| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366430 | A. Building<br>B. Wing | 06/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Otterbein Gahanna | 402 Liberty Way<br>Gahanna, OH 43230 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to notify the physician and/or registered dietician when Resident #44 did not have physician ordered enteral nutrition available and failed to report Resident #48's weight loss. This affected two (Resident #44 and Resident #48) of three residents reviewed for change in condition. The facility census was 54.<br><br>Findings include:<br><br>1. Review of the medical record revealed Resident #44 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included nontraumatic intracerebral hemorrhage, type II diabetes, and dysphagia.<br><br>On 03/18/25 Resident #44 weighed 228 pounds.<br><br>A nutrition/dietary note dated 03/20/25 at 11:33 A.M. revealed Resident #44 was ordered nothing by mouth and received enteral support as the sole source of nutrition. Resident #44 received Osmolite (therapeutic nutrition that provided complete and balanced nutrition for tube feeding (enteral nutrition) residents) 1.5 cal (caloric density of 1.5 calories per milliliter) at 80 milliliter per hour (ml/hr) for 20-hours a day with 300 ml water flushes every four hours. Resident #44's weight had been more stable since mid-December after Resident #44 was ordered nothing by mouth.<br><br>On 04/15/25 Resident #44 weighted 228 pounds.<br><br>Review of the medication administration record (MAR) revealed on 04/21/25 at 8:00 AM the Osmolite 1.5 was marked with 9 which indicated to see other/progress notes. The administration note dated 04/21/25 at 3:52 P.M. revealed Osmolite 1.5 was not available. Further review of the MAR and progress notes revealed no evidence of the Osmolite being administered at a later time on 04/21/25 or the physician or registered dietician being notified Osmolite was not available for Resident #44.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #44 had cognitive impairment and required a feeding tube.<br><br>An interview on 06/12/25 at 9:19 A.M. with Licensed Nursing Home Administrator (LNHA) verified the MAR was marked as the Osmolite was not administered.<br><br>(continued on next page) |



| 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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on 06/12/25 at 2:24 P.M. with Registered Dietician (RD) #502 verified he was not notified Resident #44 did not receive Osmolite on 04/21/25.<br><br>On 06/13/25 at 10:56 A.M. the DON verified the documentation revealed Osmolite was not administered and there was no documentation of the physician or registered dietician being notified.<br><br>Review of notification of change of condition policy revised 11/22/21 revealed the facility will immediately inform the resident, consult with the resident's physician, nurse practitioner or clinical nurse specialist, and resident representative when there is a need to alter treatment significantly such as the need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment.<br><br>Review of enteral tube feeding, continuous, gastrostomy and jejunostomy policy revised 11/18/24 revealed documentation associated with gastrostomy and jejunostomy continuous enteral tube feeding problems or complications include the name of the practitioner notified, date and time of the notification, prescribed interventions, and the response to those interventions.<br><br>2. Review of the medical record revealed Resident #48 was admitted on [DATE] with diagnoses that included<br><br>senile degeneration of brain and vascular dementia.<br><br>On 04/07/25 Resident #48 weighed 189 pounds<br><br>Review of a plan of care dated 04/08/25 revealed Resident #48 was at risk for malnutrition. Interventions included to offer a substitute if Resident #48 did not like what was being served. If food intake decreased, family and friends would be encouraged to bring in food and fluids that Resident #48 liked.<br><br>Review of the admission MDS dated [DATE] revealed Resident #48 had significant cognitive impairment and had no weight loss.<br><br>A nutrition/dietary note dated 04/15/25 at 4:40 P.M. revealed Resident #48 received a no added salt diet. Resident #48's meal intakes varied from 50 to 75-percent, and Resident #48 weighed 189 pounds. No new recommendations were made at this time.<br><br>Review of the resident's weights revealed:<br><br>On 04/22/25 Resident #48 weighed 188 pounds.<br><br>On 04/23/25 Resident #48 weighed 178 pounds.<br><br>On 04/29/25 Resident #48 weighed 176 pounds<br><br>On 05/01/25 Resident #48 weighed 176 pounds<br><br>On 06/09/25 Resident #48 weighed 180 pounds.