

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Violet Springs Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE  603 Diley Road 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100</b></p> <p>Based on medical record review and staff interview, the facility failed to take vital signs in connection to an as needed blood pressure medication. This affected one (Resident #5) of five residents reviewed for unnecessary medications. Also, the facility failed to hold blood pressure medications and notify the physician when vital signs were outside safe/accepted parameters. This affected one (Resident #27) of five residents reviewed for unnecessary medications. The census was 46.</p> <p>Findings Include:</p> <p>1. Resident #5 was admitted to the facility on [DATE]. Diagnoses included multiple fractures of pelvic with stable disruption of pelvic ring, pneumonia, type II diabetes, hypertensive heart and chronic kidney disease with heart failure, heart failure, chronic kidney disease (stage III), acute posthemorrhagic anemia, hypothyroidism, vitamin B deficiency, hypo-osmolality and hyponatremia, pure hypercholesterolemia, depression, unspecified hearing loss, gastroesophageal reflux disease (GERD), parasthesia of skin, dysphagia, and need for assistance with personal care. Review of Resident #5's Minimum Data Set (MDS) assessment, dated 06/21/24, revealed Resident #5 was cognitively intact.</p> <p>Review of Resident #5's current physician orders revealed an order for hydralazine 25 milligrams (mg) as needed once daily if systolic blood pressure reading was above 140. This order was started on 10/01/24. Further review of Resident #5's physician orders revealed there was not an for Resident #5's blood pressure to be taken daily.</p> <p>Review of Resident #5's vital signs, dated 10/01/24 to 10/16/24, revealed her blood pressure was taken on 10/03/24, 10/10/24, 10/13/24, and 10/16/24; it was not completed daily to determine if hydralazine 25 mg should be administered due to the parameters noted within the medication order.</p> <p>Interview with the Director of Health Services (DHS) on 10/16/24 at 11:00 A.M. and 11:26 A.M. revealed Resident #5 was on skilled nursing services, which meant she got her vital signs taken daily. When her skilled nursing services were discontinued, the order went to monthly vital signs, and her blood pressure order should have remained at daily. The DHS confirmed the blood pressure checks were not taken as they should have been.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #27 was admitted to the facility on [DATE]. Diagnoses included encephalopathy, compression of brain, nontraumatic intracranial hemorrhage, aphasia, dysarthria and anarthria, sick sinus syndrome, abdominal aortic aneurysm, obesity, peripheral vascular disease, dementia, hypertensive chronic kidney disease, hyperlipidemia, hypothyroidism, occlusion and stenosis of unspecified carotid artery, altered mental status, restlessness and agitation, and prediabetes. Review of her MDS assessment, dated 09/13/24, revealed she had a significant cognitive impairment.</p> <p>Review of Resident #27's physician orders, dated 09/17/24 to 09/25/24, revealed an order for hydralazine 25 mg to be given three times daily.</p> <p>Review of Resident #27 physician orders, dated 09/25/24 to 10/16/24, revealed an order for hydralazine 12.5 mg to be given twice daily.</p> <p>Review of Resident #27's physician orders, dated 10/16/24, revealed an order for hydralazine 12.5 mg to be given twice daily. Also, a parameter of the medication to be held if the systolic blood pressure was less than 100 over 60, or her pulse was less than 60 beats per minute.</p> <p>Review of Resident #27's vital signs, dated 09/16/24 to 10/16/24, revealed the following dates where her blood pressure was below the accepted parameters: 10/12/24 at 11:20 A.M., 10/09/24 at 1:58 P.M., 10/03/24 at 3:03 P.M., 10/03/24 at 10:26 A.M., 10/02/24 at 1:38 P.M., 9/28/24 at 11:44 A.M., 09/25/24 at 2:12 P.M., 09/25/24 at 10:23 A.M., 09/25/24 at 7:51 A.M., and 09/19/24 at 11:43 A.M.</p> <p>Review of Resident #27's medication administration record (MAR), dated 09/17/24 to 10/16/24, revealed the hydralazine order was held on 09/28/24 and 09/29/24, due to her blood pressure being low and the nurse practitioner being notified. The blood pressures for those dates were 89 over 74 and 98 over 58. But, the hydralazine was not held, and the physician was not notified when Resident #27's blood pressure was below the safe/accepted parameters as listed above from the MAR.