| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366421 | A. Building<br>B. Wing | 06/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Florentine Gardens | 409 Wards Corner Road<br>Loveland, OH 45140 |

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|---|---|
| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to obtain an order for self-administration of medication and failed to assess the resident's capacity to self-administer medication prior to leaving medication in the room for 1 (Resident #49) of 19 sampled residents.<br><br>Findings included:<br><br>A facility policy titled, Self-Administration of medications, dated 10/30/2017, indicated, Each resident who desires to self-administer medication is permitted to do so if the interdisciplinary team has determined that the practice would be safe for the resident and other residents in the facility.<br><br>An admission Record revealed the facility admitted Resident #49 on 05/08/2024. According to the admission Record, the resident had a medical history that included chronic obstructive pulmonary disease (COPD) and unspecified macular degeneration.<br><br>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/16/2025, indicated Resident #49 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition.<br><br>Resident #49's Care Plan Report, included a focus area initiated 08/29/2024, that indicated the resident had COPD. Interventions directed staff to provide inhalers as ordered.<br><br>Resident #49's Order Summary Report, with active physician's orders as of 06/02/2025, included an order dated 05/09/2025, for Breo Ellipta inhalation aerosol powder 200-25 milligrams per actuation, with directions to inhale one puff orally one time per day and to rinse the mouth with water and spit after each use. The Order Summary Report revealed no physician orders or instructions to self-administer Breo Ellipta or to keep the medication at the resident's bedside.<br><br>On 06/01/2025 at 11:15 AM, the surveyor observed a Breo Ellipta inhaler on Resident #49's bedside table. Resident #49 stated Licensed Practical Nurse (LPN) #4 left the inhaler in their room when the LPN left the room to attend to another task. The resident stated they told LPN #4 that they would take the medication. Resident #49 stated that leaving medication in their room was not a common occurrence, and prior to facility admission they had taken their medication independently. Resident #49 stated they were interested in keeping the inhaler at their bedside and self-administering the medication as needed.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LPN #4 was interviewed on 06/01/2025 at 12:07 PM. LPN #4 stated the facility policy indicated medications should not be left at a resident's bedside. She stated before staff could leave medication at a resident's bedside, a physician's order had to be obtained, and an assessment for self-administration had to be completed. LPN #4 stated she was unsure whether Resident #49 had been assessed for medication self-administration. Per LPN #4 she forgot that she left the inhaler in Resident #49's room. LPN #4 stated she left Resident #49's room to care for another resident who was calling her name, for a non-emergent situation.<br><br>The Director of Nursing (DON) was interviewed on 06/02/2025 at 9:00 AM. The DON stated leaving medications at the bedside was not good practice and was not his expectation. The DON stated nurses were expected to watch residents take medications to verify the right medication was taken. The DON stated that prior to self-administration of medications, an assessment had to be completed. The DON further stated that Resident #49 had the capacity to self-administer medications but had not been assessed and did not have a physician's order for self-administration.<br><br>The Administrator was interviewed on 06/05/2025 at 11:22 AM. The Administrator stated that prior to self-administration of a medication, she expected the nurses to complete an assessment. The Administrator stated she was unaware of Resident #49's cognitive ability or the ability to self-administer medications. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure they maintained an environment as free from accident hazards as possible by ensuring staff did not leave medication at a resident's bedside who was not assessed to administer their own medication. The deficiency affected 1 (Resident #5) of 2 sampled residents reviewed for accident hazards.<br><br>Findings included:<br><br>A facility policy titled, Medication Administration, effective 06/21/2017, revealed 11. Administer medication and remain with resident while medication is swallowed. Never leave a medication in a resident's room without orders to do so. Per the policy, 14. Return to the medication cart and document medication administration with initials on the Medication Administration Record (MAR) immediately after administering medication to each resident.