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on 06/12/25 at 9:12 A.M. with the DON and the LNHA revealed an agency nurse worked on 04/07/25 and 04/22/25. The agency nurse was contacted after the surveyor inquired about the weight loss and the nurse stated they remembered that they typed in the wrong weight on 04/07/25 and 04/22/25. The LNHA verified there was nothing in the medical record indicating the weights had been entered incorrectly on 04/07/25 and 04/22/25. The DON verified the EMR revealed Resident #48 had a 10 pound weight loss in one day and 12 pound weight loss in seven days without anyone being made aware of the weight loss. The DON stated the registered dietician would usually be notified of weight changes and would review the weight changes at least weekly. The DON verified the last nutrition/dietary note was dated 04/15/25.<br><br>Review of notification of change of condition policy revised 11/22/21 revealed the facility will immediately inform the resident, consult with the resident's physician, nurse practitioner or clinical nurse specialist, and resident representative when there was a significant change in the resident's physical, mental, or psychosocial status.<br><br>Review of the weight policy dated 12/02/21 revealed the food coordinator, DON/Health Care Coordinator (HCC), and/or Dietician/Tech will request reweighs for those persons with significant weight changes (5% in 30 days or 10% in 180 days) and/or fluctuation for three to five pounds. The reweighs will be completed by the 10th of the month. If a significant weight change was noted, the dietitian and/or diet technician will then proceed with the following as appropriate: observe person regarding weight change, speak with person at mealtime, make recommendations for interventions, and document in the medical record.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00164452. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and policy review, the facility failed to provide a comprehensive and individualized pressure ulcer plan to aid in the prevention and/or treatment of pressure ulcers. This affected two (Resident #4 and #50) of three residents reviewed for pressure ulcers.<br><br>Findings include:<br><br>1. Review of the medical record revealed Resident #4 was admitted on [DATE] with diagnosis that included multiple fractures of pelvis, osteoporosis, and psoriasis.<br><br>An admission summary dated [DATE] at 6:35 P.M. revealed Resident #4 was admitted to the facility with a pelvic fracture and open reduction and internal fixation of the left hip. Resident #4 had a pressure ulcer to the coccyx. A new skin observation form dated 04/30/25 at 11:47 P.M. revealed Resident #4 was admitted with a skin tear to the coccyx that measured two centimeters (cm) long and one cm wide and surgical incision to the left thigh.<br><br>An admission screen and baseline care plan dated 05/01/25 at 1:42 A.M. revealed Resident #4 had an area to the coccyx. No description or measurement of the area was documented.<br><br>A plan of care dated 05/01/25 revealed Resident #4 had the potential for skin breakdown and was admitted with a surgical wound to the left hip. Interventions included treatments as ordered and turn and reposition frequently and as needed, moisture barrier to perineal and buttocks after incontinence, and weekly skin screening.<br><br>The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had cognitive impairment and a Stage III (full thickness skin loss) pressure ulcer that was present upon admission.<br><br>The initial wound evaluation dated 05/06/25 revealed Resident #4 had a Stage III pressure ulcer to the sacrum that measured 5.5 cm long, 2.8 cm wide, and 0.1 cm deep. There was a moderate amount of serous (thin, watery, and clear or slightly yellow fluid) exudate. A treatment was put in place for the wound to be cleansed, patted dry, calcium alginate (highly absorbent to maintain a moist wound environment) applied and covered with a gauze island bordered dressing. Recommendations included a low air loss mattress to be put in place.<br><br>Review of physician orders revealed treatment orders were entered on 05/06/25 but an order for a low air loss mattress was not provided.<br><br>A plan of care plan updated on 05/09/25 revealed Resident #4 had the potential for skin breakdown. Resident #4 was admitted with a Stage III pressure injury to the sacrum and a surgical wound to the left hip. Interventions included treatments as ordered, turn and reposition frequently and as needed, moisture barrier to perineal and buttocks after incontinence, and weekly skin screening.<br><br>A wound evaluation dated 05/15/25 revealed Resident #4 had a Stage III pressure ulcer to the sacrum that measured 4.5 cm long, two cm wide, and 0.1 cm deep.