</p> <p>Interview with the DHS on 10/16/24 at 11:00 A.M. and 11:26 A.M. revealed that typically if blood pressure was less than 100 over 60 or pulse was less than 60 beats per minute, that medication for blood pressure was held. The DHS also confirmed the physician or nurse practitioner should be notified if the blood pressure was low.</p> <p>Interview with Registered Nurse (RN) #212 on 10/16/24 at 11:15 A.M. revealed there should be parameters for blood pressure medications. If there was not, the standard was holding blood pressure medications if the resident's blood pressure was less than 100. She confirmed she would also contact the physician if the blood pressure was less than 100.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49039</p> <p>Based on record review, observation and interview the facility failed to ensure care planned interventions for falls were implemented for Resident #20. This affected one (Resident #20) out of four residents reviewed for falls. The facility census was 46.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #20 revealed an admitted [DATE], with diagnoses including hydrocephalus, disorientation, altered mental status, hemiplegia, type two diabetes, depression, and anxiety. Review of the most recent Minimum Data Set (MDS) 3.0 assessment, completed on 08/23/24, indicated that the resident was severely cognitively impaired and required assistance with ambulation.</p> <p>Review of the care plan, dated 06/16/23, revealed Resident #20 was at risk for falls related to impaired balance, left hemiparesis, right thalamic mass, medication side effects, incontinence and cognition deficits. Review of interventions for the falls care plan revealed an intervention, dated 07/26/23, for bed mat on the floor.</p> <p>Observation of Resident #20's room and bathroom on 10/15/24 at 9:23 A.M. and 4:39 P.M. while Resident #20 was in bed revealed the fall mat was not present at the bedside or anywhere in the resident's room.</p> <p>Interview on 10/16/24 with Licensed Practical Nurse #174 and Certified Resident Care Associate #114 while in Resident #20's room confirmed that the resident was at risk for falls, and the fall mat was not currently present at the bedside, as specified in the care plan.</p> <p>Interview on 10/17/24 at 9:44 A.M. with the Director of Nursing (DON) confirmed the care planned intervention for a mat at the bedside for Resident #20.</p> <p>Review of falls management program guidelines dated 12/31/23 revealed the facility strived to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. The facility identified all care plan interventions should be implemented.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>47059</p> <p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on employee file review and staff interview, the facility failed to ensure State tested Nursing Assistants (STNAs) received annual performance reviews. This had the potential to affect all residents residing in the facility. The facility census was 46 residents.</p> <p>Findings Include:</p> <p>Review of STNA #139's employee file revealed a date of hire of 05/30/23. STNA #139's file contained a 90-day evaluation dated 11/10/23. STNA #139's file did not include an annual performance appraisal as of 10/17/24.</p> <p>Interview on 10/17/24 at 10:25 A.M. with Business Office Staff (BOS) #136 confirmed there was no annual evaluation present in the employee file for STNA #139. BOS #136 stated they were not required to do evaluations after the 90-day evaluation.</p> <p>Interview on 10/17/24 at 12:00 P.M. with the administrator confirmed there was no annual evaluation in the employee file for STNA #139.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37100</p> <p>Based on medical record review and staff interview, the facility failed to provide evidence to support pharmacy recommendations were reviewed in a timely manner. This affected three (Residents #5, #27, and #7) of five residents reviewed for unnecessary medications. Also, the facility failed to follow a pharmacy recommendation after the physician agreed to the recommendation. This affected one (Resident #7) of five residents reviewed for unnecessary medications. The census was 46.</p> <p>Findings Include:</p> <p>1. Resident #5 was admitted to the facility on [DATE]. Diagnoses included multiple fractures of pelvic with stable disruption of pelvic ring, pneumonia, type II diabetes, hypertensive heart and chronic kidney disease with heart failure, heart failure, chronic kidney disease (stage III), acute posthemorrhagic anemia, hypothyroidism, vitamin B deficiency, hypo-osmolality and hyponatremia, pure hypercholesterolemia, depression, unspecified hearing loss, gastroesophageal reflux disease (GERD), parasthesia of skin, dysphagia, and need for assistance with personal care. Review of Resident #5's Minimum Data Set (MDS) assessment, dated 06/21/24, revealed Resident #5 was cognitively intact.