| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366474 | A. Building<br>B. Wing | 06/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Violet Springs Health Campus | 603 Diley Road<br>Pickerington, OH 43147 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, hospital record review, review of an Emergency Medical Services (EMS) run report, staff interview, and facility policy review, the facility failed to timely and adequately identify an acute change in medical condition resulting in a delay in medical intervention/hospital care for Resident #54 resulting in the resident being found unresponsive and requiring cardiopulmonary resuscitation (CPR).<br><br>Actual harm occurred beginning during the night shift on [DATE] when staff failed to identify an acute change in Resident #54's condition to ensure timely and adequate medical intervention was provided. At 6:00 A.M. Resident #54 sustained an unwitnessed fall. Resident #54 had an emesis (vomiting) and voiced complaints of not feeling well. The resident did not consume any breakfast and continued vomiting. At approximately 8:00 A.M., Certified Nurse Practitioner (CNP) #521 ordered intravenous (IV) fluids to be given to the resident; however, the IV fluids were not initiated until approximately 4:20 P.M. The resident was assessed to be hypotensive (low blood pressure) at 8:48 A.M. (91/51), 11:57 A.M. (95/62), 1:04 P.M. (90/58), and 4:55 P.M. (92/70). The resident did not consume lunch and continued vomiting at approximately 4:20 P.M. On [DATE] at 5:20 P.M., Resident #54 was found unresponsive and required cardiopulmonary resuscitation (CPR). Emergency Medical Services were called at that time, and the resident was subsequently transported to the emergency room. This affected one resident (#54) of three residents reviewed for change in condition. The facility census was 52.<br><br>Findings include:<br><br>Review of Resident #54's closed medical record revealed an admission date [DATE] with diagnoses including acute respiratory failure, congestive heart failure (CHF), high blood pressure, cardiomegaly, atrial fibrillation, and history of hemorrhagic stroke. Record review revealed the resident was admitted for short term rehabilitation (therapy services) following a stroke with a goal to discharge to home. Resident #54 was transferred to the hospital on [DATE] and did not return to the facility.<br><br>Review of Resident #54's physician (admission) orders revealed an order dated [DATE] for advance directives indicating the resident was a Full Code (a medical directive that instructs healthcare providers to perform all possible life-saving measures in the event of a medical emergency, such as cardiac or respiratory arrest), Torsemide 20 milligrams (mg) (a diuretic medication used to to treat blood pressure, heart, and kidney conditions by increasing elimination of water, sodium, and potassium and resulting in increased urination) twice a day, an order to obtain daily weight related to CHF, and Metoprolol 50 mg (a beta blocker medication used to treat a variety of heart and blood pressure conditions) to be given two times per day. There were no parameters with the orders for the medications to be held.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident #54's physician orders dated [DATE] revealed orders for 2000 milliliters (ml) fluid restriction for 360 ml (12 ounces (oz) or 1.5 cups) three times per day (per meal) from dietary, 360 ml (12 oz) day shift from nursing, 360 ml (12 oz) evening shift from nursing, and 200 ml (6.8 oz) night shift from nursing to equal 2000 ml, an order dated [DATE] for Zofran (an antiemetic) 4 mg as needed with instructions to give one tablet every six hours as needed for nausea and/or vomiting, and an order dated [DATE] for continuous oxygen at two liters via nasal cannula. There was no documented evidence of an order for an Ensure nutritional drink.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 required (staff) assistance for transfers, ambulation, and personal hygiene tasks and was independent with eating. The MDS revealed the resident had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 9 out of 15.<br><br>Review of Resident #54's physician orders revealed on [DATE] an order was obtained for Torsemide 20 mg with instructions to administer an extra 20 mg dose in the morning if weight gain for two days, as needed and on [DATE] an order was obtained for Torsemide 20 mg with instructions to administer 40 mg daily for CHF.<br><br>Review of Resident #54's plan of care dated [DATE] revealed Resident #54 had potential for cardiovascular distress related to congestive heart failure, high blood pressure, and arterial fibrillation with interventions including, but not limited to, administer oxygen per physician orders, obtain laboratory testing as ordered and report results to the physician, administer medications as ordered, and observe for signs and symptoms of cardiovascular distress and report as needed.