STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365047	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Community Village Healthcare Ctr	1800 Riverside Drive Columbus, OH 43212

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 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** 44070 Based on record review, review of the facility policy, and physician and staff interview, the facility failed to monitor the effectiveness of the pain interventions for a resident per the resident's plan of care and professional standards of practice. This affected one (Resident #35) of three residents reviewed for pain management. The facility census was 33. Findings include: Review of the medical record for Resident #35 revealed an admitted [DATE] and discharge date [DATE]. Diagnoses included spinal cerebrospinal fluid leak, spinal fusion, and spondylolisthesis lumbosacral region. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively intact. Review of the hospital records prior to admission revealed the resident was admitted to the hospital on 11/01/23 and had spinal surgery 11/01/23. Review of the hospital after visit summary (AVS) dated 11/07/23 revealed the discharge recommendation was to start taking Oxycodone (narcotic pain medication) one tablet by mouth every six hours as needed (PRN) for pain for up to three days and take acetaminophen 325 milligram (mg) tablet to take two tablets by mouth every six hours for mild pain. The AVS instructed to use muscle relaxants to help with muscle spasms and pain. Review of the physician orders dated 11/07/23 revealed an order for acetaminophen tablet 325 mg with instructions to give two tablets by mouth every six hours PRN for mild pain (pain level of one to four on a pain scale from zero (no pain) to 10 (most severe pain). An order dated 11/07/23 to 11/08/23 for Oxycodone HCL oral tablet five mg with instructions to provide one tablet by mouth every six hours as needed for moderate pain (pain level from five to seven). An order dated 11/08/23 to 11/14/23 was for Oxycodone HCL oral tablet five mg with instructions to give one tablet by mouth every six hours for pain. The order dated 11/14/23 to 11/21/23 revealed an order for Oxycodone five mg with instructions to give one tablet by mouth every four hours for pain. Review of the plan of care dated 11/08/23 revealed Resident #35 had acute pain related to a postoperative discomfort with interventions to administer analgesia as per orders, anticipate residents need for pain relief and respond immediately to any complaint of pain, evaluate the effectiveness of the pain including dosing schedules and resident satisfaction with results, monitor and record side effects of pain medication and notify the physician if interventions were unsuccessful or if current complaint was significant change from past reports of pain, provide the resident and family with information about pain and options available for pain management. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse Practitioner (NP) note dated 11/08/23 revealed Resident #35 was on Oxycodone five mg every six hours as needed for pain but also stated Oxycodone five mg was scheduled every six hours. The note stated the resident's pain was unstable, but the resident was responding well to current regimen. The note was not clear if the Oxycodone was scheduled or PRN at the time of the assessment as both were listed. This date the Oxycodone medication changed from every six hours as needed to scheduled medication. The NP did mention in the note that the muscle relaxant dose was adjusted as well. Review of the progress notes dated 11/10/23 at 12:17 P.M. revealed Resident #35 had pain with protective body movements, facial expressions stabbing and burning that was worse with movement with interventions of changed position, cool compress applied, and PRN medications administered. The progress notes dated 11/11/23 at 6:06 P.M. revealed the resident had pain level of 10 with vocal complaints of pain, generalized pain, lumbar back pain, The resident was on scheduled Oxycodone and other interventions included a changed in position, cool compress applied, and scheduled PRN pain medication given. The progress notes dated 11/12/23 at 1:32 P.M. revealed the resident had pain level of 10 with sharp, burning numbing stabbing pain worse with movement with interventions of changed position, cool compress applied, and scheduled PRN pain medication given. The progress notes dated 11/13/23 at 12:54 P.M. revealed the resident had pain level of 10 with sharp, burning numbing stabbing pain worse with movement with interventions of changed position, cool compress applied, and scheduled PRN pain medication given. The progress notes dated 11/14/23 at 10:54 P.M. revealed the resident had pain level of 10 with sharp, burning numbing stabbing pain worse with movement with interventions of changed position, cool compress applied, and scheduled PRN pain medication given. The progress notes did not include a follow up pain assessment to indicate if the interventions aided in the resident's pain management and there was no indication if the physician