STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365990	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Dawn Rehabilitation and Healthcare Center	865 East Iron Avenue Dover, OH 44622

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on review of Controlled Medication Shift Change Log, controlled medication signature sheets, record review, review of the staff schedule, policy review, and interview, the facility failed to prevent misappropriation of resident medications. This had the potential to affect 11 residents (#7, #8, #11, #16, #17, #23, #25, #26, #28, #29 and #71) who received narcotic medication and resided on the 200 hall. The facility census was 70. Findings include: On [DATE] at 3:19 P.M. review of the 200 front hall Controlled Medication Shift Change Log revealed the staff was counting the medication cards/containers and controlled medication signature sheets at the change of shift and signing the log. However, staff were not consistently writing the number of medications and signature sheets counted and the new medications delivered or medications removed from the cart. Review of the November (2024) Controlled Medication Shift change log for the 200 front hall medication cart revealed the amount of cards/containers and signature sheets in the locked box was decreasing without any entries of medications being removed from the controlled medication drawer. However, the amount of medication cards/containers continued to match the number of Controlled Medication Signature sheets. The Controlled Medication Shift Change Log indicated on [DATE] there were 15 cards of medication and control sheets. On [DATE] the count sheet was signed as 14 without an entry as to what medication was removed from the locked box. On [DATE] evening shift the Controlled Medication Shift change log was signed but did not indicate the current count. On [DATE] morning shift the count dropped to 11 without an entry in the log of what medication was removed from the controlled substance drawer. Interview on [DATE] at 3:32 P.M. with Licensed Practical Nurse (LPN) #100 verified the Controlled Medication Shift Change log indicated there were 15 cards of medication in the locked drawer on [DATE] and on [DATE] there were 11 cards without the log indicating any medications were removed. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 3:50 P.M. with the Director of Nursing (DON) revealed when a controlled medication was finished the staff put the completed signature sheet in the slot on her door. When a medication is discontinued, a resident is discharged or expired the staff will hand the remaining medication and corresponding controlled medication signature sheet to her or the assistant director of nursing. The DON stated she logs the medications given to her and destroys them with a second person. The DON did not find any full/completed signature sheets from the 200 hall in her mailbox. The DON stated she was not handed any medication from the 200 hall to be destroyed. On [DATE] between 3:55 P.M. and 4:20 P.M. during observation and interview, the DON and surveyor went to the 200 hall and checked the medication room. No completed signature sheets or controlled substances were located. The front and back 200 hall medication carts were checked to see if there were controlled substances placed in the wrong locked box or in with the regular medication. There were no controlled medications located out of place. The DON called the pharmacy to learn what medications had recently been delivered to the 200 hall and learned Resident #71 was sent Morphine 15 mg immediate release on [DATE], and on [DATE], 30 tablets and Morphine 15 mg extended release on [DATE]. The DON was not able to find the medications or the signature sheets for the medications. Review of the Controlled Medication Shift Change Log indicated on [DATE] there were 15 cards of medication and control sheets. LPN #100 counted at 6:00 P.M. with Registered Nurse (RN) #174. On [DATE] at 6:00 A.M. the count sheet was signed as 14 without an entry as to what medication was removed from the locked box. Registered Nurse #174 and LPN #178 counted the controlled medication. On [DATE] evening shift, 6:00 P.M. the Controlled Medication Shift change log was signed by LPN #178 and RN #174 but did not indicate the current count. On [DATE] morning shift, 6:00 A.M. the count dropped to 11 without an entry in the log of what medication was removed from the controlled substance drawer. RN #174 and LPN #178 signed the morning count. Interview on [DATE] at 4:25 P.M. with LPN #178 revealed hall 200 was not her usual hall to work. She indicated she only administered one medication from the controlled substance drawer on her [DATE] 6:00 A. M. to 6:00 P.M. shift. Interview on [DATE] at 4:34 P.M. with LPN #100 revealed she worked [DATE] 6:00 A.M., to 6:00 P.M. and returned [DATE] at 6:00 A.M. She indicated hall 200 was her usual hall to work. LPN #100 was asked if she could recall what medications were in the locked controlled substance drawer at 6:00 P.M. on [DATE] that were not there at 6:00 A.M. on [DATE]. She revealed Resident #71 expired at the end of her shift. She had two or three bubble packs/cards of Morphine IR, immediate release and Morphine ER, extended release in the drawer when she left on [DATE] that were not in the drawer on [DATE]. Interview on [DATE] at 5:32 P.M. with LPN #178 revealed there were two cards of Morphine in the lock box for Resident #71 who expired when she counted on the morning and evening of [DATE]. She did not remove them to be destroyed because hall 200 was not her usual floor. Review of the staff schedule revealed RN #178 was due to work on [DATE] at 6:00 P.M. and was phoned at approximately 5:20 P.M. not to report to work pending investigation. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 6:55 P.M. with the Administrator verified the facility's Controlled Substance policy did not address the type of reconciliation of narcotics form the facility used. The policy did not discuss documenting on the log, the resident, medication name and quantity when the new medications arrived. The policy did not include in the procedure to write when medications were removed from the locked drawer, who they were for, the name of the medication and quantity remaining. The policy indicated the controlled substances must be stored in the medication room in a locked container. The facility stored their controlled medications in the locked drawer of medication cart which was kept in the hall. Review of electronic communication (email) dated [DATE] at 1:22 P.M. the Administrator identified a Self Reported Incident (SRI) #254090 was filed and a Police Report was filed (Case Number ,d+[DATE]) related to misappropriation of resident medication. Review of electronic communication dated [DATE] at 2:55 P.M. from the Administrator revealed that RN #178 resigned voluntarily. Interview on [DATE] at 2:22 P.M. with the Administrator and DON revealed RN #178 did not come to the facility for an interview. They revealed she denied taking the morphine and was resigning since she was being accused. The Administrator indicated the pharmacy was going to do an audit and they were following the pharmacy policy. They have not located the missing morphine. Medication record review revealed 11 residents resided on the 200 hall and received narcotic medications (Residents #7, #8, #11, #16, #17, #23, #25, #26, #28, #29 and #71). Review of the facility Pharmacy Policy [NAME] (revised 2018) revealed in regard to loss of theft of drugs, any theft or loss of drugs must be reported immediately to facility management and appropriate actions taken. Employees are instructed to immediately report suspected theft or loss of drugs to their supervisor/manager for appropriate documentation, investigation, and follow-up. For Controlled Substances: 1. Suspected theft or loss is reported immediately to the Director of Nursing. 2. The Director of Nursing is responsible for investigating discrepancies and making every reasonable effort to reconcile the discrepancies according to facility policy. 3. The Director of Nursing notifies the Administrator of controlled substance discrepancies. If discrepancies are not reconciled, the Administrator, in conjunction with the facility's legal counsel (as appropriate), is responsible for directing: a. The notification of appropriate enforcement agencies according to state or federal regulations (e.g., local law enforcement, DEA, etc.). b. Any other actions to be taken (e.g., notifying the pharmacy, initiating quality improvement (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measures to prevent future occurrences). This deficiency represents non-compliance investigated under Master Complaint Number OH00159793.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review, observation, and interview, the facility failed to ensure care and treatment was completed of diabetic foot ulcers. This affected one resident (#8) of three residents reviewed for skin impairment. The facility census was 70. Findings include: Review of the medical record revealed Resident #8 was admitted on [DATE] with diagnoses including fractured neck of right femur, chronic lymphocytic leukemia of B-cell type in remission, abnormal posture, difficulty walking, muscle weakness, falls, obstructive sleep apnea, type 2 diabetes, hypertension, mixed hyperlipidemia, atherosclerotic heart disease, gastroesophageal reflux disease and cardiac pacemaker. The resident was admitted with a right and left plantar diabetic foot ulcers. Review of the 09/24/24 Admission Minimum Data Set Assessment revealed the resident was independent for daily decision making. Physician orders included a 09/25/24 treatment to bilateral plantar wounds to cleanse wound with normal saline, apply prism, and cover with dry dressing or Band-Aid daily and as needed. The treatment was changed on 10/28/24 to bilateral plantar wounds: cleanse wound with normal saline; apply bacitracin and cover with dry dressing or band-aid daily and as needed for wound maintenance. An order dated 11/06/24 revealed for right plantar foot wound: cleanse wound with normal saline; apply bacitracin and cover with dry dressing or band-aid daily and as needed for wound maintenance. Review of the record revealed wound assessments included an assessment dated [DATE] for the left plantar foot diabetic ulcer resolved. The right plantar foot diabetic ulcer was 2.0 centimeters (cm) length x 0.5 cm width x 0.1 cm depth. Interview on 11/12/24 at 11:32 A.M. with Resident #8 revealed he has sores on both feet he has been doctoring for years through the Veterans Administration. He said his right foot hurt. He is suppose to get dressing changes everyday. Yesterday the nurse brought the dressings in, put them on the stand (pointed to dressings on a dresser across from his bed), said she would be back and never came back. He said he did not get his dressing changed yesterday. The resident was in the recliner with his foot elevated wearing diabetic shoes. Review of the October (2024) treatment record revealed there was no evidence of the dressings being changed 10/18/24 and 10/27/24. Review of the November (2024) treatment record revealed no record of the dressings being changed on 11/06/24. Review of 11/11/24, the date Resident #8 said the dressings were left in the room and not changed, revealed the dressing change was signed off as completed by Licensed Practical Nurse (LPN) #100. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/12/24 at 12:07 P.M. with LPN #100 revealed she had an admission (on 11/11/24) and did not do Resident #8's dressing change 11/11/24. She said she passed it off to night shift but did sign the treatment sheet that she had completed the dressing change. Interview on 11/12/24 at 7:32 P.M. with the Director of Nursing verified there were days the foot dressings were not signed off as completed for Resident #8. This deficiency represents non-compliance investigated under Complaint Number OH00158850.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review, observation, policy review, and interview, the facility failed to ensure care and treatment of pressure ulcers was completed and consistent with professional standards of practice to promote healing, This affected one resident (#32) of three residents reviewed for skin impairment. The facility census was 70. Findings include: Review of Resident #32's medical record revealed the resident was readmitted on [DATE] with diagnoses including hyperkalemia, congestive heart failure, cerebral infarction, dementia, depression, atrial flutter, peripheral vascular disease, anemia, type II diabetes, chronic obstructive pulmonary disease, Stage IV pressure ulcer (defined as full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) to the sacrum, and cardiac pacemaker. Record review revealed the resident was originally admitted on [DATE] with osteomyelitis of left foot, methicillin resistant staphylococcus aureus infection, with pressure ulcers to sacrum, bilateral heels, left and right foot, right lower leg, and right ankle. Review of a quarterly Minimum Data Set assessment dated [DATE] revealed the resident was moderately impaired for daily decision making. The resident required substantial/maximum assist to roll from side to side. The resident had one Stage IV pressure ulcer. Physician orders included on 05/14/24 a low air loss mattress set per resident weight with bolster overlay, check placement and function every shift, on 06/24/24 an order for Enhanced Barrier Precautions (EBP) for wounds every shift, on 11/12/24 an order for left lateral foot- cleanse with normal saline , apply xeroform to open areas, cover with ABD. Pad and protect heel with ABD, wrap with Kerlix daily and as needed, and on 11/12/24 Sacrum- cleanse with normal saline, apply collagen with silver alginate then cover with border foam daily and as needed. Review of the October (2024) treatment record revealed there was no evidence of the sacral dressing being changed 10/05/24, 10/11/24, 10/22/24 and 10/29/24. Review of weights revealed the resident's weight never reached 240 pounds since admission. The resident weighed 217.7 pounds on 11/11/24. Review of the record revealed a current skin impairment of a chronic sacral pressure ulcer on 11/12/24 assessed as Stage IV that measured 2 centimeter (cm) x 0.8 cm x 0.3 cm with inflamed peripheral tissue roll. New vascular areas noted on 11/12/24: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/12/24 at 2:33 P.M. revealed the resident's door had a sign on it for EBP. Observation revealed the resident was on a Proactive mattress set on 260 pounds. Observation of the sacral wound dressing change with Licensed Practical Nurse (LPN) #132 and LPN #166 revealed the only Personal Protective Equipment (PPE) they utilized was gloves. Interview on 11/12/24 at 7:12 P.M. with LPN #132 verified the resident's low air loss mattress was to be set according to weight. She verified it was set too high at 260 pounds when it should of been set on 220 pounds. LPN #132 verified the resident had an order for EBP and she should have worn a mask, gloves and gown when changing his sacral dressing. LPN #132 further verified there were days when the sacral dressing was not signed off as being changed. Review of the Facility's Prevention of Pressure Ulcers policy (revised 2013) included to review the resident's care plan for any special needs of the resident. This deficiency represents non-compliance investigated under Complaint Number OH00158850.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on medical record review, review of facility policy, and staff interview the facility failed to ensure accurate reconciliation of controlled medications. This affected 33 residents (#2, #3, #5, #6, #7, #8, #10, #11, #16, #17, #20, #22, #23, #24, #25, #26, #28, #29, #37, #43, #44, #46, #48, #49, #51, #53, #59, #60, #61, #62, #65, #66 and #67) who were ordered controlled medications. The facility census was 70. Findings include: 1. On [DATE] at 2:13 P.M. review of the 100 hall Controlled Medication Shift Change Log revealed there was no record of controlled medication reconciliation the morning of [DATE]. Review of the Controlled Medication Shift Change Log revealed staff was to count the number of cards/containers of medication in the locked controlled medication staff drawer and the number of sign off sheets for each medication. The staff was to write down the resident's name, medication, strength