<br><br>Review of Resident #54's blood pressure vital signs from [DATE] through [DATE] revealed abnormal ranges on [DATE] at 9:38 P.M. (81/55), [DATE] at 8:48 A.M. (96/60), [DATE] at 5:53 P.M. (99/60), [DATE] at 9:12 A. M. (97/61), and [DATE] at 8:09 P.M. (96/58).<br><br>Review of Resident #54's physician orders dated [DATE] revealed an order was obtained for the diuretic medication, Torsemide 40 milligrams twice a day related to increased daily weight and increased edema.<br><br>Review of the skilled nursing progress note dated [DATE] revealed Resident #54 was alert and oriented and able to make needs known. Resident #54 had bilateral lower extremity weakness, her lung sounds were clear and regular, with a steady and regular heart rate. There was no edema observed to the resident's lower extremities.<br><br>Review of Resident #54's laboratory results dated [DATE] revealed abnormal results of blood urea nitrogen (BUN) 25 milligrams per deciliter (mg/dL) (normal levels 6 - 21 mg/dL) (an elevated level could indicate kidney issues or dehydration), white blood count (WBC) 13.42 microliters (uL) (normal levels 3.40 - 10.80 uL) (an elevated value could indicate infection), hemoglobin 10.40 grams per deciliter (g/dL) (normal levels 12.3 - 15.3) and hematocrit 33.4 percent (%) (normal levels 34% - 46.6%), and creatinine 1.6 mg/dL (normal levels 0.5 - 0.9). The resident's sodium 137 milliequivalents per liter (mEq/L) (normal levels 136 - 145) and potassium 3.6 mEq/L (normal levels 3.5 - 5.1) levels were normal.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident #54's nursing progress note dated [DATE] at 6:00 A.M. revealed the resident was observed lying on the floor on her right side with her feet facing the recliner. Resident #54 attempted to self-transfer from the recliner. Resident #54 was educated on using the call light for assistance with transfers.<br><br>Review of Resident #54's fall investigation, dated [DATE], revealed the resident attempted to transfer independently, but could not due to having a history of a stroke and the resident required assistance with activities of daily living. The investigation noted that the resident did not strike her head during the fall on [DATE], but that the resident was more confused. did not feel well, and had several episodes of emesis noted during the day.<br><br>Review of Resident #54's abnormal vital signs dated [DATE] at 7:53 A.M., revealed her pulse was 92 beats per minute (bpm); At 7:56 A.M. her pulse was 70 bpm and her oxygen saturation (SpO2) was 90% on two liters of oxygen via nasal cannula. At 8:48 A.M. her blood pressure was 91/51; And at 8:50 A.M. her blood pressure was 98/60.<br><br>Review of Resident #54's [DATE] Medication Administration Record (MAR) revealed on [DATE] during the morning medication administration, Resident #54 received the following medications: Folic Acid 1 mg, Jardiance 10 mg, Lantus insulin 22 units, Sennosides-docusate sodium tablet 8.6-50 mg, Metoprolol 50 mg (her blood pressure read 103/71), Miralax 17 grams, potassium chloride 20 milliequivalents (mEq), and Torsemide 40 mg. The exact time of the medication administration was not available for review.<br><br>Review of Resident #54's meal/fluid intakes from [DATE] revealed Resident #54 ate 76% to 100% of most meals and drank 360 ml of fluids per meal. The meal/fluid intakes for [DATE] revealed the resident did not eat breakfast or lunch and she drank a total of 360 ml of fluids (Ensure nutritional drink).<br><br>Review of Resident #54's progress note dated [DATE] at 9:57 A.M. authored by CNP #521 revealed Resident #54 was assessed by CNP #521 at 8:00 A.M. related to a vomiting episode the morning of [DATE]. CNP #521 noted Resident #54's recent laboratory results, her WBC and BUN were elevated. CNP #521 ordered a chest x-ray to be obtained and gave an order for sodium chloride 0.9% parenteral solution 500 milliliters (ml) via intravenous route (IV) with instructions for the fluids to be administered 100 ml per hour for kidney protection and potential dehydration related to vomiting and the use of a diuretic medication.<br><br>Review of Resident #54's abnormal vital signs dated [DATE] at 11:57 A.M. revealed her blood pressure was 95/62 and at 1:04 P.M. her blood pressure was 90/58.<br><br>Review of Resident #54's evaluation/event form dated [DATE] at 1:12 P.M. authored by Licensed Practical Nurse (LPN) #240 revealed Resident #54 had an episode of vomiting on [DATE] at 8:00 A.M. following the administration of Resident #54's morning medications and after the resident consumed 240 ml of a clear Ensure supplement drink related to Resident #54 not eating the breakfast meal due to not feeling well. LPN #240 notified CNP #521 and requested Resident #54 to be assessed and for the CNP to review the recent laboratory results dated [DATE]. LPN #240 administered Zofran four mg disintegrating tablet with effective results noted.