STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365615	A. BUILDING _____ B. WING _____	06/23/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF BELLEFONTAINE	221 NORTH SCHOOL STREET BELLEFONTAINE, OH 43311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, family and staff interviews, and review of facility policy, the facility failed to immediately report and investigate an allegation of verbal abuse and mistreatment for one resident. This affected one (#6) of three residents reviewed for abuse. The facility census was 75. Review of the record of Resident #6 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the 14 day Minimum Data Set (MDS) assessment revealed the residents cognition was intact. Further review of the MDS revealed her to need minimal assistance of one staff member for transfers and ambulation with a wheeled walker. Review of the current care plan dated 05/22/17, revealed Resident #6 required assistance with ambulation and participated in therapy. Interview with Resident #6 on 06/21/17 at 8:09 A.M., revealed that on 06/15/17, Physical Therapist (PT) #209 humiliated her in the therapy room by saying, You should stop sticking your butt out and stand straight. PT #209 further humiliated her by imitating Resident #6's walk. This event occurred in the presence of other therapists and residents, but Resident #6 could not recall which ones. PT #209 was not even assigned to Resident #6 on that day. Also, while in the hallway, PT #209 said to Resident #6, We should put a feather on your butt as it looks like you are looking for men. Interview on 06/21/17 at 8:25 A.M. with the Administrator, revealed she was not aware and had no prior knowledge of the event before the surveyor reported it. She further stated PT #209 had been suspended pending an investigation as of 06/20/17, and a self-reported incident was initiated. Interview on 06/21/17 at 8:30 A.M. with Licensed Social Worker (LSW) #208, revealed she was informed of the event on 06/20/17 and immediately went to speak with Resident #6. Resident #6 reported not feeling threatened or singled out but did feel humiliated. Interview on 06/22/17 at 9:21 A.M. with Resident #6's daughter, revealed Resident #6 told her of the event on 06/16/17, and the daughter went to Admission Director's (AD) #212's office to inform the facility. She further stated the investigation started immediately after the Administrator was informed and PT #209 was suspended pending the investigation. Review of the facility policy titled, Abuse, Neglect and Misappropriation of Patient Property Prevention Policy Statement, dated 04/05/17, revealed the most critical step toward detecting and preventing abuse was no one should be subjective to humiliating behavior. Employees were educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse involving a resident.
F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, family and staff interviews, and review of facility policy, the facility failed to immediately report and investigate an allegation of verbal abuse and mistreatment for one resident per facility policy. This affected one (#6) of three residents reviewed for abuse. The facility census was 75. Review of the record of Resident #6 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the 14 day Minimum Data Set (MDS) assessment revealed the residents cognition was intact. Further review of the MDS revealed her to need minimal assistance of one staff member for transfers and ambulation with a wheeled walker. Review of the current care plan dated 05/22/17, revealed Resident #6 required assistance with ambulation and participated in therapy. Interview with Resident #6 on 06/21/17 at 8:09 A.M., revealed that on 06/15/17, Physical Therapist (PT) #209 humiliated her in the therapy room by saying, You should stop sticking your butt out and stand straight. PT #209 further humiliated her by imitating Resident #6's walk. This event occurred in the presence of other therapists and residents, but Resident #6 could not recall which ones. PT #209 was not even assigned to Resident #6 on that day. Also, while in the hallway, PT #209 said to Resident #6, We should put a feather on your butt as it looks like you are looking for men. Interview on 06/21/17 at 8:25 A.M. with the Administrator, revealed she was not aware and had no prior knowledge of the event before the surveyor reported it. She further stated PT #209 had been suspended pending an investigation as of 06/20/17, and a self-reported incident was initiated. Interview on 06/21/17 at 8:30 A.M. with Licensed Social Worker (LSW) #208, revealed she was informed of the event on 06/20/17 and immediately went to speak with Resident #6. Resident #6 reported not feeling threatened or singled out but did feel humiliated. Interview on 06/22/17 at 9:21 A.M. with Resident #6's daughter, revealed Resident #6 told her of the event on 06/16/17, and the daughter went to Admission Director (AD) #212's office to inform the facility. She further stated the investigation started immediately after the Administrator was informed and PT #209 was suspended pending the investigation. Review of the facility policy titled, Abuse, Neglect and Misappropriation of Patient Property Prevention Policy Statement, dated 04/05/17, revealed the employees were educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse involving a resident. The policy further indicated the investigation would begin immediately.