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation on 06/04/25 at 12:25 P.M. of the treatment to Resident #4's sacrum revealed no concerns. An air mattress was not observed to Resident #4's bed.<br><br>An observation on 06/11/25 at 12:28 P.M. revealed an air mattress was not in place to Resident #4's bed.<br><br>An interview on 06/11/25 at 12:33 P.M. with Certified Nursing Assistant (CNA) #106 revealed she frequently provided care for Resident #4. CNA #106 verified Resident #4 did not have a low air loss mattress and CNA #106 could not recall there ever being one to Resident #4's bed.<br><br>An interview on 06/12/25 at 9:26 A.M. with the Director of Nursing (DON) verified Resident #4 was admitted on [DATE] and a skin tear was documented to Resident #4's coccyx. The DON verified there was no documentation of a treatment to Resident #4's coccyx. The DON also verified a treatment was not put in place until 05/06/25 when Resident #4 was evaluated by the wound doctor on 05/06/25. The area was identified as a Stage III pressure ulcer to Resident #4's sacrum. The DON verified there was not an order put in place for the low air loss mattress as recommended by the wound doctor on 05/06/25.<br><br>2. Review of the medical record revealed Resident #50 was admitted on [DATE] with diagnoses that included atrial fibrillation, mild protein-calorie malnutrition, disorders of bone density, and dysphagia.<br><br>A physician order dated 09/25/24 revealed Resident #50 was to have a low air loss mattress in place.<br><br>A plan of care dated 10/03/24 revealed Resident #50 had actual impairment to skin integrity of the sacrum. Interventions included keep skin clean and dry, monitor location, size, and treatment of skin injury, a low air loss mattress, and treatment documentation was to include the measurement of each area of skin breakdown included the width, length, depth, type of tissue and exudate and any other notable changes or observations. Weekly skin screenings were to be completed.<br><br>Further review of the medical record revealed a wound management summary dated 01/28/25 that indicated the Stage III pressure ulcer to Resident #50's sacrum was resolved.<br><br>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #50 had severe cognitive impairment. The MDS also revealed Resident #50 was at risk for the development of pressure ulcers. Resident #50 had no current pressure ulcers.<br><br>Review of the Body audit forms dated 05/04/25, 05/07/25, 05/11/25, and 05/14/25 revealed no skin concerns. A shower sheet dated 05/19/25 revealed no skin concerns.<br><br>A weekly skin assessment dated [DATE] revealed Resident #50 had an on going open area to the coccyx. There was no additional information regarding the pressure ulcer.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A nursing note dated 05/31/25 at 4:10 P.M. revealed Resident #50 had a red rash on their back. A skin assessment was completed and two small open areas were also found to Resident #50's coccyx. The one open area measured 0.5 cm long, 0.3 cm wide, and the other measured one cm long and 0.8 cm wide. The wound doctor was notified and the areas were cleansed with normal saline, calcium alginate was applied, and the area was covered with a gauze island bordered dressing<br><br>A wound evaluation and management summary dated 06/01/25 revealed at the request of the referring provider, a thorough wound care assessment and evaluation was performed. Resident #50 had a Stage III pressure ulcer to the sacrum that measured 2.7 cm long, 2.3 cm wide, and 0.2 cm deep. There was moderate serous exudate. The area was to be cleansed with normal saline, calcium alginate applied, and covered with a bordered gauze. A low air loss mattress was to be in place. The summary revealed Resident #50 weighed 116 pounds.<br><br>An observation on 06/04/25 at 8:54 A.M. revealed Resident #50's air mattress was beeping and flashing and had an error code.<br><br>An observation and interview on 06/04/25 at 10:23 A.M. with Licensed Practical Nurse (LPN) #155 verified the low air loss mattress to Resident #50's bed was making a beeping sound and showed an error code.<br><br>Interview on 06/04/25 at 2:06 P.M. with Licensed Nursing Home Administrator (LNHA) verified the bed had been fixed that morning after surveyor intervention.<br><br>An observation and interview on 06/04/25 at 2:19 P.M. the DON verified the air mattress setting for Resident #50 was set for a person that weighed 210 to 220 pounds. The DON verified Resident #50 weighed probably between 110 and 120 pounds.<br><br>An additional interview on 06/11/25 at 8:35 A.M. with the DON verified a skin assessment on 05/26/25 revealed Resident #50 had an open area to the coccyx and the medical record revealed no further documentation of the open areas or a treatment being put in place until 05/31/25. The DON stated the wound physician evaluated Resident #50 on 06/01/25 and identified the two areas as one area and put a treatment in place at that time.