STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365643	A. Building B. Wing	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portsmouth Health and Rehab	727 Eighth Street Portsmouth, OH 45662

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on medical record review and staff interview, the facility failed to ensure resident Pre-Admission Screening and Resident Review (PASRR) documents were accurate to resident current conditions and diagnoses. This affected three (Resident #6, Resident #40, and Resident #49) of four residents reviewed for PASRR documents. The census was 72. Findings Include: 1. Resident #6 was admitted to the facility on [DATE]. His diagnoses were dementia, schizoaffective disorder, dysphagia, falls, hyperlipidemia, myocardial infarction, depression, obstructive uropathy, chronic pain, anemia, hypertension, anxiety, dysphagia, altered mental status, acute kidney disease, cervicobrachial syndrome, and restless leg syndrome. Review of his Minimum Data Set (MDS) assessment, dated 07/09/23, revealed he was minimally impaired. Review of medical diagnoses for this resident revealed a new diagnosis of schizoaffective disorder was added on 09/14/21. Most recent PASARR was completed on 04/01/21 and does not reflect this diagnosis. A corrected PASARR was completed on 10/03/23 reflecting the new diagnosis addition. Interview with the Administrator on 10/03/23 at 02:42 P.M. verified a new PASARR should have been completed with the addition of the new diagnosis. 2. Resident #40 was admitted to the facility on [DATE]. His diagnoses were arthritis, dementia, schizoaffective disorder, atherosclerosis, hypertension, hypothyroidism, hyperlipidemia, atrial fibrillation, aortic valve insufficiency, hypokalemia, chronic kidney disease stage 4, macular degeneration, venous insufficiency, congestive heart failure, muscle weakness, abnormalities of gait and mobility, anxiety, depression, and hearing loss. Review of his MDS assessment, dated 07/11/23, revealed he was minimally to moderatelyimpaired. Review of the PASARR from 04/19/23 revealed no indications of schizoaffective disorder diagnosis from the admission PASARR. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A new PASARR was not completed with the new diagnosis from 04/19/23. A correct PASARR was completed on 10/03/23 during the survey. Interview with the Administrator on 10/03/23 at 02:42 P.M. verified a new PASARR should have been completed with the addition of the new diagnosis. 3. Resident #49 was admitted to the facility on [DATE]. His diagnoses were cardiomyopathy, schizoaffective disorder, depression, osteoporosis, bipolar disorder, alopecia, anxiety, aphagia, atherosclerosis, cognitive communication deficit, diverticulosis, hypertension, mood disorder, atrial fibrillation, constipation, dementia, and falls. Review of his MDS assessment, dated 07/09/23, revealed she was rarely/never understood. Review of medical diagnoses for this resident revealed a new diagnosis of schizoaffective disorder was added on 04/21/23. Most recent PASARR was completed on 09/14/22 and does not reflect this diagnosis. A corrected PASARR was completed on 10/03/23 reflecting the new diagnosis addition. Interview with the Administrator on 10/03/23 at 02:42 P.M. verified a new PASARR should have been completed with the addition of the new diagnosis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observation, interview and record review the facility to adequately assess and provide treatment for Resident #64 who had red, dry, flaky scalp. This affected one (Resident #64) of two residents reviewed for activities of daily living. The facility census was 72. Findings include: Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses including rhabdomyolysis, dementia without behaviors, pain, dysphagia and fracture of unspecified part of neck of right femur. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #64 required extensive assistance of one person for personal hygiene and was totally dependent on two staff for bathing needs. Resident #64 had a surgical wound with application of dressing and application of ointment/medications other than to feet. Review of the weekly skin integrity checks for Resident #64 dated 09/11/23 indicated Resident #64 had an area to the lower part of head and back region with dry, cracked skin. The weekly skin integrity checks dated 09/13/23 and 09/20/23 revealed no changes to Resident #64 skin. Review of the physician orders for 10/2023 revealed Resident #64 was not ordered any treatment to his red, dry, flaky scalp. Review of the plan of care revealed no plan related to altered skin integrity or risk of altered skin integrity. Observations on 10/02/23 at 11:22 A.M., 10/03/23 at 11:03 A.M. and on 10/04/23 at 10:40 A.M revealed Resident #64 had red scalp with large white flakes in his hair and along his hair line. Interview on 10/03/23 at 11:08 A.M. with Registered Nurse (RN) #125 confirmed Resident #64 had large white flakes in his hair and along his hair line. Interview on 10/04/23 at 10:45 A.M. with Director of Nursing (DON) confirmed Resident #64 had impaired skin integrity as evidenced by large white flakes in his hair and along his hair line.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observation, interview, record review and review of facility policy revealed the facility failed to implement non-pharmacological interventions for Resident #48 prior to administering as needed narcotic pain medications. This affected one resident (Resident #48) reviewed for pain management. The facility census was 72. Findings include: Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including nonalcoholic steathohepatitis (NASH), fatty liver, urinary retention, peripheral vascular disease, chronic kidney disease and gout in left knee. Review of the Medicare five day Minimum Data Set (MDS) dated [DATE] revealed Resident #48 was cognitively intact, required assistance with activities of daily living and had no scheduled or as needed pain medications. Resident #48 did not have any pain. Review of the physician orders dated 09/23 for Resident #48 revealed an order for hydrocodone-acetaminophen (narcotic pain medication) tablet 5-325 milligrams (mg) by mouth every six hours as needed for pain. Review of the Medication Administration Record (MAR) for 09/23 for Resident #48 revealed he received hydrocodone-acetaminophen tablet 5-325 mg by mouth at least once a day from 