</p> <p>Review of Resident #5 pharmacy recommendations, dated 07/05/24, 07/15/24, and 08/12/24, revealed recommendations were made, the physician addressed the recommendations, but did not date the recommendations as to when they were actually addressed. There were no progress notes or other medical documents to support the physician signed and dated when the recommendations were addressed.</p> <p>2. Resident #27 was admitted to the facility on [DATE]. Diagnoses included encephalopathy, compression of brain, nontraumatic intracranial hemorrhage, aphasia, dysarthria and anarthria, sick sinus syndrome, abdominal aortic aneurysm, obesity, peripheral vascular disease, dementia, hypertensive chronic kidney disease, hyperlipidemia, hypothyroidism, occlusion and stenosis of unspecified carotid artery, altered mental status, restlessness and agitation, and prediabetes. Review of Resident #27's MDS assessment, dated 09/13/24, revealed Resident #27 had a significant cognitive impairment.</p> <p>Review of Resident #27's pharmacy recommendations, dated 09/15/24, revealed a recommendation was made, the physician addressed the recommendation, but did not date the recommendation as to when it was actually addressed. There were no progress notes or other medical documents to support the physician signed and dated when the recommendation was addressed.</p> <p>Interview with the Director of Health Services (DHS) on 10/16/24 at 8:56 A.M. verified the physician had not indicated the date of their response to the pharmacy recommendations.</p> <p>43064</p> <p>3. Review of Resident #7's medical record revealed an admitted [DATE] with diagnoses including kidney transplant, osteomyelitis, thrombocytopenia, atherosclerotic heart disease, parkinsonism, fibromyalgia, rheumatoid arthritis, spinal stenosis, type two diabetes mellitus, depression, and hemiplegia and hemiparesis.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #7's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition.</p> <p>Review of Resident #7's pharmacy recommendation dated 02/27/24 revealed the pharmacist had a recommendation. The physician responded to the recommendation but there was no date to indicate his response was completed in a timely manner.</p> <p>Review of Resident #7's pharmacy recommendation dated 04/13/24 revealed the pharmacist had a recommendation. The physician responded to the recommendation but there was no date to indicate his response was completed in a timely manner.</p> <p>Review of Resident #7's pharmacy recommendation dated 05/08/24 revealed the pharmacist had a recommendation. The physician responded to the recommendation but there was no date to indicate his response was completed in a timely manner.</p> <p>Review of Resident #7's pharmacy recommendation dated 08/09/24 revealed the pharmacist had a recommendation. The physician responded to the recommendation but there was no date to indicate his response was completed in a timely manner.</p> <p>Review of Resident #7's pharmacy recommendation dated 09/06/24 revealed the pharmacist recommended reviewing the resident's 'as needed' pain medications and considering discontinuing Tramadol. The physician indicated Tramadol should be discontinued but there was no date to indicate his response was completed in a timely manner.</p> <p>Review of Resident #7's physician's orders on the morning of 10/16/24 revealed an order dated 07/09/24 for Tramadol 50 milligrams every eight hours as needed for pain.</p> <p>Interview on 10/16/24 at 8:56 A.M. with the Director of Health Services (DHS) verified the physician had not indicated the date of their response to the pharmacy recommendations. She additionally verified the Tramadol was still in place despite the physician's indication it should be discontinued.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37100</p> <p>Based on medical record review and staff interview, the facility failed to provide proper parameters for as needed and scheduled medications. This affected four (Residents #5, #27, #137, and #7) of five residents reviewed for unnecessary medications. The census was 46.