 verified the presence of two medication cups at her bedside. One medication cup contained one tablet, identified as atorvastatin, and the other medication cup contained with seven various medications. Resident #1 stated she did not recall when the medications were from, but she decided not to take them because she had not been feeling well.</p> <p>Interview on 06/03/24 at 11:35 A.M. with Assistant Director of Nursing (ADON) #1 verified the presence of medications at Resident #1's bedside during observation.</p> <p>Review of a policy titled, Administration Oral Medications, dated 12/2021, revealed the nurse or medication aide administering the medication remains with the resident until the medicine is swallowed.</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:  366380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2024
NAME OF PROVIDER OR SUPPLIER  Indianspring of Oakley		STREET ADDRESS, CITY, STATE, ZIP CODE  4900 Babson Place Cincinnati, OH 45227	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00153632.</p>		