F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident family and staff interview, review of personnel files and policy review, the facility failed to ensure one resident (Resident #6) was treated in a dignified manner while receiving therapy. This affected one (#6) out of three residents reviewed for dignity. The facility census was 75. Findings include: Review of the medical record of Resident #6 was admitted on [DATE]. [DIAGNOSES REDACTED]. Review of the 14-day Minimum Data Set (MDS) revealed her to be cognitively intact. Further review revealed her to need minimal assistance of one staff member

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

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F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) for transfers and ambulation with a wheeled walker. Interview on 06/21/17 at 8:09 A.M. Resident #6 informed this surveyor of a situation on Thursday (06/15/17) when a Physical Therapist (PT #209) humiliated her in the therapy room by saying You should stop sticking your butt out and stand straight. PT #209 further humiliated her by imitating Resident #6's walk. This event occurred in the presence of other therapists and residents, but Resident #6 could not recall which ones. PT #209 was not even assigned to Resident #6 on that day. Also, while in the hallway, PT #209 said to Resident #6 We should put a feather on your butt as it looks like you are looking for men. Interview on 06/21/17 at 8:25 A.M. with the Administrator revealed no prior knowledge of the event with PT #209 and Resident #6 before the surveyor mentioned it. She further stated PT #209 had been suspended pending an investigation as of 06/20/17 and a self-reported incident was started. Interview on 06/21/17 at 8:30 A.M. with Licensed Social Worker (LSW) #208 revealed she was informed of the event on 06/20/17 and immediately went to speak with Resident #6. Resident #6 reported not feeling threatened or singled out' but did feel humiliated. Interview on 06/22/17 at 9:21 A.M. with Resident #6's family member revealed Resident #6 told her of the event on 06/16/17 and the daughter went straight into the Admission Director's (AD) #212 office to inform the facility. AD #212, PT #209 and the Director of Nursing were all unavailable to be interviewed during the surveyor. Review of the employee files of AD #212 revealed the most recent Employee Performance Evaluation dated 01/13/17 indicated she had met expectations on protecting resident's rights by reporting any complaints. The in-service transcripts indicated she had completed the mandatory Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and 2017 Resident Rights learning modules were completed on 03/20/17. No disciplinary action was documented in the file. Review of the employee files of PT #209 revealed her Employee Performance Evaluation had not yet been completed for the yearly appraisal period of 05/22/16 to 05/22/17. The most recent evaluation had been completed on 03/29/16. The in-service transcripts indicated she had completed the mandatory Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and 2017 Resident Rights learning modules were completed on 01/02/17. No disciplinary action was documented in the file, from this facility. Review of the facility policy titled Abuse, Neglect and Misappropriation of Patient Property Prevention Policy Statement dated 04/05/17 revealed the most critical step toward detecting and preventing abuse is no one should be subjective to humiliating behavior. Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse involving a patient. The facility had no policy specifically related to dignity.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and staff and family interview the facility failed to provide assistance to dependent residents with activity of daily living (ADL). This affected two Residents (#133 and #52) of three reviewed for ADL's. Resident #133 was not provided feeding assistance and Resident #52 was not provided incontinence care. The facility identified three residents as being dependent on staff for eating. The facility identified 20 residents as being incontinent of bowel. The facility census was 75. Findings include: 1. Review of Resident #133's medical record revealed she was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Due to her recent admission the minimum data set (MDS) assessment and plan of care were not completed as of yet. Review of a dietary care plan initiated on 06/20/17 indicated the resident had inadequate oral intakes and failure to thrive. The