STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366461	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wooded Glen	2900 Bechtle Avenue Springfield, OH 45504

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 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** 46613 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed ensure proper labeling of insulin vials. This affected one (Resident #33) resident of three reviewed for medication administration. The facility census was 50 residents. Findings include: Review of the medical record for Resident #33 revealed an admitted [DATE] with medical diagnoses including pancreatitis, diabetes mellitus, disorder of the thyroid, osteoarthritis, and asthma. Review of the admission Minimum Data Set (MDS) assessment for Resident #33 dated [DATE] revealed the resident had moderate cognitive impairment and required supervision and staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #33 revealed an order dated [DATE] for Humalog (insulin) inject 15 units subcutaneously three times per day. Observation on [DATE] at 7:56 A.M. revealed Licensed Practical Nurse (LPN) #209 prepared the Humalog injection for Resident #33. Neither the box containing the vial of insulin nor the vial itself were dated upon opening. LPN #209 drew up 15 units of Humalog and subcutaneously injected the insulin into Resident #33's right upper arm. Interview on [DATE] at 8:04 A.M. with LPN #209 confirmed Resident #33's insulin had not been dated upon opening and she was unsure if it had expired or not. LPN #209 further confirmed insulin should be dated upon opening. Review of the facility policy titled Medication Storage revised [DATE] revealed medications and biologicals should be stored safely, securely, following manufacturer's recommendations or those of the supplier. Multiple dose injectable vials, once opened, need an expiration date shorter than the manufacturer's expiration date to insure medication's purity and potency. When the original seal of a manufacturer's container or vial that requires a shorter expiration is initially broken, the vial should be dated with a dated. A date opened sticker should be placed on these mediations and nurses should check the expiration date of each medication before administering it. No expired mediations should be administered to the resident.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366461	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wooded Glen	2900 Bechtle Avenue Springfield, OH 45504

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to follow proper infection control practices during medication administration. This affected one (Resident #25) of the three residents reviewed for medication administration. The facility census was 50 residents. Findings include: Review of the medical record for Resident #25 revealed an admitted [DATE] with diagnoses of sepsis, clostridium difficile, colitis, hypertensive heart disease, and congestive heart failure. Review of the admission Minimum Data Set (MDS) assessment for Resident #25 dated 07/22/24 revealed the resident was cognitively intact and required staff assistance with activities of daily living. Review of the physician's orders for Resident #25 revealed an order dated 08/12/24 for hydralazine 10 milligram (mg) one tablet by mouth four times per day. Observation on 08/15/24 at 8:12 A.M. revealed Registered Nurse (RN) #208 prepared Resident #25's medications for administration. RN #208 dropped Resident #25's hydralazine 10 mg tablet on the top of the medication cart, picked the tablet up with her bare hands and placed the tablet into the pill cup. RN #208 administered medications from the pill cup to Resident #25 which included the hydralazine tablet. RN #208 did not perform hand hygiene at any time during the observation. Interview on 08/15/24 at 8:20 A.M. with RN #208 confirmed she touched Resident #25's hydralazine tablet with her bare hands and then administered the medication to the resident. RN #208 further confirmed she had not performed hand hygiene prior to, during, or after medication administration to Resident #25. Review of the facility policy titled Medication Administration revised November 2018 revealed hand hygiene should be performed before beginning of med pass, prior to handling any medications, after coming into direct contract with a resident, and before and after gastroenteric tube medication administration. Policy stated staff are to perform appropriate hand hygiene prior to handling tablets and examination gloves must be worn to prevent touching of tablets during the process.