<br><br>Review of the skin assessment policy dated 11/17/22 revealed a thorough head to toe skin assessment was to be completed upon admission, weekly, upon any identified significant change and as needed.<br><br>Review of the skin management procedure revised 12/09/22 revealed staff should remain alert to potential changes in the skin condition and should evaluate and document the identified changes: an evaluation of the site, the status of the area around the ulcer, and presence of possible complications. The physician will be notified of all skin areas of concern and consulted for treatment orders. The use of the wound clinic or specialist may occur for those areas in which the physician makes a referral.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00164452. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a comprehensive, resident centered treatment plan was implemented to support identified needs related to enteral nutrition and failed to maintain appropriate parameters to accurately assess nutritional status. This affected two (Resident #44 and Resident #60) of three residents reviewed for nutrition. The facility census was 54.<br><br>Findings include:<br><br>1. Review of the medical record revealed Resident #44 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included nontraumatic intracerebral hemorrhage, type II diabetes, and dysphagia.<br><br>On 03/18/25 Resident #44 weighed 228 pounds.<br><br>A nutrition/dietary note dated 03/20/25 at 11:33 A.M. revealed Resident #44 was ordered nothing by mouth and received enteral support as the sole source of nutrition. Resident #44 received Osmolite (therapeutic nutrition that provided complete and balanced nutrition for tube feeding (enteral nutrition) residents) 1.5 cal (caloric density of 1.5 calories per milliliter) at 80 milliliter per hour (ml/hr) for 20-hours a day with 300 ml water flushes every four hours. Resident #44's weight had been more stable since mid-December after Resident #44 was ordered nothing by mouth.<br><br>On 04/15/25 Resident #44 weighted 228 pounds.<br><br>Review of the medication administration record (MAR) revealed on 04/21/25 at 8:00 AM the Osmolite 1.5 was marked with the number 9 which indicated to see other/progress notes. The administration note dated 04/21/25 at 3:52 P.M. revealed Osmolite 1.5 was not available. Further review of the MAR and progress notes revealed no evidence of the Osmolite being administered at a later time on 04/21/25 or the physician or registered dietician being notified Osmolite was not available for Resident #44.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #44 had cognitive impairment and required a feeding tube.<br><br>An interview on 06/12/25 at 9:19 A.M. with Licensed Nursing Home Administrator (LNHA) verified the MAR was marked as the Osmolite was not administered. The LNHA stated she thought a case of Osmolite had been obtained from another facility around that time. The LNHA provided invoices for Osmolite. Review of invoice number (#)77582734 revealed Osmolite was ordered on 04/24/25 and delivered on 04/28/25. The LNHA stated an agency nurse had been working on 04/21/25 and multiple attempts had been made to contact the nurse to verify Osmolite had not been administered but the attempts were unsuccessful. Please note, the facility did not identify the agency nurse they had attempted to contact.<br><br>An interview on 06/12/25 at 2:24 P.M. with Registered Dietician (RD) #502 verified he was not notified Resident #44 did not receive Osmolite on 04/21/25.<br><br>On 06/12/25 at 3:27 P.M., the Director of Nursing (DON) contacted the surveyor and stated Licensed Practical Nurse (LPN) #155 had worked on 04/22/25 and reported that a new nurse (unidentified) worked 04/21/25 and was unable to find the Osmolite, but the Osmolite was available in the store room.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on 06/12/25 at 5:01 P.M. with LPN #155 revealed she had worked day shift on 04/22/25 and a new nurse (unidentified) had worked on 04/21/25. LPN #155 stated the new nurse could not find the Osmolite that was in the storage room but the Osmolite was available. LPN #155 stated she worked 04/22/25, 04/23/25, and 04/24/25 and noticed the Osmolite was almost gone on 04/24/25 so pharmacy drop shipped the Osmolite.<br><br>On 06/13/25 at 10:56 A.M. the DON notified the surveyor that it was not an agency nurse but according to the schedule facility nurse LPN #131 worked on 04/21/25. LPN #131 used an agency badge to log into the computer because she did not have a facility badge. The DON verified the documentation revealed Osmolite was not administered and there was no documentation of the physician or registered dietician being notified.