interventions listed were for staff to encourage and assist as needed to consume foods, supplements and fluids. On 06/20/17 at 8:55 A.M. Resident #133 was observed in a tilt in space wheelchair in her room. A breakfast tray was sitting on the over bed table to the right of the resident. Two glasses of thickened orange juice and one glass of thickened water had sanitary covers which were placed by the kitchen on the glasses. A bowl of oatmeal and cooked apples appeared untouched. There was a spoon in a bowl of what appeared to be meat and gravy. At 9:15 A.M., State tested Nursing Assistant (STNA) #202 entered the room and removed the breakfast tray. She placed it on a dietary cart to be returned to the kitchen along with other residents trays and shut the door of the cart. Upon approach and request, STNA #202 removed Resident #133's tray from the cart and verified the drinks on the tray were still covered indicating the drinks had not been offered to the resident. She stated she did not feed Resident #133, but Registered Nurse (RN) #205 had fed the resident this morning, Interview with Dietary Manager #206 on 06/20/17 at 9:30 A.M. verified he delivered the breakfast trays to the 300 hallway where Resident #133 resided at 7:50 A.M. During an interview with RN #205 on 06/20/17 at 9:45 A.M. she stated she gave Resident # 133 her medications but did not feed her. On 06/21/17 at 2:30 P.M. during an interview with Resident #133's family member he stated he lived with the resident prior to admission. He stated he told the nurses upon admission and several times since admission she needed to be fed. 2. Review of Resident #52's medical record revealed she was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the plan of care revised 02/03/17 indicated the resident had bowel incontinence related to impaired mobility. She was at risk for alteration in skin integrity related to very fragile skin and incontinence. The goal was to maintain a clean, dry, and dignified state as possible. The interventions included provide incontinent care following incontinent episodes. Review of the MDS significant change in status dated 03/22/17 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating she was alert and oriented with no memory loss. She required extensive assist of one staff member for bed mobility and transfers. She was frequently incontinent of bowel and bladder. On 06/21/17 at 11:00 A.M. during observation of a dressing change to the resident's coccyx RN #200 noted the resident had a small bowel movement in her protective undergarment. She changed the liner of the garment and pulled the undergarment up. She did not provide incontinent care to the resident. On 06/21/17 at 11:15 A.M., RN #200 verified she did not provide the resident with incontinent care when changing the liner of her disposable undergarment. This deficiency substantiates Complaint Number OH 924.
F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of manufacturer's instructions for use of [MEDICATION NAME] dressing and Santyl ointment, the facility failed to ensure treatment to a Stage III pressure ulcer was performed according to the physician orders [REDACTED].#52) of three residents reviewed for pressure ulcers. Facility census was 75. Findings include: Review of the medical record revealed Resident #52 was admitted to the facility on at 01/12/11. [DIAGNOSES REDACTED]. Review of the significant change in status Minimum Data Set (MDS) assessment, dated 03/22/17, revealed the resident had intact cognition. She required extensive assistance of one staff member for bed mobility and transfers and did not ambulate. She was frequently incontinent of bowel and bladder. She was at risk for skin breakdown and had a Stage III pressure ulcer. Review of the plan of care, revised 03/22/17, noted the resident was at risk for alteration in skin integrity related to very fragile skin and incontinence. The interventions include providing incontinent care following incontinent episodes. The plan of care noted the resident was non compliant with using a pressure relieving cushion in chair. She will allow an

