

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Wooded Glen		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to ensure residents were free from significant medication errors. This affected two (Residents #40 and #197) of eight residents reviewed for medications administration. The facility census was 50.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #197 revealed an admitted [DATE] with diagnoses including orthostatic hypotension, methicillin-resistant staphylococcus aureus (MRSA) bacteremia, persistent postprocedural fistula, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of the admission assessment for Resident #197 dated 06/08/24 revealed the resident was cognitively intact, had a current infection, and received an intravenous (IV) medication.</p> <p>Review of the hospital discharge summary for Resident #197 dated 06/08/24 revealed an order for daptomycin (an antibiotic) IV 940 milligrams (mg) daily for six weeks.</p> <p>Review of the June 2024 monthly physician orders for Resident #197 revealed a physician order dated 06/10/24 for daptomycin 940 mg IV daily.</p> <p>Review of the Medication Administration Record (MAR) for Resident #197 dated June 2024 revealed daptomycin IV was administered as ordered starting on 06/10/24. The medication was not administered on 06/08/24 or 06/09/24.</p> <p>Interview on 06/10/24 at 10:09 A.M. with Resident #197 confirmed he admitted to the facility on [DATE] and was supposed to receive IV medication daily for an infection, but he hadn't received any medication through his peripherally inserted central catheter (PICC) since he left the hospital.</p> <p>Interview on 06/12/24 at 9:33 A.M. with DON confirmed the hospital discharge summary dated 06/08/24 included an order for daptomycin 940 mg IV daily. The DON confirmed the facility did not order or administer the medication until 06/10/24 which was an error of omission for daptomycin on 06/08/24 and 06/09/24.</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
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/12/24 at 9:37 A.M. with Licensed Practical Nurse (LPN) #127 confirmed she was notified per verbal report from night shift nurse on the morning of 06/10/24 that Resident #197 was supposed to receive an IV antibiotic but did not see an order for the medication. LPN #127 stated she reviewed Resident #197's medical record and saw the order for daptomycin in the hospital discharge summary, entered the ordered into the electronic medical record, and ordered the medication from the pharmacy. LPN #127 confirmed she administered the daptomycin 940 mg IV to Resident #197 via PICC line on 06/10/24 as ordered.</p> <p>2. Review of the medical record for Resident #04 revealed an admitted [DATE] with diagnoses including hypertensive heart disease, congestive heart failure, chronic respiratory failure, COPD, and diabetes mellitus.</p> <p>Review of the annual Minimum Data Set (MDS) assessment for Resident #04 dated 03/06/24 revealed the resident was cognitively intact and required staff assistance with bathing and toilet hygiene and supervision with bed mobility and transfers.</p> <p>Review of the progress note for Resident #04 dated 12/07/23 timed at 3:04 P.M. per the nurse practitioner (NP) revealed Aldactone (a diuretic medication) should be discontinued due to hyperkalemia (a high level of potassium in the blood.).</p> <p>Review of the pharmacy recommendation for Resident #04 dated 12/15/24 revealed the NP progress note dated 12/07/24 stated the Aldactone should be discontinued but the resident was still receiving the medication. The pharmacy recommendation was for staff to clarify the order.</p> <p>Review of the physician's orders for Resident #04 revealed an order dated 12/20/24 to discontinue Aldactone.</p> <p>physician order dated 09/23/23 for Aldactone 25 milligram (mg) by mouth one tab daily. Review of a physician order dated 12/20/23 revealed the Aldactone was discontinued.</p> <p>Review of the MAR for Resident #04 dated December 2023 revealed the received Aldactone by mouth daily until 12/20/24.</p> <p>Interview on 06/13/24 at 9:15 A.M. with the Director of Nursing (DON) confirmed the NP intended for the staff to discontinue Resident #04's Aldactone on 12/07/24, but it was not discontinued until 12/20/24. The medication was administered in error from 12/07/24 to 12/20/24.</p> <p>Review of the facility policy titled Medication Administration revised November 2018 revealed medications were to be administered in accordance with the written orders of the prescriber.</p>		