</p> <p>Findings Include:</p> <p>1. Resident #5 was admitted to the facility on [DATE]. Resident #5's diagnoses included multiple fractures of pelvic with stable disruption of pelvic ring, pneumonia, type II diabetes, hypertensive heart and chronic kidney disease with heart failure, heart failure, chronic kidney disease (stage III), acute posthemorrhagic anemia, hypothyroidism, vitamin B deficiency, hypo-osmolality and hyponatremia, pure hypercholesterolemia, depression, unspecified hearing loss, gastroesophageal reflux disease (GERD), parasthesia of skin, dysphagia, and need for assistance with personal care. Review of Resident #5's Minimum Data Set (MDS) assessment, dated 06/21/24, revealed Resident #5 was cognitively intact.</p> <p>Review of Resident #5's current physician orders revealed an order for hydralazine 25 milligrams (mg) as needed once daily if systolic blood pressure reading was above 140. This order was started on 10/01/24. There was no order Resident #5's blood pressure to be taken daily.</p> <p>Interview with the Director of Health Services (DHS) on 10/16/24 at 11:00 A.M. and 11:26 A.M. confirmed Resident #5 was on skilled nursing services, which meant her vitals would be taken daily. When her skilled nursing services were discontinued, the order went to monthly vital signs, and her blood pressure order should have remained at daily. The DHS confirmed there should have been parameters in place to check her blood pressure.</p> <p>2. Resident #27 was admitted to the facility on [DATE]. Her diagnoses were encephalopathy, compression of brain, nontraumatic intracranial hemorrhage, aphasia, dysarthria and anarthria, sick sinus syndrome, abdominal aortic aneurysm, obesity, peripheral vascular disease, dementia, hypertensive chronic kidney disease, hyperlipidemia, hypothyroidism, occlusion and stenosis of unspecified carotid artery, altered mental status, restlessness and agitation, and prediabetes. Review of Resident #27's MDS assessment, dated 09/13/24, revealed Resident #27 had a significant cognitive impairment.</p> <p>Review of Resident #27's physician orders, dated 09/17/24 to 09/25/24, revealed an order for hydralazine 25 mg to be given three times daily. There were no parameters as to when to take Resident #27's blood pressure.</p> <p>Review of Resident #27's physician orders, dated 09/25/24 to 10/16/24, revealed an order for hydralazine 12.5 mg to be given twice daily. There were no parameters as to when to take Resident #27's blood pressure.</p> <p>Review of Resident #27's physician orders, dated 10/16/24, revealed an order for hydralazine 12.5 mg to be given twice daily. Also, a parameter of the medication to be held if the systolic blood pressure was less than 100 over 60, or her pulse was less than 60.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #27's vital signs, dated 09/16/24 to 10/16/24, revealed the following dates in which blood pressure was not taken prior to and/or after the hydralazine was taken: 10/14/24 morning, 10/13/24 morning, 10/11/24 morning, 10/10/24 two missing, 10/08/24 one missing, 10/07/24 morning, 10/06/24 morning, 10/05/24 morning, 10/04/24 morning, 10/01/24 morning and evening, 09/30/24 morning, 09/24/24 afternoon, 09/23/24 morning, 09/22/24 afternoon, 09/21/24 afternoon, and 09/17/24 afternoon.</p> <p>Interview with the DHS on 10/16/24 at 11:00 A.M. and 11:26 A.M. and Registered Nurse (RN) #212 on 10/16/24 at 11:15 A.M. revealed there should be parameters set for a resident who was taking hydralazine for their blood pressure. They both confirmed if there were not parameters, they should contact the physician.</p> <p>3. Resident #137 was admitted to the facility on [DATE]. Her diagnoses were morbid obesity, pancytopenia, chronic lymphedema, kidney cancer status post nephrectomy, hypertension, and hypothyroidism. Review of her MDS assessment revealed it had not been completed, but according to resident interviews, she was deemed to be cognitively intact.</p> <p>Review of Resident #137's current physician orders for the following as needed pain medications: acetaminophen 325 mg two tablets every eight hours, oxycodone five mg every four hours, Tramadol-acetaminophen 37.5-325 mg one tablet every six hours for pain level one to four, and Tramadol-acetaminophen 37.5-325 mg two tablets every six hours for pain level five to ten. There were no pain level parameters documented for acetaminophen or oxycodone.</p> <p>Review of Resident #137's Medication Administration Record (MAR), dated 10/13/24 to 10/16/24, revealed as needed oxycodone was given three times on 10/15/24 for pain levels of seven, nine, and nine. Also, acetaminophen was given on 10/14/24 for the pain level of eight. As needed Tramadol-acetaminophen was not given during this period for any pain level.