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F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) alternating air mattress to her bed and will sleep in bed. Review of nursing progress note dated 03/07/17 documented Resident #52's skin was assessed while the resident was up to the bedside commode for toileting. There was moisture associated skin breakdown at the anal cleft measuring 2.2 centimeters (cm) by 0.3 cm by 0.1 cm. The wound bed was pale pink, moist with no drainage. The peri wound tissue had white maceration. New orders were received to remove the dressing with adhesive remover, cleanse with wound cleanser, apply Fibrocol to area, cover with foam dressing , and change every other day and as needed. Review of nursing progress notes dated 03/14/17 documented Resident #52 refuses an alternating air mattress and gel cushion to chair. She had a pressure reducing mattress on bed and sits on a pillow. Discussed with the resident the use of an air mattress and gel cushion again today and she once again refused. She was often non-compliant with turning and repositioning at routine times. Encouraged the resident to allow frequent repositioning. She takes a nutritional supplement. She remains at risk for skin breakdown due to incontinence, impaired mobility, weight loss, decreased tissue perfusion, advanced age and resident's choices. Will continue to monitor skin for breakdown. The skin assessment reveals a Stage III pressure ulcer to the coccyx measuring 1.8 cm length by 0.5 cm wide and 0.4 cm depth. The physician and family were updated on her condition and new orders received. Review of nursing notes and physician order [REDACTED]. Observation of a dressing change to the coccyx for Resident #52 on 06/21/17 at 11:00 A.M. Registered Nurse (RN) collected the supplies from the medication room. RN #200 washed her hands, donned gloves, and removed the foam dressing from the resident's coccyx. RN #200 stated the brown color on the dressing was due to a bowel movement getting under the dressing. RN #200 disposed of the soiled dressing, removed her gloves, and used hand sanitizer. She donned new gloves and cleansed the wound with wound cleaner. She removed a cotton tip swab from a package and coated the swab with the Santyl ointment and placed the ointment on the tissue outside of the pressure ulcer. She took a new cotton tip swab and applied more Santyl ointment and placed it in the wound. She took a small piece of Fibrocol dressing and placed it half in the wound and half outside the wound. She covered the open area with a foam dressing. Interview on 06/21/17 at 11:15 A.M., RN #200 verified Santyl ointment was used to debride dead skin and she had placed Santyl on the healthy tissue around the open wound. She stated she did not know what Fibrocol was used for. Review of the manufacturer's instructions for use of [MEDICATION NAME] dressing noted to debride the wound when necessary, irrigate the wound site with normal saline solution, and apply Fibrocol directly to the wound bed. Review of the manufacturer's instructions for use of Santyl ointment noted to make sure to apply the ointment only to the wound and not surrounding tissues.
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, fall investigation review, resident interviews, family interview, staff interviews, and observation, the facility failed to ensure fall prevention and mobility interventions were utilized. This resulted in actual physical and emotional harm to one resident (#11) who sustained a fall with a fractured foot when staff failed to transfer the resident using a stand up lift. This also affected one resident (#52) who sustained a fall with a laceration when her bed was not placed in the low position. Two residents were reviewed for falls with injuries. The facility census was 75. Findings include: 1. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment, dated 06/01/17, revealed the resident had intact cognition and did not refuse care. She required extensive assistance of two staff members for bed mobility, transfers, toilet use, and personal hygiene. She has functional limitations in range of motion on both sides, did not ambulate, and used a wheelchair. Review of the Care Area Assessment (CAA) summary, dated 06/01/17, documented the resident was admitted from home. She experienced vomiting and diarrhea at home, had increased weakness, and her caregiver was having more difficulty with transfers and caring for her at home. She has [DIAGNOSES REDACTED], weakness, and impaired balance. She no longer walked and used a wheelchair for mobility. Care was provided in the home by a family member. She needed assistance with bed mobility, transfers, toileting, bathing, and a wheelchair for locomotion. Used a standing lift for transfers. She was receiving physical therapy and occupational therapy services to improve on activity of daily living deficits. She was planning to return home with her spouse and home health services when her therapy goals