<br><br>An interview on 06/13/25 at 11:07 A.M. with LPN #131 stated she was a facility nurse but used an agency nurse badge to log in to document in the electronic medical record on 04/21/25. LPN #131 stated she documented incorrectly and the Osmolite was administered to Resident #44. LPN #131 verified she had documented the Osmolite was not available and was not administered but was unable to say why there was no documentation in the medical record to support that the Osmolite was administered on 04/21/25.<br><br>Review of enteral tube feeding, continuous, gastrostomy and jejunostomy policy revised 11/18/24 revealed documentation associated with gastrostomy and jejunostomy continuous enteral tube feeding problems or complications include the name of the practitioner notified, date and time of the notification, prescribed interventions, and the response to those interventions.<br><br>2. Review of the medical record revealed Resident #60 was admitted on [DATE] and discharged to the hospital on [DATE] with diagnoses that included osteoarthritis of right knee, hypertension, type 2 diabetes, shortness of breath, seizures, major depressive disorder, neurocognitive disorder with Lewy Bodies, dementia, chronic obstructive pulmonary disease, and retention of urine.<br><br>Plan of care dated 03/21/25 revealed Resident #60 was at risk for malnutrition. Interventions included diet as ordered, monitor oral intake and document any negative findings, and monitor weight weekly for one month and then monthly.<br><br>An order dated 03/21/25 revealed Resident #60 was to be weighed weekly for four weeks on Mondays.<br><br>On 03/21/25 Resident #60 weighed 239 pounds.<br><br>The Medicare 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #60 was cognitively intact.<br><br>The medical record revealed no evidence of Resident #60 being weighed after 03/21/25.<br><br>An interview on 06/12/25 at 1:36 P.M. the DON verified Resident #60 was not weighed weekly as ordered.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The weight policy dated 12/02/21 revealed people will be weighed weekly for the first four weeks to establish a baseline weight. If weekly weights are requested, they will be done on a daily basis or weekly based on the day the initial weight was obtained. The weight will be recorded in the electronic medical record.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00164452. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, hospital record review, interview, and policy review, the facility failed to ensure medications were necessary prior to administration and were administered per orders, non-pharmalogical interventions were attempted prior to administration of as needed pain medication and residents did not experience adverse effects from prescribed medications that resulted in hospitalization. This affected one (Resident #60) of three residents reviewed for narcotic medication use. The facility census was 54.<br><br>Findings include:<br><br>Review of the hospital prescription (from the resident's hospitalization prior to admission to the facility) dated 03/19/25 revealed Resident #60 was ordered Dilaudid two milligram (mg) every four to six hours as needed for pain.<br><br>Review of the medical record revealed Resident #60 was admitted on [DATE] and discharged to the hospital on [DATE] with diagnoses that included osteoarthritis of right knee, hypertension, type 2 diabetes, shortness of breath, seizures, major depressive disorder, neurocognitive disorder with Lewy Bodies, dementia, chronic obstructive pulmonary disease, and retention of urine.<br><br>Review of physician orders revealed Resident #60 was ordered Flexeril (muscle relaxer), hydroxyzine (antihistamine) 25 mg at bedtime for itching, Buspar (antianxiety) five mg three times a day, Cymbalta (antidepressant) 20 mg twice a day, Dilaudid two mg give one mg every four hours as needed for pain from 03/21/25 through 03/25/25, pain monitoring included observe for pain. If pain was present, treat trying non-pharmacological interventions prior to medicating if appropriate, such as an ice pack, warm compress, repositioning, massage, distraction activity, and other. Document interventions in the progress note and document the number of interventions tried every shift. Resident #60 was also ordered Celebrex (nonsteroidal anti-inflammatory) 200 mg every 24 hours as needed for pain, Abilify (antipsychotic for major depressive disorder) two mg daily, Effexor (antidepressant) 225 mg at bedtime, and Trazodone (antidepressant) 250 mg at bedtime.<br><br>Review of the medication monitoring/control record revealed Resident #60 was ordered Dilaudid two mg by mouth every four to six hours as needed for pain.