</p> <p>Interview with the DHS on 10/16/24 at 11:00 A.M. and 11:26 A.M. confirmed there was not an order/parameters as to which pain medication should be given for each level of pain that Resident #137 had. The DHS confirmed there were parameters for the Tramadol-acetaminophen, but also confirmed that it was never administered, even though Resident #137 had documented pain. The DHS stated she spoke with the nurse practitioner and put pain level parameters in place for each as needed pain medication.</p> <p>Interview with RN #212 on 10/16/24 at 11:15 A.M. confirmed there needed to be parameters for as needed pain medications, so they knew which pain medication to give. If there were no parameters listed, they would ask the resident which pain medication they wanted or contact the nurse practitioner to receive guidance/parameters.</p> <p>43064</p> <p>3. Review of Resident #7's medical record revealed an admitted [DATE] with diagnoses including kidney transplant, osteomyelitis, thrombocytopenia, atherosclerotic heart disease, parkinsonism, fibromyalgia, rheumatoid arthritis, spinal stenosis, type two diabetes mellitus, depression, and hemiplegia and hemiparesis.</p> <p>Review of Resident #7's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #7's plan of care dated 02/29/24 revealed they were at risk for pain related to their diagnoses. Interventions included administering medications as ordered, attempting non-pharmacological interventions, notifying the physician of increased pain, observing and recording verbal and nonverbal pain, and repositioning during routine rounds and as needed.</p> <p>Review of Resident #7's physician order dated 07/09/24 revealed an order for Acetaminophen 650 milligrams (mg) every six hours as needed. There were no parameters for administration.</p> <p>Review of Resident #7's physician order dated 07/09/24 revealed an order for Tramadol 50 mg every eight hours as needed. There were no parameters for administration.</p> <p>Review of Resident #7's physician order dated 08/07/24 revealed an order for oxycodone five mg every six hours as needed. There were no parameters for administration.</p> <p>Review of Resident #7's Medication Administration Record (MAR) from 09/16/24 to 10/16/24 revealed she did not receive Tramadol. Acetaminophen was administered twice on 09/16/24 for pains of seven, once on 09/17/24 for a pain of eight, once on 09/18/24 for a pain of six, once on 09/24/24 for a pain of five, once on 09/29/24 for a pain of six, once on 10/01/24 for a pain of five, once on 10/03/24 for a pain of six, once on 10/06/24 for a pain of five, and once on 10/15/24 for a pain of five. Oxycodone was administered on 09/17/24 for a pain of eight, on 09/25/24 for a pain of seven, on 10/02/24 for a pain of seven, on 10/03/24 for a pain of seven, on 10/05/24 for a pain of seven, on 10/08/24 for a pain of seven, on 10/09/24 for a pain of seven, on 10/10/24 for a pain of seven, on 10/13/24 for a pain of seven, and on 10/16/24 for a pain of seven.</p> <p>Interview on 10/16/24 at 11:18 A.M. with the Director of Health Services (DHS) verified there were no parameters in place for 'as needed' pain medication.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49039</p> <p>Based on medical record review, medication administration observation, staff interviews, and medication administration policy review, the facility failed to ensure a medication error rate of five percent or less. Two errors occurred in 35 opportunities for error. The medication error rate was 5.77 percent. This affected one resident (Resident #20) of four residents observed for medication administration. The facility census was 46.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #20 revealed an admitted [DATE], with diagnoses that include hydrocephalus, disorientation, altered mental status, hemiplegia, type two diabetes, depression, and anxiety. The most recent Minimum Data Set (MDS) 3.0 assessment, completed on 08/23/24, indicated Resident #20 was severely cognitively impaired.</p> <p>Review of the care plan dated 08/08/23 revealed Resident #20 utilized anti-depressant and chemical interventions related to the signs and symptoms of depression.</p> <p>Review of physician orders for Resident #20 revealed the following orders:</p> <ul style="list-style-type: none"> <li>-Duloxetine capsule, delayed release, 60 milligrams (mg), to be administered once daily. Ordered on 06/14/23.</li> <li>-Prednisone tablet, 10 mg, to be given once daily. Ordered on 10/14/24.</li> <li>- One to one feeding assistance, ensuring the resident was in an upright position. Encourage small bites and sips, and suggest a drink after every bite. Ordered on 08/23/24.</li> <li>-Mechanical soft texture and thin liquid consistency for dietary needs. Ordered on 05/16/24.