and quantity when a controlled medication is delivered from the pharmacy as well as the adjusted card and count sheets. When a card of medication was removed from the controlled medication drawer the staff was to subtract the number of cards/containers removed and record the resident's name, medication and strength as well as the quantity removed. The adjusted amount of cards/containers and corresponding signature sheets was to be recorded. The removal could be due to discharged resident, medication discontinued, dosage change or death. On [DATE] at 2:13 P.M. review and observation of the November (2024) Controlled Medication Shift Change Log for the 100 hall cart revealed the amount of cards/containers and signature sheets was fluctuating up and down without entries of medications being added or removed. On [DATE] there were nine cards of medication and control sheets, on [DATE] the count went to eight without an entry of a medication being removed. The count returned to nine on the next count, then to 15, and to 13 on [DATE] without record of any resident medications being added or removed from the controlled substance drawer. Observation revealed Resident's #2, #3, #5, #6 and #67 had controlled medications locked in the drawer. On [DATE] at 2:13 P.M. interview with Licensed Practical Nurse (LPN) #125 verified the process of the count of controlled substances was not recorded so staff would not know if there were missing medications and count sheets. The count verified the amount of controlled medications in the drawer and the number of controlled medication signature sheets match. By not recording what medication was coming in and what medication was going out the facility was missing the check and balance step of tracking all controlled medications. LPN #125 further included they use agency nurses who do not sign the log at times or know the proper way to record the controlled medications. 2. On [DATE] at 2:30 P.M. review of the 300 hall Controlled Medication Shift Change Log revealed there was not a signature of the nurse going off duty the morning of [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the November (2024) Controlled Medication Shift Change Log for the 300 hall medication cart revealed the amount of cards/containers and signature sheets was fluctuating up and down without entries of medications arriving being added or removed. On [DATE] there were 21 cards of medication and control sheets, on [DATE] the count went to 20 without an entry as to what medication was removed for the controlled drawer. On [DATE] there were signatures of two nurses who counted the controlled medication without a number of how many controlled medications were in the drawer. The second shift on [DATE] at 6:00 P.M. the count went to 18 without an entry of a medication being removed. On [DATE] the count dropped to 17 without an entry of medication being removed from the controlled substance drawer. At this time, observation revealed Resident's #37, #43, #44, #46. #48, #49 and #51 had controlled medications locked in the drawer. On [DATE] at 2:33 P.M. interview with LPN #125 revealed agency staff left that morning without signing the Controlled Medication Shift Change Log. LPN #125 revealed she adds the resident name and medication when medication is delivered and the resident and medication name when the medication card is empty, discharged or discontinued. She indicated the agency staff does not fill out the form to account for medication arriving and leaving the lock box. LPN #125 verified a card of medication and the corresponding signature sheet could be removed without the staff questioning it. LPN #125 verified looking at the amount of medications added and the amount removed did not match the counts being documented by staff. On [DATE] at 2:45 P.M. review of the 400 hall Controlled Medication Shift Change Log revealed the staff was counting the medication cards/containers and controlled medication signature sheets at the change of shift and signing the log. Review of the November Controlled Medication Shift change log for the 400 hall medication cart revealed the amount of cards/containers and signature sheets was fluctuating up and down without the entries of medications arriving or leaving the controlled medication drawer matching the number of controlled medication in the drawer. On [DATE] there were 14 cards of medication and control sheets. The log indicated seven medications were added [DATE] but did not list the resident, medication, or amount received. The count was then 21 on [DATE]. On the second shift [DATE] the log indicated two cards were removed and the count was marked as 20 cards left, instead of subtracting two for a 19 count. On [DATE] the count dropped to 18 without explanation. On [DATE] second shift the count went to 19 without an entry as to what medication was added for the controlled drawer. On [DATE] there were entries of two medications being removed from the drawer but the count dropped by three to 16. At this time, observation revealed Resident's #53, #59, #60, #61, #62, #65, and #66 had controlled medications locked in the drawer. On [DATE] at 2:49 P.M. interview with LPN #178 verified counting cards/containers of medication and the corresponding signature sheets was not accurate because staff was not consistently documenting when medication was delivered and removed from the controlled medication drawer. LPN #178 verified the number of medications documented on the log in the controlled substance drawer may be accurate however, the number did not match the log of the amount of medication that arrived and the amount of cards/containers used or destroyed. 