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident #54's evaluation/event form dated [DATE] at 6:15 P.M. revealed Resident #54 had another vomiting episode on [DATE] at approximately 4:00 P.M. LPN #240 notified CNP #521 of Resident #54's second episode of vomiting and Resident #54's lack of eating breakfast and lunch meals related to not feeling well. There were no new orders received, and Zofran was not recorded as administered following the vomiting episode.<br><br>Review of Resident #54's physician orders revealed orders dated [DATE] at 4:20 P.M. for sodium chloride 0. 9% parental solution 500 milliliters (ml) via IV to be administered 100 ml per hour which had initially been ordered on [DATE] at 8:00 A.M. There was no documented evidence of an order for a urinalysis to be completed.<br><br>Review of Resident #54's abnormal vital signs dated [DATE] at 4:55 P.M. revealed her blood pressure was 92/70.<br><br>Review of Resident #54's progress note dated [DATE] at 6:40 P.M. authored by LPN #240 revealed Resident #54's chest x-ray results were pending and sodium chloride 0.9% parental solution 500 milliliters (ml) via IV to be administered 100 ml per hour was initiated. Resident #54 was observed breathing heavily and then stopped breathing. LPN #240 attempted to arouse Resident #54 and checked for vital signs. Resident #54 did not respond, and CPR was initiated. Emergency Medical Services (EMS) were called and arrived at the facility, assessed Resident #54, noted there was a pulse, and EMS then transported Resident #54 to the emergency room. Resident #54's family and CNP #521 were notified.<br><br>Review of the EMS run report for Resident #54 dated [DATE] at 5:33 P.M. revealed upon arrival to the facility, facility staff were performing CPR, there was a pulse obtained on the resident, and Resident #54 was transported to the hospital. While enroute, Resident #54 required CPR again, with CPR continuing upon arrival to the emergency department.<br><br>Review of the hospital paperwork for Resident #54 dated [DATE] at 5:50 P.M. revealed Resident #54 arrived at the hospital at 5:47 P.M. with CPR initiated at 5:50 P.M. and continuing until 6:26 P.M. when Resident #54 was pronounced deceased .<br><br>Review of Resident #54's chest x-ray results, dated [DATE] and fax timed 11:31 P.M. [obtained by the facility after the resident expired], revealed the chest x-ray was ordered due to an elevated WBC count. Cardiomegaly was identified as well as opacities in the right lung bases which may have been due to atelectasis or pneumonia.<br><br>Following the resident's transfer to the hospital, the facility completed an investigation (due to the resident being found unresponsive and subsequently passing away). The investigation information consisted of a review of the resident's vital signs, witness statements, laboratory results, nurse notes, physician progress notes, and resident demographics.<br><br>Review of the statement from the Executive Director, dated [DATE], revealed the county Coroner contacted the facility and asked basic questions concerning Resident #54's fall and how the resident was prior to the code. The Coroner stated he had no concerns with the fall contributing to her death. He stated he felt the cause of death was related to the resident's heart issues. He stated he was not looking into it any further and was submitting the death certificate to be signed.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the statement from Certified Resident Care Assistant (CRCA) #517, dated [DATE], revealed the CRCA had arrived in the morning and was informed by the night shift nurse that the resident had been passing emesis at night and that she should keep an eye on her. The statement included when the CRCA went in to check on her, the first thing she said was that she wasn't feeling well. The CRCA stated she informed the nurse. About 20 minutes later the resident began vomiting again. The statement indicated the CRCA assisted the resident to get cleaned up and use the bathroom and then the resident rested for a while. The Nurse Practitioner did come to evaluate the resident. The statement also included the resident later woke up and was restless. The CRCA took her to the bathroom and helped her back to the recliner but noted that after some time, she had another blow out of vomit. The CRCA cleaned the resident up and informed the nurse and noted that the resident refused to eat breakfast and lunch.<br><br>Review of the statement from LPN #240 dated [DATE] revealed Resident #54 had vomited in the morning [indicating on [DATE]] after administering morning medications. When CNP #521 rounded, LPN #240 requested for Resident #54 to be assessed due to her not feeling well. CNP #521 evaluated Resident #54 and ordered a chest X-ray to be obtained and to initiate IV fluids of normal saline. At around 4:00 P.M. Resident #54 vomited again and CNP #521 was notified and requested the IV normal saline to be started and to notify her if the nurse was unable to initiate the IV placement. The IV was placed and normal saline fluid was initiated. LPN #240 then observed Resident #54 breathing heavily and she went to Resident #54 and called her name and Resident #54 was not responding. CPR was started immediately, and EMS was called. CPR continued until EMS arrived. Resident #54 had a pulse at the time EMS transported Resident #54 to the hospital.