</li> <li>-May crush medications or open capsules as needed, unless contraindicated; refer to the Do Not Crush list. Ordered on 06/14/23.</li> </ul> <p>Observation on 10/16/24 at 8:17 A.M. with Licensed Practical Nurse (LPN) #174 administering morning medication revealed that after retrieving the duloxetine capsule from the medication cart, LPN #174 proceeded to open the capsule and pour the sprinkles into a medication cup with applesauce. The capsule was discarded, and then LPN #174 gathered all of Resident #20's medications into a crush bag, proceeding to crush all tablets, including a tablet of prednisone 10 mg. Once all medications were crushed they were added to the cup of applesauce. The medications were administered to Resident #20 without concerns.</p> <p>Interview on 10/16/24 at 8:25 A.M. with LPN #174 confirmed Resident #20 was prescribed the duloxetine delayed-release capsule, which she administered by sprinkling it into a cup. She also confirmed that prednisone was crushed during this process.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Violet Springs Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE  603 Diley Road 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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/17/24 at 9:44 A.M. with the Director of Nursing confirmed an extended-release capsule should not be opened and noted that prednisone was included on the Do Not Crush list.</p> <p>Review of medications not to be crushed dated 03/21 revealed prednisone delayed release and regular dosage was not be crushed due to time release formation.</p>		

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NAME OF PROVIDER OR SUPPLIER  Violet Springs Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE  603 Diley Road Pickerington, OH 43147	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>49039</p> <p>Based on observation, staff interview and review of facility policy the facility failed to ensure multi use vials of tuberculin purified protein derivative (PPD) were dated when they were opened. This had the potential to affect the 30 new admissions since 09/26/27 which included Residents #18, #38, #39, #40, #41, #42, #43, #132, #133, #134, #135, #136, #137, #138, #232, #234, #235, #236, #237, #239, #240, #241, #242, #243, #244, #245, #246, #247, #244 and #245. The facility census was 46.</p> <p>Findings Include:</p> <p>Observation on 10/17/24 at 10:08 A.M. of the 200 hallway medication room with the Director of Nursing (DON) revealed three open, used and unlabeled tuberculin purified protein derivative (PPD) solutions.</p> <p>Interview on 10/17/24 at 10:10 A.M. with the DON confirmed the tuberculin PPD solution was opened but neither the box nor the vials were dated as to when opened. The DON revealed the facility received the PPD solution on 09/26/24 confirming the medication was not past its possible use by date. The DON confirmed the opened vials should have been labeled with a date.</p> <p>Review of the facility's general guidelines for administration of medication dated 12/01/22 revealed any medication in a multi-vial dose may be used up to 30 days after being opened. Staff must date and initial the vial when opened. After 30 days the vial shall be disposed.</p> <p>Review of the list provided by the facility revealed Residents #18, #38, #39, #40, #41, #42, #43, #132, #133, #134, #135, #136, #137, #138, #232, #234, #235, #236, #237, #239, #240, #241, #242, #243, #244, #245, #246, #247, #244 and #245 were admitted after 09/26/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>47059</p> <p>Based on record review and staff interview, the facility failed to ensure State tested Nurse Aides (STNAs) completed the minimum required 12 hours of in-servicing a year. This affected one (STNA #139) of two STNAs reviewed for required in-services. This had the potential to affect all residents in the facility. The facility census was 46.</p> <p>Findings Include:</p> <p>Review of STNA #139's personnel record revealed a hire date of 05/30/23. The record revealed STNA #139 completed six hours of training as a new hire in orientation. STNA #139 was assigned 12 hours of inservice/ on-line training that had not been completed.</p> <p>Interview on 10/17/23 at 10:35 A.M., with Business office staff member #136 verified STNA #139 did not complete the required 12 hours of in-service training for the last year.</p> <p>Interview on 10/17/23 at 12:00 P.M., with the administrator verified the facility assigned 12 hours of on-line training but STNA #139 did not complete the training. The administrator agreed the minimum requirements for STNA staff was to complete 12 hours of in-servicing/training annually.</p>