4. On [DATE] at 3:01 P.M. review of the 200 back hall Controlled Medication Shift Change Log revealed the staff was counting the medication cards/containers and controlled medication signature sheets at the change of shift and signing the log. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the November (2024) Controlled Medication Shift Change Log for the 200 back hall medication cart revealed the amount of cards/containers and signature sheets was getting less without any entries of medications being removed from the controlled medication drawer. However, the amount of medication cards/containers continued to match the number of Controlled medication signature sheets. On [DATE] there were eight (8) cards of medication and control sheets. On [DATE] second shift the count sheet was signed but there was not a number written as to the amount of medications in the locked controlled substance drawer. On [DATE] the count dropped to seven (7) without an entry in the log of what medication was removed from the controlled substance drawer. On [DATE] the count dropped to six (6) without an entry in the log of what medication was removed from the controlled substance drawer. A this time, observation revealed Resident's #16, #20, #22, and #23 had controlled medications locked in the drawer. On [DATE] at 3:09 P.M. interview with LPN #100 verified staff was not consistently documenting when medication was delivered and removed from the controlled medication drawer. LPN #100 verified the number of medications documented on the log and in the controlled substance drawer matched the count sheet however, there were not entries on the log indicating what medications were added or removed from the locked box. 5. On [DATE] at 3:19 P.M. review of the 200 front hall Controlled Medication Shift Change Log revealed the staff was counting the medication cards/containers and controlled medication signature sheets at the change of shift and signing the log but not consistently writing the number of medications and signature sheets counted. Review of the November (2024) Controlled Medication Shift Change Log for the 200 front hall medication cart revealed the amount of cards/containers and signature sheets in the locked box was decreasing without any entries of medications being removed from the controlled medication drawer. However, the amount of medication cards/containers continued to match the number of Controlled Medication signature sheets. On [DATE] there were 15 cards of medication and control sheets. On [DATE] the count sheet was signed as 14 without an entry as to what medication was removed from the locked box. On [DATE] evening shift the Controlled Medication Shift Change Log was signed but did not indicate the current count. On [DATE] the count dropped to 11 without an entry in the log of what medication was removed from the controlled substance drawer. At this time, observation revealed Resident's #7, #8, #10, #11, #17, #24, #25, #26, #28 and #29 had controlled medications locked in the drawer. On [DATE] at 3:32 P.M. interview with LPN #100 verified the log indicated there were 15 cards of medication in the locked drawer on [DATE] and on [DATE] there were 11 cards without the log indicating any medications were removed. On [DATE] at 3:50 P.M. interview with the Director of Nursing (DON) revealed when a controlled substance was finished the staff puts the completed signature sheet in the slot on her door. When a medication is discontinued, a resident is discharged or expired the staff will hand the remaining medication and corresponding controlled medication signature sheet to her or the assistant director of nursing. The DON stated she logs the medications given to her and destroys them with a second person. The DON verified the Controlled Medication Shift Change logs were not completed as required. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Dawn Rehabilitation and Healthcare Center	865 East Iron Avenue Dover, OH 44622

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 6:55 P.M. interview with the Administrator verified the facility's Controlled Substance policy did not address the type of reconciliation of narcotics form the facility used. The policy did not address documenting on the log, the resident, medication name and quantity when the new medications arrived. The policy did not include in the procedure to write when medications were removed from the locked drawer, who they were for, the name of the medication and quantity remaining. The policy indicated the controlled substances must be stored in the medication room in a locked container. The facility stored their controlled medications in the locked drawer of a medication cart which was kept in the hall. Review of the facility's Controlled Substance policy (revised ,d+[DATE]) included the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of Schedule II and other controlled substances. The policy included controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. This deficiency represents non-compliance investigated under Master Complaint Number OH00159793.