STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366468	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vancrest of Payne	650 North Main Street Payne, OH 45880

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on medical record review, staff interview, physician interview, and review of medication information from Medscape, the facility failed to administer seizure medications for a resident who was admitted to the facility from the hospital with a new onset of seizure disorder resulting in significant medication errors. This affected one (Resident #30) of three residents reviewed for medication administration. The facility census was 29. Findings include: Review of the medical record of Resident #30 revealed an admitted [DATE], a transfer to the hospital on 09/25/24 and then discharged home on 09/25/2024, with a return to the facility on [DATE] after retruning to the hosptial on 09/29/2024. Diagnoses included unspecified convulsions, Parkinson's disease with dyskinesia without mention of fluctuations, repeated falls, wedge compression fracture of T5-T6 vertebra (on admission), and type II diabetes mellitus. Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #30 was cognitively intact and required supervision assistance for toileting, bathing, and dressing. Review of the progress note dated 09/25/24 at 8:21 A.M. LPN #100 documented Resident #30 was nonresponsive and shaking all over with seizure-like activity. Resident #30 was sent to the emergency room . Further review of the medical record revealed Resident #30 returned to the facility from the hospital on 10/10/24 at approximately 4:15 P.M. with a new diagnosis of new onset seizures. Review of the hospital discharge paperwork dated 10/10/24 revealed new orders for Keppra (anticonvulsant medication) 1000 milligrams by mouth twice daily for convulsions and Vimpat (anticonvulsant medication) 100 mg by mouth twice daily for convulsions. Review of the document titled, Electronically Transmitted Prescription, dated 10/10/24 at 8:19 P.M. revealed the pharmacy was advised of the admission medications for Resident #30. The form did not indicate if the medications were ordered as stat. Review of the Medication Administration Record (MAR) revealed the Keppra and Vimpat were not administered on 10/10/24. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed no documentation the physician was notified Keppra and Vimpat were not administered. Review of the progress note dated 10/10/24 at 11:23 P.M. documented by Licensed Practical Nurse (LPN) #106, revealed Resident #30 was alert and oriented to person, place, time, and event, pleasant and cooperative. Her speech was clear. Focal seizure-like activity had been noted during supper lasting 10 minutes. Seizure precautions were in place and Resident #30 had been able to answer questions during the active episode. Blood pressure, heart rate, and respiratory rate were within normal limits. Resident #30 remained continent of bowel and bladder with minimal intermittent urinary incontinence. The documentation is absent of any family or physician notification. Review of the progress note dated 10/11/24 at 9:01 A.M. documented by Registered Nurse (RN) #128, revealed the nurse was alerted to Resident #30's room by son-in-law. Upon entry to the room, RN #128 noted Resident #30 lying in bed, her body was shaking, her eyes were fixed open and pupils dilated. Resident #30 was not responsive to verbal or tactile stimuli. Resident #30's respirations varied but the partial oxygen saturation remained between 89 to 97% (percent) on room air. The episode occurred for an extended period with the convulsions slowly subsiding. The Director of Nursing (DON) arrived at the room and the son-in-law refused to have Resident #30 transported to the emergency room stating ,what good would it do? She will end back up in a larger hospital and she does not want to be there. The DON notified the physician of the interaction. Review of the progress note at 9:45 A.M., documented by RN #166, revealed a late entry: received orders from Nurse Practitioner to administer two mg of Ativan twice to help control the seizures and a one time dose to administer Keppra 1000 mg liquid orally. A progress note, on 10/11/24 at 4:21 P.M. documented by RN #128 revealed an order to begin Diastat (anticonvulsant) rectally as needed. Review of the MAR revealed Levetiracetam (Keppra) 100 mg per milliliters (ml), 10 ml was administered 10/11/24 at 9:34 A.M. Review of the pharmacy, Delivery Sheet, dated 10/11/24 and time stamped 12:22 P.M. revealed six tablets of Keppra 1000 mg was delivered, along with 11 other medications for Resident #30. Interview on 10/22/24 at 8:40 A.M. with the Director of Nursing (DON) revealed Resident #30 arrived at the facility on 10/10/24 at a little after 4:00 P.M. without the transferring hospital having given any report. The facility did not have some of her medications. Interview on 10/22/24 at 3:00 P.M. with Pharmacist #500 revealed medications were delivered on 10/11/24 between 1:00 P.M. and 1:30 P.M. which included Keppra 1000 mg six tablets, among others. Interview on 10/31/24 at 9:34 A.M. with LPN #101 revealed she had been on duty when Resident #30 arrived back to the facility from the hospital on 10/10/24. LPN #101 stated she had put the medication orders into the computer. She stated she normally will also print out a copy of the orders and fax them to the pharmacy but could not be certain she had done that. The facility does not keep a record of fax transactions. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 10/31/24 at 9:39 A.M. with Certified Nurse Practitioner (CNP) #500 revealed she had not been contacted related to the unavailability of the Keppra and Vimpat. CNP #500 stated if she would have been notified, she would have called the pharmacy herself or called a local pharmacy to have an emergency supply drop shipped and also given an order for an as needed medication the facility does have in the emergency box. She further reported having been called on 10/11/24 of the active seizure occurring and had given the Ativan order and added the Diastat order. CNP #500 stated she had attempted to have Resident #30 returned to the hospital numerous times and the family refused. Interview on 10/31/24 at 10:30 A.M. with the DON revealed the Keppra liquid was borrowed from another resident. Telephone interview on 10/31/24 at 11:02 A.M. with RN #128 revealed she guessed Resident #30's seizure began on 10/11/24 a little after 8:00 A.M. RN #128 stated she remained with Resident #30 for the duration and had sent a State tested Nursing Assistant (STNA) to get another nurse. RN #128 stated the DON came and assisted and got the order for the Ativan. Interview on 10/31/24 at 11:54 A.M. with the DON revealed there was no documentation in the medical record indicating the physician was made aware of Keppra and Vimpat not being available for Resident #30. The DON further verified the medications were not administered timely. Review of medication information from Medscape at https://reference.medscape.com/drug/keppra-spritam-levetiracetam-343013#91 revealed Vimpat and Keppra are used for seizure disorder. Further review revealed, Do not stop taking this medication without consulting your doctor. Your seizures may become worse when the drug is suddenly stopped. This deficiency represents non-compliance investigated under Complaint Number OH00159061.