were met. Review of the plan of care dated 05/25/17, reveled the resident has activity of daily living self care deficits as evidenced by weakness and pain related to [DIAGNOSES REDACTED]. The goal was not to develop any complications related to decreased mobility. The interventions include using a standing lift for transfers. Review of the nursing progress note dated 06/04/17 at 10:00 A.M. revealed the nurse was called to the shower room on the 400 Hallway. Resident #11 was on the floor complaining of left ankle pain. The nurse was told the resident fell when the State tested Nurse Aide (STNA) did not use the standing lift during a transfer. Two staff members assisted the resident into the wheelchair with the use of a mechanical lift. A mobile x-ray of the left ankle was obtained and the results were negative for a fracture. Review of the fall investigation revealed a witness statement written by STNA #202 on 06/04/17, documented she lowered Resident #11 to the floor in the shower room. She did not use the standing lift for the transfer to the shower chair. Review of the orthopedic consult note date 06/15/17 revealed additional x-rays of Resident #11's left foot were taken. The note documented there were three fractures to the foot. The consult documented the resident was to wear a fracture boot and could bear weight to the left foot as tolerated. Interview on 06/20/17 at 4:45 P.M., Resident #11 stated on 06/04/17 STNA #202 came into her room to help her from the bed to the bedside commode. STNA #202 did not use a gait belt or a standing lift for the transfer. When the resident told her she should have used a lift STNA #202 stated she did alright without it. After using the commode STNA #202 transferred her back to bed and did not use the lift. At about 10:00 A.M. STNA #202 came back into the room and transferred her from the bed to the wheelchair with a standing lift because the resident insisted STNA #202 use it. STNA #202 took her to the shower room and attempted to transfer her from the wheelchair to the shower chair without the use of a gait belt or a standing lift. The resident stated she told STNA #202 she needed to use the lift to transfer and STNA #202 told her she did fine without it when she transferred to the commode earlier so she could try it without the lift now. Resident #11 stated during the transfer her knees buckled and STNA#202 tried to catch her by grabbing her hands, which did not break her fall. She stated she fell hard onto the floor breaking her foot. She stated she started to cry due to the pain and STNA #202 stated don't cry let's just get you up and go on with the shower like this never happened. The resident stated she could not get up and continued to cry. STNA #202 called the nurse who came in and and asked STNA #202 why she did not use the lift to transfer the resident. STNA # 202 stated she knew she was suppose to use the lift but she did not. The resident stated her foot was very painful and it really hurts when she tries to stand on it. Interview on 06/20/17 at 5:40 P.M., the Administrator stated STNA #202 was educated on the use of lifts on 06/20/17 and was not scheduled to work with Resident #11. The Administrator verified STNA #202 had been educated on the use of lifts on 05/15/17 and was aware Resident # 11 was to use a lift, but chose not to use the lift causing the resident harm. Interview on 06/21/17 at 1:20 P.M., Resident #11 stated she was very depressed that she has to stay longer due to a broken foot and cries often since the incident. She stated she was admitted for strengthening following an illness of vomiting and diarrhea and was told she could return home after about a weeks stay when she was able to stand and pivot. Due to her foot being fractured her stay will four to six weeks. If it does not heal in six weeks she may have to have surgery. She stated she was fearful STNA #202 may retaliate against her when she came back to work. 2. Review of the medical record for Resident #133 revealed an admission to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the social service note, dated 06/14/17, documented the resident was alert but had confusion. She was planned a short term stay at the facility for rehabilitation. Prior to admission she lived at home, with a family member and planned to return home with family providing continued care. Review of the nursing progress notes dated 06/18/17 documented Resident #133 rolled out of her bed onto the floor. An STNA