<br><br>An admission Record revealed the facility admitted Resident #5 on 10/05/2021. According to the admission Record, the resident had a medical history that included diagnoses of dementia with mood disturbance, late onset Alzheimer's disease, chronic diastolic congestive heart failure, anemia, recurrent major depressive disorder, essential hypertension, and dorsalgia (back pain).<br><br>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/20/2025, revealed Resident #5 had Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment.<br><br>Resident #5's Care Plan Report included a focus area initiated 10/08/2021, that indicated Resident #5 had altered cognitive/communication related to a diagnosis of dementia as evidenced by confusion related to time and impaired short-term memory. Interventions directed staff to assist the resident with necessary decision making, be consistent with daily routines, and offer verbal reminders and cues, as necessary. The Care Plan Report revealed no indication that the resident self-administered their medication.<br><br>Resident #5's Order Summary Report, with active orders as of 06/02/2025, included the following orders:<br><br>- acetaminophen 325 milligrams (mg) two tablets every six hours as needed for pain or elevated temperature.<br><br>- aspirin 81 mg one tablet daily.<br><br>- ferrous gluconate (an iron supplement) 324 mg one tablet daily.<br><br>- midodrine hydrochloride (HCl) (an anti-hypotensive medication) 5 mg twice a day, to be held for a blood pressure exceeding 150/100 millimeters of mercury (mmHg).<br><br>- potassium chloride (a mineral supplement) extended release (ER) 20 milliequivalents (MEQ) one tablet twice a day.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - potassium chloride ER 10 MEQ one tablet two times a day, to be given with the 20 MEQ tablet.<br><br>- pantoprazole sodium (a medication that relieved symptoms such as heart burn, difficulty swallowing, and persistent cough) 40 mg one tablet twice a day.<br><br>- senna (a laxative) 8.6 mg one tablet on Mondays, Wednesdays, and Fridays.<br><br>- sertraline HCl (an anti-depressant medication) 100 mg one tablet a day.<br><br>- sertraline HCl 25 mg one tablet a day.<br><br>An observation on 06/02/2025 at 8:43 AM revealed multiple medications on a paper towel on Resident #5's overbed table. Medication observed on the paper towel included a white pill, a grayish white tablet broken into three pieces, a pink pill, an orange pill, a green tablet, a blue pill, a tan pill, and one-half of a white tablet. Resident #5 stated they left the medication every morning in their room for them to take. Resident #5 stated they were unable to name the pills or what the medications were for.<br><br>Resident #5's MAR for the timeframe 06/01/2025-06/30/2025, revealed Registered Nurse (RN) #1 signed Resident #5's MAR on 06/02/2025, indicating she administered medication to Resident #5.<br><br>RN #1 was interviewed on 06/02/2025 at 8:47 AM. RN #1 stated the facility's policy indicated medications were not to be left at a resident's bedside. The RN stated she did not leave medication in resident rooms because the resident may throw the medication away instead of taking the medication. RN #1 stated there were residents in the facility that were able to self-administer medications and identified Resident #5 as a resident who was able to self-administer medication. She stated she was unsure if Resident #5 had been assessed for self-administration or had a physician's order to self-administer medication. RN #1 stated she had been trained by multiple staff, and they all told her it was fine to leave medication at Resident #5's bedside. RN #1 checked Resident #5's physician orders and stated the medications she left at the resident's bedside included potassium, ferrous gluconate, aspirin, two tablets of acetaminophen, sertraline, midodrine, pantoprazole, and senna. RN #1 stated she gave the resident the medications around 8:30 AM on 06/02/2025. RN #1 stated she should not have left the medication in the resident's room without knowing if there was an order to leave the medication at the bedside or if the resident had been assessed to self-administer medications.<br><br>On 06/02/2025 at 8:59 AM, the Registered Nurse (RN) Regional Clinician stated medication was not to be left at a resident's bedside without a physician's order and a completed self-administration assessment. The RN Regional Clinician went to Resident #5's room and heard Resident #5 say the nurse left the medication in the room. The RN Regional Clinician stated she had not reviewed Resident #5's medical record and was unaware if the resident had been assessed to self-administer medication.