STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366464	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs of Lima The	370 North Eastown Road Lima, OH 45807

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34745 Based on medical record review and staff interview, the facility failed to ensure a care plan was initiated to address care and services for a resident with a respiratory infection. This affected one (#15) of three reviewed for respiratory infections. The census was 55. Findings included : Review of the medical record for Resident #15 revealed an admitted [DATE]. The resident was admitted with diagnoses including rhabdomyolysis and pulmonary fibrosis. The resident was discharged on [DATE]. Review of a chest x-ray image for Resident #15 dated 06/04/24 revealed there were bilateral opacities which may represent multifocal infectious process, to include viral agent with out pleural effusion. Review of physician orders for Resident #15 revealed an order dated 06/05/24 for the antibiotic Zithromax (azithromycin) 500 milligrams (mg) to give one tablet orally with special instructions give for three days and once a day. Review of Resident # 15's care plan revealed there was no care plan initiated to include care and services, with measurable objectives, for the treatment of the resident's respiratory infection. Interview with Regional Nurse #600 on 08/15/24 at 1:30 P.M. verified there was not a care plan initiated for Resident #15's respiratory infection which occurred on 06/04/24. This deficiency represents an incidental finding discovered during investigation of Complaint Number OH00156307.

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
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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34745 Based on medical record review and staff interview, the facility failed to ensure care and treatment of a resident's colostomy was provided. This affected one (#16) of one resident reviewed for colostomy care. The census was 55. Findings included: Review of the medical record for Resident #16 revealed an admitted [DATE]. The resident was admitted with a diagnosis including the encounter for attention to a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall). The resident was discharged on [DATE]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was assessed with intact cognition and an ostomy. Review of Resident #16's admission physician orders from 04/19/24 were absent for care of the colostomy. Further review revealed orders for care and treatment of the colostomy were not initiated until 05/24/24 which included to burp and empty the colostomy bag and wafer every three days and as needed when soiled and dislodged. On 05/26/24, Resident #16 received an order for staff to apply Adapt stoma powder topically with special instructions to use as needed on the skin around the stoma when the colostomy bag was changed. There was no evidence of care or treatment to Resident #16's colostomy until the initiation of the orders. Interview with Regional Nurse #600 on 08/15/24 at 1:30 P.M. verified Resident #16 did not have orders for care and services of the colostomy until 05/24/24 and there was lack of documentation of colostomy care in the medical record. This deficiency represents non-compliance investigated under Complaint Number OH00156307.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34745 Based on observation, medical record review, resident and staff interview, and review of a facility policy, the facility failed to ensure medications were taken by the resident when administered and administered as ordered. This one (#13) of three residents reviewed for medications. The census was 55. Findings included: Review of Resident #13's medical record revealed an admitted [DATE]. Diagnoses included acute kidney failure, syncope and collapse, orthostatic hypotension, congestive heart failure, and anemia. Review of Resident #13's admission physician orders from 08/09/24 revealed the resident was ordered the stool softeners Colace 100 milligrams (mg) and Citrucel one tablet by mouth, the antidepressant fluoxetine 40 mg by mouth, the pain medication gabapentin 600 mg two tablets by mouth, a probiotic tablet by mouth, the vitamin Foltx 2.6/25/2 mg one tablet by mouth, the pain medications Mobic 7.5 mg one tablet by mouth and tramadol 50 mg one tablet by mouth, the blood pressure medication metoprolol 25 mg one tablet by mouth, and the medication to treat an overactive bladder oxybutynin 10 mg one tablet by mouth. Further review of the physician order for gabapentin 600 mg two tablets by mouth revealed the order was discontinued on 08/12/24. Observation on 08/14/24 at 9:48 A.M. revealed on Resident #13's bedside table was a medication cup filled with medications. Further observation revealed no staff members in Resident #13's room. Interview with Resident #13 on 08/14/24 at 9:48 A.M. verified the nurse gave the resident the medication to be taken with his meal and the nurse had left them on the bedside table. Resident #13 stated he had dropped the medications on the floor and the person who brought the breakfast tray in picked them up and placed them back into the cup. Interview with License Practical Nurse (LPN) #200 on 08/14/24 at 9:51 A.M. verified she left the medications on the bedside for Resident # 13 so the resident could take the medication with breakfast. LPN #200 stated she administered 11 tablets to Resident #13 including one Colace 100 mg tablet, one Citrucel tablet, one fluoxetine 40 mg tablet, two gabapentin 600 mg tablets, one probiotic tablet, one Foltx 2.6/25/2 mg tablet, one Mobic 7.5 mg tablet, one tramadol 50 mg tablet, one metoprolol 25 mg tablet, and one oxybutynin 10 mg tablet. Interview with Regional Nurse #600 on 08/14/24 at 3:00 P.M. verified LPN #200 administered Resident #13 the resident gabapentin 600 mg in error due the medication being discontinued on 08/12/24. Review of the facility policy titled, Medication Administration - General Guidelines, revised January 2018, revealed medications are administered in accordance with written orders of the prescriber. The resident is always observed after administration to ensure that the dose was complete ingested. This deficiency represents an incidental finding discovered during investigation of Complaint Number OH00156307.