<br><br>The medication monitoring/control record revealed Resident #60 was administered Dilaudid two mg on:<br><br>03/22/25 at 2:00 P.M.<br><br>03/23/25 at 9:41 P.M.<br><br>03/24/25 at 10:00 A.M.<br><br>03/24/25 at (illegible time)<br><br>03/25/25 at 2:00 P.M.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366430 | A. Building<br>B. Wing | 06/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Otterbein Gahanna | 402 Liberty Way<br>Gahanna, OH 43230 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the medication administration record (MAR) revealed Resident #60 was ordered Dilaudid one mg every four hours as needed for pain from 03/21/25 to 03/25/25. The only documentation on the MAR for Dilaudid one mg being administered was on 03/23/25 at 9:41 P.M. for a seven out of ten (on a 0-10 pain scale with 0 indicating no pain and 10 indicating the worst pain the resident has felt) pain rating. The MAR revealed no documentation of Celebrex being administered from 03/22/25 to 04/01/25.<br><br>The Medicare 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #60 was cognitively intact. The MDS also revealed Resident #60 received antipsychotic, antianxiety, antidepressant, and opioid medications.<br><br>On 03/26/25 a new order was received to discontinue Resident #60's Dilaudid one mg every four hours as needed and to start Dilaudid two mg twice a day for pain.<br><br>The medication monitoring/control record revealed Resident #60 was administered Dilaudid two mg on 03/26/25 at 2:00 P.M. Resident #60 was administered Dilaudid two mg twice a day on 03/27/25 through 03/30/25.<br><br>The MAR revealed Resident #60 was administered Dilaudid two mg twice a day from 03/26/25 at 2:00 P.M. to 03/31/25 at 9:00 A.M. for zero out of ten pain.<br><br>A DON/Health Care Coordinator Note dated 03/31/25 at 4:40 P.M. revealed the DON and physician had an in-depth conversation with Resident #60's son-in-law. Resident #60's medications were reviewed and several medications were reduced in milligrams and some were discontinued. Resident #60 had increased lethargy and altered mental status. The physician explained that the amount of medication Resident #60 was on was not recommended. The physician wanted to decrease and discontinue medications.<br><br>Review of physician orders revealed Resident #60's Flexeril and Hydroxyzine were discontinued and Dilaudid 2 mg twice a day was decreased to Dilaudid one mg in the morning on 03/31/25.<br><br>On 04/01/25 Resident #60's Dilaudid two mg twice a day was discontinued and a new order was received for Dilaudid one mg every four hours as needed for pain.<br><br>A plan of care dated 04/01/25 revealed Resident #60 was at risk for acute/chronic pain. Interventions included to administer analgesia as ordered and a half an hour before treatments or care, monitor for side effects of pain medication, and monitor and report loss of appetite and weight loss.<br><br>A nursing note dated 04/01/25 at 9:00 P.M. revealed Resident #60's wife called and requested Resident #60 be sent to the emergency department because Resident #60 had not been feeling well all day. Resident #60 was alert to self and trying to get out of bed. Resident #60 had no facial expression of pain. A nursing note dated 04/01/25 at 9:45 P.M. revealed Resident #60's wife arrived at the facility to take Resident #60 to the hospital. Resident #60's wife stated Resident #60 looked dehydrated and his condition was getting worse. Resident #60's wife called 911 and had Resident #60 transported to the hospital at 10:43 P.M.<br><br>(continued on next page) |

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| | 366430 | A. Building<br>B. Wing | 06/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Otterbein Gahanna | 402 Liberty Way<br>Gahanna, OH 43230 |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the hospital records dated 04/02/25 revealed Resident #60 had a positive opioid screening. Resident #60 appeared delirious and had an altered mental status. Resident #60 had acute metabolic encephalopathy likely due to narcotic pain medication use. The plan was to hold Dilaudid and monitor resident. Buspar, Trazodone and Meclizine were to also be held. The initial testing was unrevealing, it was suspected that Dilaudid was causing worsening of mentation status. A hospital psychiatry consult note dated 04/08/25 revealed Resident #60 presented to the hospital with altered mental status. Over the past few days, Resident #60's mental status had improved. Resident #60 denied hallucinations today but stated he had visual hallucinations a few days ago. Resident #60 was oriented to person, place, month and only off two days of the exact date. The hospital Discharge summary dated [DATE] revealed Resident #60 had altered mental status that was probably related to polypharmacy. Trazodone, Buspar, Abilify, and Dilaudid were discontinued. Resident #60's pain was controlled with Tylenol (for mild pain) in the hospital. The discharge therapy notes revealed Resident #60 was able to complete range of motion and could tolerate the right knee range of motion to usually 90 degrees of flexion.