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F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) alerted staff to the resident's fall. Resident #133 was observed lying on her right side. A laceration was observed on her forehead and a skin tear to her right elbow. Pressure was applied to her forehead. Vitals signs and neurological checks were done. The physician was contacted and ordered for the resident to be transferred to the emergency room (ER) to be evaluated. Review of the nursing progress note dated 06/19/17 at 4:41 P.M. documented the interdisciplinary team reviewed the resident's fall. The team decided the root cause of the fall was the resident becoming restless when waking up. All fall interventions were reviewed and the team felt the interventions were appropriate at this time and will periodically review and implement changes as needed. Review of the fall investigation revealed a witness statement dated 06/19/17, written by STNA #204, which documented when she entered Resident #133 room on 06/18/17 at approximately 8:00 A.M. the resident was on the floor and the bed was low but not all the way down. Interview on 06/19/17 at 1:43 P.M., Resident #90, who resided in the room across the hall from Resident #133, stated over the weekend Resident #133 had her call light on for a long time and then started yelling. She fell out of bed and had a cut on her forehead . He saw her lying on the floor with her head bleeding and went to the nurses station to tell the nurse she fell . He stated the bed was not in the low position when he saw her on the floor. Interview on 06/19/17 at 2:00 P.M., Resident #133's family member asked the surveyor and STNA #204 to come into the resident's room. The family member stated he wanted the surveyor to see the residents face. The resident was observed to have a black right eye and bruising down the right side of her face with a laceration above her right eye. Her family member stated she rolled out of bed and the family was told the bed was not in the lowest position when the incident occurred. He stated he asked them to put side rails up or place the bed against the wall to prevent her from falling out of bed again . He stated he was told they could not put these interventions in place because it was a restriction. It was verified by observation at this time the bed was in the low position with no other fall interventions in place. Review of an untitled facility form, printed on 06/19/17, documented for safety Resident #133's bed was to be in low position, body pillows when in bed, and reinforce need to call for assistance . Interview on 06/22/17 at 9:30 A.M., Licensed Practical Nurse (LPN) MDS Coordinator #207 stated the untitled form was the plan of care used by the STNAs to know how care for residents. She verified the low bed position was initiated 06/14/17, the body pillows were initiated on 06/19/17, and reinforce the use of call light was initiated on 06/19/17. Interview on 06/20/17 at 4:45 P.M., Licensed Practical Nurse (LPN) #211 stated she was at the nurses station when Resident #90 came down the 300 Hall and stated the lady at the end of the hall, Resident #133, was on the floor and she was bleeding from her head. She stated she ran to Resident #133's room and found her on the floor with a cut above her right eye. She stated the call light was activated when she entered the room. The bed was approximately knee height when she entered the room, which was not the lowest position.
F 0332 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medication administration observation, medical record review, and staff interview, the facility failed to administer three medications according to physician orders [REDACTED].#29) resident observed for medication administration out of 28 opportunities resulting in an 10.7% medication error rate. The facility census was 75. Findings include: During medication administration observation on 06/21/17 at 8:30 A.M., Registered Nurse (RN) #220 administered [MEDICATION NAME] (calcium channel blocker to treat high blood pressure) 240 milligrams (mg). She administered seven additional medications. She did not administer [MEDICATION NAME] (iron supplement) 324 mg or potassium chloride (potassium supplement) 20 milliequivalent (meq). Review of the June 2017 monthly physician orders [REDACTED]. Interview on 06/21/17 at 10:10 A.M., RN #220 verified Resident #29's blood pressure was 105/69 and she had administered the [MEDICATION NAME] 240 mg. She verified the physician order [REDACTED]. This represented a total of three medications out of 28 opportunites for a 10.7% medication error rate.