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Director of Nursing (DON) was interviewed on 06/02/2025 at 9:00 AM. The DON stated it was not good that medications had been left at Resident #5's bedside and he expected nurses not to leave medications at the bedside. He stated that the danger of leaving medication at bedside included the resident not taking the medication. The DON stated the expectation was for nurses to watch residents take medications to verify the medications were taken. The DON stated he felt RN #1 showed poor judgement in not returning to the room after she was notified the medications were at the resident's bedside and RN #1 required more training. The DON stated it was a standard of practice not to leave medication at a resident's bedside, and Resident #5 lacked the capacity for self-administration of medications.<br><br>The Administrator was interviewed on 06/05/2025 at 11:22 AM. The Administrator stated that prior to a resident self-administering medication, the nurses were expected to complete a self-administration assessment. The Administrator stated she was familiar with Resident #5 and stated she did not think the resident had the ability to self-administer medication. The Administrator stated she would not have expected the nurse to leave the medication at the resident's bedside. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to secure an indwelling urinary catheter for 1 (Resident #39) of 4 sampled residents reviewed for urinary catheters.<br><br>Findings included:<br><br>A facility policy titled, Catheter Care/Urinary, revised 07/2006, indicated staff should 12. Secure catheter utilizing a leg band.<br><br>An admission Record revealed the facility readmitted Resident #39 on 03/28/2025. The admission Record indicated the resident had a medical history that included a diagnosis of urinary retention.<br><br>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/04/2025, indicated Resident #39 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #39 required substantial to maximal assistance with toileting hygiene and had an indwelling urinary catheter.<br><br>Resident #39's Care Plan Report, revealed a focus area initiated 04/17/2025, that indicated the resident had the potential to develop complications due to the use of an indwelling urinary catheter. Interventions directed staff to secure the urinary catheter tubing to prevent accidental dislodgement.<br><br>Resident #39's Order Summary Report for active physician orders as of 06/03/2025 revealed an order started dated 06/03/2025, for an indwelling urinary catheter. The Order Summary Report also revealed an order dated 03/28/2025, for a urinary catheter securement device to be replaced every seven days and as needed, alternating sites/legs.<br><br>On 06/02/2025 at 8:31 AM, Resident #39 stated they used an indwelling urinary catheter due to pelvic floor muscle issues. The surveyor noted Resident #39 was in a wheelchair and no device was observed that secured the resident's urinary catheter tubing.<br><br>An observation on 06/03/2025 beginning at 11:36 AM, revealed State Tested Nurse Aide (STNA) #5 and STNA #6 were providing catheter care for Resident #39. The observation revealed the resident's indwelling urinary catheter tubing was not secured. STNA #6 stated when Resident #39 was initially readmitted to the facility, there was a piece of tape being used to secure the urinary catheter tubing to the resident's leg. At the time of the observation, a piece of tape was observed wrapped and knotted on the catheter tubing but was not connected to the resident's leg to secure the tubing in place. The STNA's stated the facility had other devices to secure urinary catheter tubing but was unsure whether a device had been tried for Resident #39.<br><br>STNA #2 was interviewed on 06/03/2025 at 12:00 PM. STNA #2 stated she was the resident's primary STNA for 06/03/2025 and had taken care of Resident #39 off and on since admission. She stated the resident had a urinary catheter securement device at times, but she was unsure the last time she had seen the catheter secured. The STNA stated she had been in Resident #39's room on 06/03/2025 but had not paid attention to the resident's indwelling urinary catheter.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Licensed Practical Nurse (LPN) #7 was interviewed on 06/03/2025 at 12:07 PM. LPN #7 stated she was assigned to provide care for Resident #39. LPN #7 stated the facility policy was to monitor every shift to ensure a securement device was in place and to replace the device weekly and as needed. LPN #7 stated she had not received any reports about Resident #39's securement device not being in place. She stated having the catheter secured was important to prevent trauma to the resident.<br><br>The Director of Nursing (DON) was interviewed on 06/03/2025 at 1:46 PM. The DON stated the urinary catheter tubing should be secured to the resident to ensure the catheter did not become displaced. He stated if the device was not in place he expected the STNA to report to the nurse, who should apply a device for the resident.<br><br>The Administrator was interviewed on 06/05/2025 at 11:20 AM. She stated that she expected staff to secure Resident #39's catheter to prevent the catheter from being pulled and causing the resident trauma. |