09/01/23 through 09/30/23. There were no non pharmacological interventions implemented or documented as provided before administering the pain medication. Review of the nursing progress notes from 09/01/23 through 09/30/23 was silent on providing non pharmacological interventions prior to administering the pain medication. Review of the plan of care dated 05/22/23 and revised on 09/18/23 revealed Resident #48 needed pain management and monitoring related to NASH, general debility and peripheral vascular disease. The Interventions included administer medication as ordered, monitor for effectiveness of medication, evaluate and establish level of pain on numeric scale, and implement Resident #48 preferred non pharmacological interventions for pain relief-rest, repositioning and relaxation. Interview on 10/02/23 at 2:29 P.M. and 10/03/23 at 9:00 A.M. with Resident #48 revealed the resident had pain and received pain medication when he requested it. Interview on 10/04/23 at 2:03 P.M. with Unit Manager #157 revealed non pharmacological interventions were in the residents care plan. Unit Manager #157 stated the nurse would document the non pharmacological interventions that were attempted on the MAR. Interview on 10/04/23 at 2:28 P.M. with the Director of Nursing confirmed Resident #48 did not receive non pharmacological interventions before administration of narcotic pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Pain Management dated 09/29/22 revealed non pharmacological interventions would include but no limited to environmental comfort measures, loosening any constrictive bandage, clothing or device, applying splinting, physical modalities, exercises to address stiffness and prevent contractures and cognitive/behavioral interventions such as music, relaxation techniques, activities, diversions, comfort support, teaching the resident coping techniques and education about pain.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observation, interview, and medical record review, the facility failed to provide care and services to address Resident #48's verbalization of being sad and depressed. This affected one resident (Resident #48) reviewed for behavioral-emotional issues. The facility census was 72. Findings include: Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including nonalcoholic steathohepatitis (NASH), fatty liver, urinary retention, peripheral vascular disease, chronic kidney disease and gout in left knee. Review of the Medicare five day Minimum Data Set (MDS) dated [DATE] revealed Resident #48 was cognitively intact and had trouble with sleeping, feeling down, depressed and hopeless, feeling tired with no energy, poor appetite and trouble concentrating. Resident #48 scored 10 on mood assessment indicating moderate depression. Review of the physician orders dated 09/23 for Resident #48 revealed there were no orders for antidepressant medications or other mood disorder medications. There was not any orders related to psychiatric care and treatment. Review of the nursing progress notes from 09/01/23 through 09/30/23 was silent in regards to mood disorder or signs and symptoms of depression. Review of the plan of care dated 06/27/23 revealed Resident #48 felt sad, could not sleep, had no appetite or energy and felt inadequate at times. The interventions included to encourage Resident #48 to get involved in activities related to his interests, help the resident to keep in contact with family and friends, introduce the resident to others with similar interests, offer food and beverages the resident liked and take the time to discuss the residents feelings when he was feeling sad. Interview on 10/03/23 at 9:00 A.M. with Resident #48 revealed he felt down about his life and was sad. Resident #48 became tearful and expressed he was feeling sad. Interview on 10/04/23 at 3:34 P.M. with Social Services revealed she completed the mood section of the MDS assessment. Social Services stated she had visited with Resident #48 several times and he talked more about moving out of the facility and not his feelings. Social Services stated she did not document all the conversations she had with residents as their conversations were private and confidential. Social Services did not provide any documentation of conversations with Resident #48 about his feelings of depression.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observation, interview, medical record review, and facility policy review revealed the facility failed to ensure the proper storage of nebulizer machine mask to prevent contamination and possible infection. This affected one resident (Resident #173)out of one resident reviewed for respiratory care. The facility census was 72. Findings include: Review of the medical record for Resident #173 revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia and hypercapnia, obstructive sleep apnea, hypertension and peripheral vascular disease. The Minimum Data Set (MDS) comprehensive assessment was not complete at this time. Review of the physician orders for Resident #173 dated 09/23 revealed an order for ipratropium-albuterol solution 0.5 to 2.5 (3) milligrams (mg) per 3 milliliters (ml) inhale orally four times daily related to acute and chronic respiratory failure with hypoxia and hypercapnia. Review of the Medication Administration Record (MAR) 09/23 revealed Resident #173 received nebulizer respiratory medication as ordered. The plan of care was silent related to providing protective barrier to nebulizer machine breathing mask. Observations made during the annual survey on 10/02/23 at 8:51 A.M., 10/03/23 at 11:14 A.M. and 10/04/23 at 1:18 P.M. revealed Resident #173 nebulizer machine was on the bedside table. The tubing was not dated and the mask was hanging over the side of the table. Interview on 10/04/23 at 1:18 P.M. with Resident #173 revealed the mask did not have a protective barrier to prevent contamination since she had been at the facility. Interview on 10/04/23 at 1:19 P.M. with State tested Nursing Assistant (STNA) #83 confirmed the nebulizer mask was not in a protective barrier for infection control. STNA #83 also confirmed there was not a date on the mask tubing. Review of the facility policy titles Oxygen Administration dated 09/29/22 revealed to change nebulizer tubing and delivery devices weekly and as needed if become soiled or contaminated. Also stated to keep deliver devices covered in plastic bag when not in use.