F 0411 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide routine and 24-hour emergency dental care for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident interview, and staff interview, the facility failed to provide follow up dental care for one (#92) of 32 residents reviewed for dental concerns. The facility census was 75. Findings include: Review of the medical record of Resident #92 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/20/17, revealed Resident #92 had intact cognition. Review of the care plan, last updated 04/24/17, revealed the resident required assistance with oral care and assistance with removing and inserting dentures. Review of the progress notes dated 12/19/16 revealed Resident #92 was to have a follow-up appointment with the dentist on 01/10/17 regarding ill-fitting dentures. The record contained no evidence Resident #92 had went to this appointment. Observations on 06/19/17 at 2:20 P.M. an on 06/21/17 at 8:19 A.M. revealed Resident #92 to have no dentures in place. Interview on 06/19/17 at 2:20 P.M, Resident #92 revealed he had dentures but they are too loose and always fall out. He stated he could eat without problems, but would like to have the dentures adjusted to enable him to wear them. He stated he had a dentist appointment scheduled but does not know why he did not see the dentist. He further added the facility is always slow at getting things, like appointments, done. Additional interview on 06/21/17 at 8:19 A.M., with Resident #92 revealed he does not usually wear the dentures because they are too loose. He has tried the paste and it will work for a while then they become loose again. He doesn't know when he will see the dentist again. Interview on 06/21/17 at 10:10 A.M., Licensed Social Worker (LSW) #208 revealed Resident #92 had been complaining of headaches which had taken precedence over the dentures. LSW #208 stated a follow-up appointment with the dentist was scheduled for 06/27/17. Interview on 06/22/17 at 9:50 A.M. with Licensed Practical Nurse #211 revealed she had rescheduled a dental appointment for Resident #92 for 06/27/17. She also verified the missed appointment on 01/10/17 and verified no explanation was located as to the cause of the missed appointment.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a program that investigates, controls and keeps infection from spreading.** Based on observation, staff interview, review of manufacturer's recommendations, and review of facility policy, the facility failed to ensure staff properly disposed of a used lancet and blood glucose strip for one (#13) of one resident observed during a finger stick blood glucose check, out of 22 residents identified to receive finger stick blood glucose monitoring. The facility also failed to ensure staff washed their hands prior to the administration of intravenous (IV) medication for one (#58) one resident observed for IV medications out of three residents identified by the facility as receiving IV medication. The facility census was 75. Findings include: 1. Observation on 06/19/17 at 5:20 P.M. of a finger stick blood sugar to monitor glucose levels, performed on Resident #13, revealed Registered Nurse (RN) #208 lanced the resident's third finger of the resident's left hand obtaining a drop of blood. She placed the blood on the glucometer glucose strip. She removed the glove from her right hand and wrapped the lancet glucose strip, and glove together and threw it in the trash on the medication cart located in the 300 Hall. Interview on 06/19/17 at 6:15 P.M., RN #208 verified she had disposed of the lancet and strip in the medication cart trash. She verified she should have placed the lancet in the sharps container. Review of the manufacturer's recommendations entitled Evencare G3, the glucometer meter used to check the blood glucose of Resident #13, under a caution label noted used lancets and glucose strips are biohazard material and can transmit blood borne diseases. Used lancets and strips should be deposited according to local regulations. 2. Observation of IV medication administration on 06/20/17 at 10 :30 A.M. revealed RN #205 went to the medication room and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365615	A. BUILDING _____ B. WING _____	06/23/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF BELLEFONTAINE	221 NORTH SCHOOL STREET BELLEFONTAINE, OH 43311

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 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) obtained an IV tubing and IV antibiotic for Resident #53. RN #205 stood at the medication cart and ran her fingers through her hair and and placed a hair clip in her hair. She put on a gown and gloves outside of the resident's room. She entered the resident's room and and spiked the the IV antibiotic bag with the tubing that was hanging from the IV pole. She realized that was the old tubing and took down the IV antibiotic bag, removed the tubing, and spiked the bag with the new tubing she had obtained from the medication room . She flushed the resident's peripherally inserted central catheter (PICC) line (IV access line) with normal saline and began infusion of the antibiotic. Interview on 06/21/17 at 10:45 A.M., RN #205 verified she had ran her fingers through her hair and did not wash her hands prior to putting on gloves and administering the IV medication. Review of the facility policy titled Infusion of Medication, dated 01/09, noted under procedure to wash hands prior or administration of medications through an intravenous line.