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review and interview, the facility failed to ensure adequate monitoring with the administration of narcotic pain medication. This affected two residents (#8 and #26) of four residents reviewed for narcotics. The census was 70. Findings include: 1. Review of Resident #8 's medical record revealed a 09/17/24 admission with diagnoses including fractured neck of right femur, chronic lymphocytic leukemia of B-cell type in remission, abnormal posture, difficulty walking, muscle weakness, muscle weakness, falls, obstructive sleep apnea, type 2 diabetes, hypertension, mixed hyperlipidemia, atherosclerotic heart disease, gastroesophageal reflux disease and cardiac pacemaker. Physician orders revealed an order dated 09/17/24 for Oxycodone 5 milligrams (mg) give one tablet every six hours as needed for pain. Review of the 09/24/24 Admission Minimum Data Set Assessment revealed the resident was independent for daily decision making. On 11/14/24 at 1:48 P.M. interview with Resident #8 revealed he just gets Tylenol for pain. At home he took something stronger. Review of an Individual Patient Controlled Substance Administration record revealed Oxycodone 5 milligrams (mg) 24 tablets was delivered to the facility on [DATE]. The packet of medication was first used on 11/07/24 at 5:45 A.M. and the 24 tablets were used by 11/14/24 at 5:35 A.M. Review of the November (2024) Medication Administration Record (MAR) revealed from 11/07/24 through 11/14/24 there were nine entries of the Oxycodone being administered to Resident #8. Review of the MAR along with the Controlled Substance Administration Record where the medications are signed out of the locked drawer revealed there were 13 doses of Oxycodone 5 mg removed between 11/07/24 and 11/14/24 from the locked controlled substance drawer without documentation on the MAR of the medication being administered to Resident #8. Review of the record revealed there was no evidence of a pain assessment for Resident #8 that identified the location of the pain, level of pain, what non-pharmacological interventions were attempted and the evaluation of the effectiveness of the interventions. The date, time, drug and dosage were not recorded on the MAR. There was no evidence of the medication being administered after removal from the locked controlled substance drawer. On 11/18/24 at 2:12 P.M. interview with the Director of Nursing (DON) verified Resident #8's medication was signed out of the controlled medication drawer without documentation of the medication being administered. The DON verified the lack of adequate monitoring for Resident #8 including comprehensive pain assessments to support the use of the narcotic for 13 doses not recorded on the MAR. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated Pain Management Policy revealed pain will be evaluated on all residents, methods of management and effectiveness will be documented. An assessment of pain will be completed prior to administration of pain medication. Documentation of the drug, dose, and route will be recorded on the Pain Management Flow Sheet, as well as on the MAR. Effectiveness of the dose will be documented on the Pain Management Flow Sheet in the Comments section. Side effects of the medication, if any, would be listed in this section, as well. Some possible side effects are listed at the bottom of the sheet, but are not all-inclusive. The Location/Type section of the Pain Management Flow Sheet requires a description of the pain in the resident's own words, if possible, or a description by the assessor, when possible. Examples are given at the bottom of the Pain Management Flow Sheet but are not all-inclusive. If possible, the resident is to use the Pain Scale to indicate a level of pain. A number will describe the intensity of the pain with O being no pain and 10 being the worst pain possible. 2. Review of Resident #26's medical record revealed a 10/12/24 readmission with diagnoses including sepsis, myocardial infarction, abnormal posture, difficulty walking, muscle weakness, hypertension, anxiety disorder, morbid severe obesity, type 2 diabetes, chronic kidney disease Stage 3, atrial fibrillation, Parkinson's disease, chronic obstructive pulmonary disease, heart failure, and protein calorie malnutrition. Review of the 09/25/24 Admission Minimum Data Set Assessment revealed the resident was moderately impaired for daily decision making. Physician orders revealed a 10/13/24 order for Tramadol HCL 50 mg, a narcotic, one every eight hours as needed for pain. On 11/14/24 at 1:50 P.M. interview with Resident #26 included she asks for Tylenol once in a while, She has an order for something stronger as needed but doesn't like to ask for it. Review of an Individual Patient Controlled Substance Administration record revealed Tramadol HCL 50 mg was delivered to the facility 09/25/24. The packet of medication was first used 11/04/24 at 8:00 P.M. There were 10 doses of Tramadol signed out on the Controlled Substance Administration Record. Review of the November (2024) Medication Administration Record (MAR) revealed from 11/04/24 through 11/14/24 there were four entries of the Tramadol being administered. Review of the MAR along with the Controlled Substance Administration Record where the medications are signed out of the locked drawer revealed there were six doses of Tramadol 50 mg removed between 11/07/24 and 11/14/24 from the locked controlled substance drawer without documentation on the MAR of the medication being administered. Review of Resident #26's record revealed there was not a pain assessment that identified the location of the pain, level of pain, what non-pharmacological interventions were attempted and the evaluation of the effectiveness of the interventions for the doses of Tramadol removed from the locked controlled substance drawer. The date, time, drug and dosage of the medication were not recorded on the MAR. There was no evidence of the medication being administered after removal from the locked controlled substance drawer. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 2:19 P.M. interview with the DON verified Resident #26's medication was signed out of the controlled medication drawer without documentation of the medication being administered. The DON verified the lack of adequate monitoring of Resident #26's pain and administration of narcotic pain medications to include the lack of comprehensive pain assessments to support the use of the narcotic for six doses not recorded on the MAR. This deficiency represents non-compliance investigated under Master Complaint Number OH00159793.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 26706 Based on review of controlled medication reconciliation records, observation, medical record review, and interview, the facility failed to ensure a narcotic medication was labeled to meet professional standards. This affected two residents (Resident #26 and #62) of 33 residents with controlled medications. The facility census was 70. Findings include: 1. On 11/14/24 at 2:45 P.M. review of the 400 hall Controlled Medication Shift Change Log revealed the staff was counting the medication cards/containers and controlled medication signature sheets at the change of shift and signing the log. Review and observation of the signature sheets for the controlled medications in the locked drawer revealed Resident #62 had a prescription for Tramadol, a Class IV narcotic. The label read: Tramadol HCL tablet 50 milligrams (mg) one tablet once daily: one tablet by mouth every 24 hours as needed. Review of the medical record revealed the resident had a physician's order dated 01/26/24 for Tramadol 50 mg by mouth every 24 hours as needed for pain. On 01/26/24 there was also an order to give Tramadol 50 mg by mouth one time a day for pain. On 11/14/24 at 2:52 P.M. interview with Licensed Practical Nurse (LPN) #178 verified there were two orders on the same label. LPN #178 verified each order should have its own label and card of medication. LPN #178 verified the label was confusing as to whether the medication should be administered once daily routinely and if an additional dose could be administered in 24 hours. LPN #178 indicated the resident was receiving the medication as needed not daily. 2, Review of Resident #26's medical record revealed a 10/12/24 readmission with diagnoses including sepsis, myocardial infarction, abnormal posture, difficulty walking, muscle weakness, hypertension, anxiety disorder, morbid severe obesity, type 2 diabetes, chronic kidney disease Stage 3, atrial fibrillation, Parkinson's disease, chronic obstructive pulmonary disease, heart failure, and protein calorie malnutrition. Review of the 09/25/24 Admission Minimum Data Set Assessment revealed the resident was moderately impaired for daily decision making. Physician orders revealed a 10/13/24 order for Tramadol HCL 50 mg, a narcotic, one every eight hours as needed for pain. There was not an order for routine Tramadol. Review of an Individual Patient Controlled Substance Administration record revealed Tramadol HCL 50 mg was delivered to the facility 09/25/24. The label read Tramadol 50 mg one tablet by mouth three times daily. The medication was first used 11/04/24 at 8:00 P.M. There were 10 doses of Tramadol signed out on the Controlled Substance Administration Record for as needed doses. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/14/24 at 3:19 P.M. with LPN #100 verified Tramadol was being administered as needed from a card that was labeled to give three times a day without an alert to make staff aware of a dosage change. This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number OH00159793.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review, interview, and policy review the facility failed to ensure accurate medical records. This affected two residents (#16, #71) of nine residents reviewed. The facility census was 70. Findings include: 1. Review of Resident #71's closed medical record revealed a [DATE] admission with diagnoses including malignant neoplasm of anus. The resident expired [DATE]. Review of an Individual Patient Controlled Substance Administration Record for Morphine Sulfate 15 mg Immediate Release delivered [DATE] revealed one tablet was ordered every six hours for pain as needed. Review revealed on [DATE] at 11:30 P.M. two doses of morphine were signed out by Registered Nurse (RN) #174 instead of one dose without explanation. Review revealed on [DATE] at 4:00 A.M. two doses of morphine were signed out by RN #174. One dose stated the resident dropped the medication. There was no evidence of RN #174 wasting the medication with a witness. Review of an Individual Patient Controlled Substance Administration Record for Morphine Sulfate 15 mg Immediate Release delivered [DATE] revealed one tablet was ordered every six hours for pain. Review revealed on [DATE] at 7:00 P.M. and [DATE] at 8:00 P.M. a dose of morphine was signed out and there was a notation pulled wrong morphine. There was no explanation of what happened to the two doses pulled in error. Review of an Individual Patient Controlled Substance Administration Record for Morphine Sulfate 15 mg Extended Release delivered [DATE] revealed one tablet was ordered every 12 hours for pain. Review revealed on [DATE] at 9:00 P.M. and [DATE] at 8:00 P.M. two doses of morphine were signed out by Registered Nurse #174 instead of one without explanation. Review of the facility's Discarding and Destroying policy (revised [DATE]) included controlled substances were to be documented as disposed on the medication disposition record with signatures of at least two witnesses. On [DATE] at 2:19 P.M. interview with the Director of Nursing verified excess medication was signed out of the controlled medication drawer without documentation of where the medication went. 2. Review of the medical record revealed Resident #16 was admitted on [DATE] with diagnoses including cancer. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Individual Patient Controlled Substance Administration Record for Oxycodone 2.5 mg every four hours as needed for pain was delivered [DATE]. Review revealed on [DATE] at 10:30 P.M. and [DATE] at 6:55 P.M. two doses of Oxycodone were signed out by Registered Nurse #174 instead of one without explanation. On [DATE] at 2:19 P.M. interview with the Director of Nursing verified excess medication was signed out of the controlled medication drawer without documentation of where the medication went. This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number OH00159793.

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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. 26706 Based on record review, observation, policy review, and interview, the facility failed to ensure infection control measures were followed as ordered during a dressing change. This affected one resident (#32) of three residents reviewed for skin impairment. The facility census was 70. Findings include: Review of Resident #32's medical record revealed a 05/03/22 admission with diagnoses including hyperkalemia, congestive heart failure, cerebral infarction, dementia, depression, atrial flutter, peripheral vascular disease, anemia, type II diabetes, chronic obstruction pulmonary disease, Stage IV (defined as full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) pressure ulcer to sacrum, and cardiac pacemaker. Review of a quarterly 09/21/24 Minimum Data Set Assessment revealed the resident was moderately impaired for daily decision making. The resident required substantial/maximum assist to roll from side to side. The resident had one Stage IV pressure ulcer. Physician orders included on 05/14/24 a low air loss mattress set per resident weight with bolster overlay, check placement and function every shift, on 06/24/24 an order for Enhanced Barrier Precautions (EBP) for wounds every shift, on 11/12/24 an order for left lateral foot- cleanse with normal saline , apply xeroform to open areas, cover with ABD. Pad and protect heel with ABD, wrap with Kerlix daily and as needed, and on 11/12/24 Sacrum- cleanse with normal saline, apply collagen with silver alginate then cover with border foam daily and as needed. Current skin impairment included a chronic sacral pressure ulcer on 11/12/24 assessed as Stage IV that measured 2 centimeter (cm) x 0.8 cm x 0.3 cm with inflamed peripheral tissue roll. On 11/12/24 at 2:33 P.M. observation revealed the resident's door had a sign on it for EBP. Observation of the sacral wound dressing change with Licensed Practical Nurse (LPN) #132 and LPN #166 revealed a barrier was on the overbed table with the dressing supplies on top. Both LPN's washed their hands and gloved. LPN #166 rolled the resident toward himself. LPN #132 sprayed wound cleanser on gauze and removed the resident's sacral dressing dated 11/11/24. There was serosanguinous drainage on the dressing. The LPN threw the dressing in the trash, removed her gloves and used hand sanitizer. She donned gloves and cleansed the Stage IV sacral wound with gauze and wound cleanser. She threw the gauze in the trash, removed her gloves and used hand sanitizer. She donned gloves and put a dressing of collagen, silver ag and boarder foam over the pressure ulcer. The LPN's both removed their gloves and removed the trash. At no time did either LPN wear a mask or isolation gown while completing the dressing change. The only Personal Protective Equipment (PPE) they utilized was gloves. On 11/12/24 at 7:12 P.M. interview with LPN #132 verified the resident had an order for EBP and the resident was on precautions due to his wounds and she should have worn a mask, gloves and gown when changing the resident's sacral dressing. LPN #132 verified there were days when the sacral dressing was not signed off as being changed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Enhanced Barrier Precautions (EBP) policy (implemented 04/01/24) included the policy of the facility to implement barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP's refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves during high contact resident care activities. An order for EBP will be obtained for residents with any of the following: wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers). Implementation of EBP make gowns and gloves available immediately near or outside the resident room. Note: face protection may also be needed if performing activity with risk of splash or spray (wound irrigation). High contact resident care activities included wound care: any skin opening requiring a dressing. EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound. This deficiency represents non-compliance investigated under Complaint Number OH00158850.