STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366494	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landings of Westerville Health and Rehab The	350 County Line Road West Westerville, OH 43082

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 Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36297 Based on observation, record review, staff interview and policy review, the facility failed to ensure medications were administered to the residents without a significant medication error. This affected one (Resident #31) of three residents reviewed for medication administration. The facility census was 110. Findings include: Review of Resident #31's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease and anxiety disorder. Review of Resident #31's physician orders dated 03/04/24 revealed an order for the resident to receive pureed foods with nectar thickened liquids. An order dated 06/14/23 for Divalproex Sodium oral tablet delayed release 250 milligrams (mg) (Divalproex Sodium), administer three tablets by mouth one time a day for convulsion. This order was discontinued on 04/30/24. A new order dated 04/30/24 for Divalproex Sodium oral capsule delayed release sprinkle 125 mg (Divalproex Sodium), administer four capsules by mouth one time a day. Interview and observation of medication administration on 04/30/24 at 7:30 A.M. revealed Registered Nurse (RN) #259 on 04/30/24 at 7:30 A.M. stated Resident #31 took her medications crushed in applesauce. RN #259 was observed to crush the Divalproex Sodium 250 mg three tablets and include them with the resident's other crushed morning medications and place all the crushed medications in applesauce. At 7:45 A.M., RN #259 was in Resident #31's room with the crushed morning medication explaining to the resident that it was time to take her medications. The Director of Nursing (DON) came to the door and told RN #259 to come out of the room with the medications. The DON asked if the Divalproex Sodium delayed release tablets were in the crushed medications and when the nurse replied yes, the DON instructed RN #259 that the medication could not be administered to the resident, as Divalproex Sodium delayed release tablets cannot be crushed. The DON was observed to open a binder on the medication cart and turn to the do not crush list provided by the pharmacy and showed the list to RN #259. RN #259 was observed to discard the medications and obtained Resident #31's morning medication again without the Divalproex Sodium delayed release tablets 250 mg, three tablets, in it as the DON stated they would need to get the order clarified. (continued on next page)

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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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the DON on 04/30/24 at 12:55 P.M. confirmed any resident who had a pureed diet order should have their medications provided to them crushed. The DON verified the facility obtained an order for Divalproex Sodium oral capsule delayed release sprinkles 125 mg, give four capsules by mouth one time a day for Resident #31 on 04/30/24 as the capsules could be opened and sprinkled on food to give to residents, and Resident #31 took her medications crushed. The DON verified the Resident #31 had an order for pureed diet on 03/04/24 and until 04/30/24 the resident's Divalproex Sodium was ordered and provided to the resident as three 250 mg tablets that were not to be crushed, but crushed was the way the resident took her medications. The DON verified the facility staff had documented on the medication administration record every day during the month of April 2024 that the Divalproex Sodium delayed release 250 mg, three tablets had been administered to the resident. Review of the facility policy titled Medication Administration General Guidelines for Administering Medications dated 06/21/17 revealed medications will be administered by legally-authorized and trained persons in accordance to applicable State, Local and Federal laws and consistent with accepted standards of practice. The noted included to refer to medication reference text for administration of any medication when added to or mixed with any substance to facilitate administration, (e.g. applesauce, juice, milk, etc.). This deficiency represents non-compliance investigated under Complaint Number OH00153179.