<br><br>Review of the statement from Coroner #525 dated [DATE] revealed there were no concerns of Resident #54's fall contributing to her death. The statement included the cause of death was related to Resident #54's heart issues, and no further investigation was required.<br><br>An interview on [DATE] at 4:34 P.M. with CNP #521 revealed the dayshift nurse had notified her of Resident #54 vomiting and not feeling well. She stated Resident #54 was the first one she saw that day, and the night nurse had notified her of the fall earlier. She stated she ordered a urinalysis culture and sensitivity (UA CS) due to her change in behavior. The wash basin was sitting by the resident's recliner and there was white mucus-looking emesis in the basin. CNP #521 revealed she assessed the resident, and she denied hitting her head, her neurological checks were normal for her, but she complained of her right shoulder hurting from her recent fall, but the more she moved it the better it felt to her. She complained of abdominal nausea and Zofran was ordered to help with that. IV fluids were also ordered due to her being on a large dose of Torsemide and she didn't want the resident to become dehydrated due to the medicine and her not feeling well, and she wanted her kidney function to be maintained as well due to her chronic kidney disease diagnosis. CNP #521 stated she also requested the chest X-ray due to the lab results from the previous week with her WBC's elevated, so she stated she was looking for a source of possible infection. She revealed the orders were not because of the fall, only to address the increased WBC's. CNP #521 stated when Resident #54 was admitted she had increased swelling and had a slight weight increase, but they managed that with medications and she was stable and the morning she assessed the resident [indicating [DATE]], though she did have some increased swelling in her lower legs and the staff had them elevated in the recliner.<br><br>Interview on [DATE] at 11:15 A.M. with CRCA #517 revealed Resident #54 had vomited two times during the day on [DATE] and was not feeling well. Resident #54 did not eat breakfast and lunch, which was not normal for her. She stated Resident #54 did participate in therapy in the afternoon of [DATE].<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on [DATE] at 8:58 A.M. with LPN #214 revealed Resident #54 had fallen at 6:00 A.M. on [DATE] while attempting to transfer from the recliner. Resident #54 did not activate the call light for staff assistance prior to the fall. LPN #214 stated Resident #54 would always use the call light for assistance from staff, so not activating the call light was abnormal behavior for the resident. She stated Resident #54 was at baseline through the night of [DATE] and activated the call light several times for assistance from staff. LPN #214 stated she notified the CNP about the fall and she ordered the UA CS to be collected to check for a urinary tract infection since the resident's behavior was abnormal. She further confirmed the residents low blood pressure readings on [DATE], but also stated the resident often had lower blood pressure readings in the mornings.<br><br>Interview on [DATE] at 4:34 P.M. with CNP #521 revealed CNP #521 evaluated Resident #54 following the first episode of vomiting at approximately 8:00 A.M. LPN #240 had administered a Zofran 4mg tablet with effective results noted. CNP #251 reviewed Resident #54's laboratory results obtained [DATE] with abnormal findings including an elevated BUN and WBC. CNP #521 ordered for a chest X-ray to be obtained and for IV fluids to be initiated of sodium chloride 0.9% parental solution 500 milliliters (ml) via IV to be administered 100 ml per hour.<br><br>An interview on [DATE] at 10:02 A.M. with LPN #240 confirmed Resident #54's order for sodium chloride 0. 9% parental solution 500 milliliters (ml) via IV to be administered 100 ml per hour was not initiated when initially received from CNP #521 at 8:00 A.M. on [DATE] and was actually initiated at approximately 4:00 P. M. (approximately 8 hours later) following Resident #54's second episode of vomiting. She further stated the urinalysis was not obtained as the resident was incontinent, but the chest X-ray was obtained.