F 0463 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's room or bathroom and bathing area.** Based on observation, resident interview, and staff interview, the facility failed to properly maintain a functioning call light in the bathroom for one (#5) of 35 residents observed in Stage 1 of the survey. The facility census was 75. Findings Include: Observation on 06/19/17 at 11:08 A.M. of Resident #5's bathroom call light revealed the call light did not light up in the hallway when the cord was pulled. Interview on 06/19/17 at 11:08 A.M., Resident #5 reported the call light had not been working since she moved into the room. Interview on 06/22/17 at 9:10 A.M. with Housekeeping Supervisor #210 verified Resident #5's bathroom call light was not lighting up in the hallway.
F 0465 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, staff interview, and facility policy review, the facility failed to provide necessary repair and maintenance of the physical environment. This affected six (Rooms #100, #101, #109, #110, #112 and #114) of thirteen rooms on the 100 hall that were found to have torn linoleum floors in the bathroom. The facility census was 75. Findings include: Observations on 06/19/17 during Stage 1 of the annual survey revealed torn linoleum floor in the bathrooms of rooms #100, #101, #109, #110, #112 and #114. Interview on 06/22/17 between 8:55 A.M. and 9:20 A.M. with Housekeeping Supervisor #210 verified the following resident bathrooms had torn linoleum floors (#100, #101, #109, #110, #112 and #114). Review of facility policy titled Facility Maintenance Manual undated revealed the maintenance director shall make daily rounds of the facility for monitoring of the physical plant.
F 0502 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.** **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 obtain physician ordered laboratory work for two (#32 and #48) of five residents reviewed for unnecessary medications. The facility census was 75. Findings Include: 1. Review of Resident #32's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #32's physician orders [REDACTED]. Review of Resident #32's laboratory reports revealed no [MEDICATION NAME] level had been obtained in April 2017. Interview on 06/21/17 at 5:35 P.M., the Assistant Director of Nursing verified Resident #32's [MEDICATION NAME] level was not completed as ordered. Review of facility policy titled Laboratory Tracking Guidelines, dated 08/2014, revealed the center is responsible for contacting the lab for any results not received when expected. Labs not drawn as ordered are reported to the attending physician for further direction and reported through the incident management system. 2. Review of the medical record of Resident #48 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the Follow-Up Visit form date 04/27/17 revealed the physician had documented a complete blood count (CBC) and iron (Fe) studies were to be obtained. A [MEDICAL CONDITION] stimulating hormone (TSH) level was to be obtained annually and a basic metabolic panel (BMP) every six months. Review of the monthly physician order [REDACTED]. Review of the laboratory results revealed no evidence the CBC or Fe studies were obtained. Interview on 06/21/17 at 2:50 P.M., the Assistant Director of Nursing and Registered Nurse (RN) #203 verified the CBC and Fe studies were not drawn and will be drawn 06/23/17.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Self-Reported Incident (SRI) and staff interview the facility failed to keep accurate medical records when an employee forged the signature of a family member on a controlled substance sheet. This affected one Resident (#19) of 17 medical records reviewed during Stage 2 of the annual survey. The facility census was 75. Findings include: Review of the SRI tracking # 5 revealed an allegation of misappropriation of a residents antianxiety medication ([MEDICATION NAME]). During the facilities investigation of the allegation, the Director of Nursing (DON) checked the scheduled (pharmaceuticals determined to require closer monitoring per government agency) medication sign out sheet and found Resident #19's expired [MEDICATION NAME] had been documented as having been sent home with a family member. There was a signature to represent the family member was noted on the form to indicate the family had taken the expired [MEDICATION NAME] home. However, the DON realized the family member's name was spelled incorrectly. Additionally, the DON had spoken with that family member and was already aware the family did not sign for the medication. Review of the facility documents and statements from the investigation of SRI # 5 revealed the written statement by the nurse involved. In the statement the former employee admitted that she forged the signature of the family member on the record. During an interview with the Administrator on [DATE] at 3:37 P.M, the above findings were verified. This deficiency substantiates Complaint Number OH 633.