STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366433	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mapleview Country Villa	775 South Street Chardon, OH 44024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review and facility policy review, the facility failed to properly complete medication administration by leaving uncapped eye drops and nasal spray with pain relief gel at Resident #16's bedside and failed to administer medications to Resident #16 as ordered by the physician by error of omission or being late. This affected one resident (#16) of three residents reviewed for medication administration. The facility census was 81. Findings include: Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included spinal stenosis, restless legs syndrome, generalized anxiety disorder, gastro-esophageal reflux disease (GERD), radiculopathy, and chronic pain. The quarterly Minimum Data Set (MDS) assessment completed 09/25/24 indicated no cognitive impairment. Observation on 11/06/24 at 9:09 A.M. of Resident #16 in bed with a bedside table positioned across the bed within the resident's reach. On the table was a tube of Voltaren pain relief gel, a vial of uncapped artificial tears eye drops, and a vial of uncapped nasal saline spray. The bedside table was visibly soiled with food debris. Interview at the time of the observation with Resident #16 complained that the nurse left the medications there because he was eating breakfast and would return later to administer them. Resident #16 denied self-administering medications, and further complained there were times when his noon medication was given late, or some medications were not given at all. The nurse was not visible on the unit. Review of Resident #16's physician orders from October to November 2024 revealed artificial tears ophthalmic solution one percent, one drop in both eyes twice daily for dry eyes; sodium chloride nasal spray 0.65 percent, two sprays in both nostrils daily for dryness; and Voltaren external gel one percent to neck and shoulders topically three times daily for pain. There was no evidence of an order for self-administration of medications or to keep medications at bedside. Observation on 11/06/24 at 9:27 A.M. revealed Resident #16 had not changed position, and the uncapped eye drops and nasal spray with the tube of pain relief gel were still on the soiled bedside table within Resident #16's reach. Interview at the time of the observation with Resident #16 confirmed the nurse had not yet administered the medications. The nurse had returned but the resident told the nurse to forget it and give them around 11:30 A.M., but the nurse still left the medications on the bedside table. The nurse was not visible on the unit but was located on a nearby secured memory care unit administering medications. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/06/24 at 9:30 A.M. with Licensed Practical Nurse (LPN) #245 confirmed Resident #16's eye drops and nasal spray were left uncapped on the bedside table with the pain relief gel, stating the medication caps were kept in the medication drawer of the cart until given. LPN #245 described preparing Resident #16's medications, taking the caps off the eye drops and nasal spray, then carried them into the room, but the resident was busy eating breakfast. LPN #245 gave the oral medications and forgot to bring the eye drops, nasal spray, and pain relief gel back to the medication cart, leaving it on the soiled bedside table. LPN #245 indicated returning later but Resident #16 did not want the medications, so LPN #245 left them at the bedside and kept the medication caps in the medication cart drawer for later. Interview on 11/06/24 at 11:03 A.M. with Assistant Director of Nursing (ADON) #254 verified medications being administered should not be left at the bedside, and the protective caps on eye drops and nasal sprays should only be removed at the time of administration and replaced immediately to prevent infection. Further review of Resident #16's medical record revealed physician orders for omeprazole 40 milligrams (mg) daily for GERD, gabapentin 800 mg three times daily for nerve pain, hydroxyzine 25 mg four times daily for anxiety, and tramadol 50 mg every six hours for moderate to severe pain. The medication administration record (MAR) for October 2024 indicated omeprazole was not administered on 10/25/24 at 6:00 A.M.; gabapentin was not administered on 10/15/24 at 5:00 P.M.; hydroxyzine was not administered on 10/15/24 at 5:00 P.M. and at 9:00 P.M.; and tramadol was not administered on 10/15/24 at 6:00 P.M. and on 10/25/24 at 6:00 A.M. The MAR also showed a weekly course of antibiotic eye drops that were administered to Resident #16 for an eye infection initiated on 10/08/24. Review of the medication administration audit report from 10/01/24 to 11/06/24 for Resident #16 revealed the 12:00 P.M. (noon) doses of tramadol were given late on 10/03/24 at 3:08 P.M., on 10/09/24 at 1:26 P.M., on 10/25/24 at 1:50 P.M., on 10/27/24 at 1:29 P.M., on 10/28/24 at 1:40 P.M., on 11/02/24 at 1:35 P.M., and on 11/03/24 at 1:44 P.M. Review of Resident #16's nursing progress note dated 10/16/24 at 11:01 A.M. revealed a dose of tramadol was missed last night; however, the resident was stable and not in any current pain. Interview on 11/07/24 at 1:22 P.M. with ADON #254 confirmed all the medication administration findings listed above for Resident #16 being omitted or given late indicating medications were administered one hour prior to or after the scheduled administration time. Review of the facility policy, Specific Medication Administration Procedures - Nasal Administration, revised January 2018, revealed for administration, remove the cap and place it on the barrier or a clean dry surface. After administration, replace the cap/cover. Review of the facility policy, Specific Medication Administration Procedures - Eye Drop Administration, revised December 2019, revealed for administration, remove the cap, taking care to avoid touching the dropper tip and place the cap on the barrier or a clean, dry surface. After administration, recap the bottle. Review of the facility policy, Medication Storage in the Facility - Storage of Medications, revised January 2018, revealed except for medications requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart or other designated area. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Medication Storage in the Facility - Bedside Medication Storage, revised January 2018, revealed bedside medication storage is permitted for residents who wish to self-administer medications, and a written order for the bedside storage of medication placed in the medical record. Review of the facility policy, Specific Medication Administration Procedures - Administration Procedures for All Medications, revised January 2018, revealed after administration of a medication, return it to the cart and document administration in the medication or treatment administration record. This deficiency represents non-compliance investigated under Master Complaint Number OH00158519.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review, and facility policy review, the facility failed to properly store medications by leaving eye drops, nasal spray, and pain relief gel at the bedside for later administration when Resident #16 did not participate in or have an order for self-medication administration. This affected one resident (#16) of three residents reviewed for medication administration. The facility census was 81. Findings include: Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included spinal stenosis, restless legs syndrome, generalized anxiety disorder, gastro-esophageal reflux disease (GERD), radiculopathy, and chronic pain. The quarterly Minimum Data Set (MDS) assessment completed 09/25/24 indicated no cognitive impairment. Observation on 11/06/24 at 9:09 A.M. of Resident #16 in bed with a bedside table positioned across the bed within the resident's reach. On the table was a tube of Voltaren pain relief gel, a vial of uncapped artificial tears eye drops, and a vial of uncapped nasal saline spray. The bedside table was visibly soiled with food debris. Interview at the time of the observation with Resident #16 complained that the nurse had left the medications there because he was eating breakfast and would return later to administer them. Resident #16 denied self-administering medications. The nurse was not visible on the unit. Review of Resident #16's physician orders from October to November 2024 revealed artificial tears ophthalmic solution one percent, one drop in both eyes twice daily for dry eyes; sodium chloride nasal spray 0.65 percent, two sprays in both nostrils daily for dryness; and Voltaren external gel one percent to neck and shoulders topically three times daily for pain. There was no evidence of an order for self-administration of medications or to keep medications at bedside. Observation on 11/06/24 at 9:27 A.M. revealed Resident #16 had not changed position, and the uncapped eye drops and nasal spray, and the tube of pain relief gel were still on the soiled bedside table within Resident #16's reach. Interview at the time of the observation with Resident #16 confirmed the nurse had not yet administered the medications. The nurse had returned but the resident told the nurse to forget it and give them around 11:30 A.M., but the nurse still left the medications on the bedside table. The nurse was not visible on the unit but was located on a nearby secured memory care unit administering medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/06/24 at 9:30 A.M. with Licensed Practical Nurse (LPN) #245 confirmed Resident #16's eye drops and nasal spray were left uncapped on the bedside table with the pain relief gel, stating the medication caps were kept in the medication drawer of the cart until given. LPN #245 described preparing Resident #16's medications, taking the caps off the eye drops and nasal spray, then carried them into the room but the resident was busy eating breakfast. LPN #245 gave the oral medications and forgot to bring the eye drops, nasal spray, and pain relief gel back to the medication cart, leaving them on the bedside table. LPN #245 indicated returning later, but Resident #16 did not want the medications, so LPN #245 left them at the bedside and kept the medication caps in the medication cart drawer for later. Interview on 11/06/24 at 11:03 A.M. with Assistant Director of Nursing (ADON) #254 verified medications being administered should not be left at the bedside, and the protective caps on eye drops and nasal sprays should only be removed at the time of administration and replaced immediately to prevent infection. Further review of Resident #16's medical record revealed the medication administration record for October 2024 indicated a weekly course of antibiotic eye drops were administered to Resident #16 for an eye infection initiated on 10/08/24. Review of the facility policy, Specific Medication Administration Procedures - Nasal Administration, revised January 2018, revealed for administration, remove the cap and place it on the barrier or a clean dry surface. After administration, replace the cap/cover. Review of the facility policy, Specific Medication Administration Procedures - Eye Drop Administration, revised December 2019, revealed for administration, remove the cap, taking care to avoid touching the dropper tip and place the cap on the barrier or a clean, dry surface. After administration, recap the bottle. Review of the facility policy, Medication Storage in the Facility - Storage of Medications, revised January 2018, revealed except for medications requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart or other designated area. Review of the facility policy, Medication Storage in the Facility - Bedside Medication Storage, revised January 2018, revealed bedside medication storage is permitted for residents who wish to self-administer medications, and a written order for the bedside storage of medication placed in the medical record. This deficiency represents non-compliance investigated under Master Complaint Number OH00158519.