<br><br>An interview on [DATE] at 12:25 P.M. with CNP #521 revealed LPN #240 did not notify CNP #521 the order for the IV fluids was not initiated following the first episode of vomiting as ordered by CNP #521. When LPN #240 notified CNP #521 of Resident #54's second episode of vomiting at approximately 4:00 P.M., CNP #521 requested the order for sodium chloride 0.9% parental solution 500 milliliters (ml) via IV to be administered 100 ml per hour to be initiated immediately. CNP #521 stated the fluids were ordered for kidney protection [not dehydration per the order] so it was acceptable to wait four to six hours to start the IV. She stated she did not feel Resident #54 was having an acute change in condition, but she did feel the resident had something going on due to her labs, but she was addressing it with the UA order and the chest X-ray order.<br><br>An interview on [DATE] at 1:17 P.M. with the Director of Nursing (DON) revealed the CNP would write the order for the IV fluids and leave it on the nurses desk, but if it was a STAT order (to be completed immediately) then she would verbally tell the nurse and they would initiate the IV immediately or as quickly as possible. She stated her understanding was that Resident #54's IV was not a STAT situation, and that the CNP would have been okay with not starting the IV until they did start it at 4:00 P.M., since it was for kidney protection.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | An interview on [DATE] at 1:30 P.M. with the Assistant Director of Health Services (ADHS) revealed she would complete the IV initiations sometimes depending on the nurse on the hall. She stated that LPN #240 notified her verbally around 4:00 P.M. on [DATE] and requested Resident #54's IV to be placed after therapy and after the second episode of emesis. She stated she placed the IV in her left hand and it was successful on the first try and there were no issues. She stated if the order was to be placed as soon as possible then the CNP would write a STAT order, but if it was just fluids then she would tell them that it was okay to start it later, up to six hours after the order was received.<br><br>An interview on [DATE] at 10:32 A.M. with Coroner #525 revealed Coroner #525 initiated an investigation into Resident #54's death due to her having been at the hospital less than 24 hours prior to death. There was no autopsy performed due to Resident #54's death had no suspicious findings upon completion of the investigation. The Coroner released jurisdiction on [DATE] to the facility's medical director.<br><br>A review of the facility's policy titled Notification of Change in Condition dated [DATE] revealed resident assessments for change in condition, suspected injury, event of unknown origin or ordered lab and/or other diagnostic tests should be completed in a timely manner.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00166297. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure fall interventions were in place for a resident at risk for falls. This affected one resident (Resident #54) out three residents reviewed for falls. The facility census was 52.<br><br>Findings Include:<br><br>Review of Resident #54's medical record revealed admission date [DATE] with the following diagnoses including but not limited to acute respiratory failure, congestive heart failure (CHF), cardiomegaly, atrial fibrillation, and history of hemorrhagic stroke. Resident #54 expired on [DATE].<br><br>Review of Resident #54's admission fall risk evaluation dated [DATE] revealed Resident #54 was at risk for falling related to poor mobility, history of stroke, and weakness.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 required assistance from staff for transfers, ambulation, and personal hygiene tasks and the resident had impaired cognition with Brief Interview Mental Status (BIMS) of 9 out of possible 15.<br><br>Review of Resident #54's post fall evaluations dated [DATE] and [DATE] revealed Resident #54 continued to be at risk for falls.<br><br>Review of Resident #54's fall care plan dated [DATE] revealed Resident #54 at risk for falls with interventions including providing non-skid footwear, staff to assist resident with transfers, and encourage Resident #54 to assume the standing position slowly.<br><br>Review of Resident #54's progress note dated [DATE] at 6:00 A.M. authored by Licensed Practical Nurse (LPN) #214 revealed Resident #54 had attempted to self-transfer from the recliner, resulting in Resident #54 being found on the floor beside the recliner. Resident #54 was observed wearing regular socks instead of non-skid socks or shoes.<br><br>An interview on [DATE] at 8:58 A.M. with LPN #214 confirmed Resident #54 was not wearing non-skid socks or shoes prior to the fall on [DATE] at 6:00 A.M. LPN #214 stated Resident #54 was wearing regular socks at the time of the fall and should have had either shoes or non-skid socks in place instead.<br><br>Review of the facility's fall management policy dated [DATE] revealed the facility strives to maintain a hazard free environment, mitigate fall risk factors, and implement preventative measures.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00166297. |