<br><br>An interview on 06/04/25 at 1:55 P.M. with Physician #500 stated the Dilaudid Resident #60 received was just a drop in the bucket compared to the other medications Resident #60 took. Physician #500 stated the psychiatric medications had been ordered by a veterans administration doctor, so Physician #500 did not want to discontinue them. Resident #60 had pain with movement and Dilaudid was scheduled because Resident #60 did not ask for the pain medication.<br><br>An interview on 06/04/25 at 2:06 P.M. with the DON verified the order from the hospital was Dilaudid two mg as needed. The order was incorrectly entered by the nurse on 03/21/25 for Dilaudid two mg to give one milligram every four hours for pain. The DON stated the order should have continued to be Dilaudid two mg (however, the discrepancies with the order, the MAR and the controlled record were never clarified). The DON verified the only administration of the as needed Dilaudid from 03/22/25 to 03/25/25 documented on the MAR was on 03/23/25 at 9:41 P.M. The DON verified the medication monitoring/control record revealed Dilaudid two mg had been administered five times from 03/22/25 to 03/25/25 without documentation to support the resident was having pain. The DON also verified the pain monitoring documentation revealed Resident #60 had zero pain except on 03/23/25. The DON also verified there was no documentation of non-pharmalogical interventions being attempted before the administration of Dilaudid.<br><br>The Medication Administration policy revised 11/09/21 revealed prior to administration, the medication and dosage schedule on the MAR is compared with the medication label. If the label and the MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for correct dosage schedule.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00164452. |

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| | 366430 | A. Building<br>B. Wing | 06/13/2025 |

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| Otterbein Gahanna | 402 Liberty Way<br>Gahanna, OH 43230 |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the physician of laboratory results for Resident #60. This affected one (Resident #60) of three residents reviewed for laboratory results. The facility census was 54.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #60 was admitted on [DATE] and discharged to the hospital on [DATE] with diagnoses that included osteoarthritis of right knee, hypertension, type 2 diabetes, shortness of breath, seizures, major depressive disorder, neurocognitive disorder with Lewy Bodies, dementia, chronic obstructive pulmonary disease, and retention of urine.<br><br>The Medicare 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #60 was cognitively intact.<br><br>Review of laboratory results dated [DATE] revealed Resident #60's Blood Urea Nitrogen (BUN) was 33 milligram/deciliter (mg/dl), the normal range was 7-25 mg/dl. An elevated BUN could indicate kidneys not functioning properly or dehydration. Resident #60's carbon dioxide was 34 milliequivalent per liter (mEq/l), the normal range was 21-33 mEq/l. An elevated carbon dioxide level could indicate lung disease, sedative overdose, or certain infections. Resident #60's red blood count was 2.86 millions per cubic millimeter (m/cmm), the normal range was 4-6.6 m/cmm, hemoglobin was 8.6 grams per deciliter (g/dl), the normal range was 14-18 g/dl, and hematocrit was 26 percent, the normal range was 42-54 percent. Resident #60's sodium was 143 mEq/l which was within the normal range of 136-145 mEq/l.<br><br>A progress note dated 04/01/25 at 8:16 A.M. by Certified Nurse Practitioner (CNP) #505 revealed the nurse was advised to ensure all follow up was done and the specialist and CNP were notified of laboratory results. Resident #60 was ordered a complete blood count (CBC) and a basic metabolic panel (BMP) to establish a baseline and find any other cause that could contribute to Resident #60's weakness such as anemia or electrolyte imbalance. Laboratory results would be addressed and corrections made as needed.<br><br>An interview on 06/03/25 at 3:30 P.M. Director of Nursing verified the physician and/or CNP were not notified of Resident #60's laboratory results dated [DATE].<br><br>An interview on 06/04/25 at 1:55 P.M. Physician #500 verified he was not notified of Resident #60 laboratory results dated [DATE]. |