was notified due to the resident's severe pain daily on three days from 11/10/23 to 11/12/23. Review of the Medication Administration Record (MAR) dated 11/2023 revealed Resident #35 was administered Oxycodone every six hours (scheduled) for pain from 11/08/23 at 6:00 P.M. to 11/14/23 at 2:27 P.M. The resident's pain was documented in the MAR and the pain tasks report as follows: On 11/10/23 at 12:00 P.M., the resident's pain level was five, and her pain level was not rechecked until 5:11 P.M. and was at five. On 11/10/23 at 6:00 P.M., the resident's pain level was five, and her pain level was not rechecked the rest of the day. On 11/11/23 at 12:00 P.M., the resident's pain level was nine, and her pain level was not rechecked until 3:23 P.M. and it was 10. On 11/11/23 at 6:00 P.M., the resident's pain level was 10, and her pain level was not rechecked until 11:45 P.M. and it was eight. On 11/12/23 at 12:00 A.M., the resident's pain level was eight, and her pain level was not rechecked until 5:14 A.M. and the pain level was at five. On 11/12/23 at 6:00 A.M., the resident's pain level was five and her pain level was not rechecked. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/23 at 12:00 P.M., the resident's pain level was five, and her pain level was documented again at 12:11 A.M. and was at pain level was five. It was not documented if this was a recheck or if it was when the resident was assessed, and medication was provided at 12:00 A.M. medication pass. On 11/12/23 at 6:00 P.M., the resident's pain level was five, and her pain level was not rechecked until 11:28 P.M. and her pain level was four. On 11/13/23 at 12:00 A.M., the resident's pain level was four, and her pain level was not rechecked until 5:06 A.M. and her pain level was six. On 11/13/23 at 6:00 A.M., the resident's pain level was six, and her pain level was not rechecked until 5:06 A.M. and her pain level was six. On 11/13/23 at 12:00 P.M., the resident's pain level was eight, and her pain level was documented again at 12:04 A.M. and her pain level was eight. It was not documented if this was a recheck or if it was when the resident was assessed, and the medication was provided at 12:00 P.M. medication pass. Review of the NP note dated 11/13/23 revealed Resident #35 was on Oxycodone five mg every six hours scheduled for pain but also stated Oxycodone five mg scheduled every six hours as needed was ordered (this was discontinued on 11/08/24). The note stated the pain was unstable but also stated the resident was responding well to current regimen. The NP mentioned in the note a discussion of using Oxycodone extended release or scheduling it every four hours. The resident was to let nursing know how it was working and staff shall reach out to provider. Review of the pain assessment dated [DATE] revealed Resident #35 occasionally had pain, and the pain occasionally affected therapy and day-to-day activities. The resident rated her worst pain in the last week was an eight out of ten. The pain assessment indicated the resident had scheduled and PRN pain medication ordered. Review of the physician note dated 11/14/23 revealed Resident #35 complained of pain and discussed with residents' spouse about pain. The Oxycodone was increased from every six hours PRN to every six hours scheduled and then to every four hours scheduled. The resident was also noted on Flexeril for muscle spasms which could be increased and Lyrica which could help with pain. Review of the NP note dated 11/14/23 revealed Resident #35's pain was not well managed. The resident was working with therapy at times but was limited due to pain. The NP discussed with family at bedside about pain control concerns. During the evaluation, the resident had muscle spasm attack causing pain all over and discussed Oxycodone medication effects last about four hours. The Oxycodone was changed to every four hours and muscle spasm medication was scheduled twice daily. If spasms continued, NP planned to increase Flexeril or switch to Robaxin. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/05/24 at 11:28 A.M. with NP #200 revealed her expectations for staff would include giving pain medications or interventions and checking back with the resident in about 45 minutes to see the effectiveness of the interventions. If the interventions were not effective, NP revealed they could make changes to medications or would possibly request staff to reach out to the surgeon's office for recommendations or get a follow up appointment. NP revealed she would expect staff to complete rechecks and if pain control was not maintained, the staff should reach out to the medical team for next steps. The NP reviewed Resident #35's pain levels and confirmed the resident had several pain levels at eight, nine and 10 without documented timely rechecks. The NP stated the medical team did not just want to increase pain medications and were trying to make small adjustments at a time. NP #200 confirmed the facility had difficulty in managing residents' pain level which was confirmed in her notes. Interview on 02/05/24 at 12:49 P.M. with Physician #250 revealed Resident #35's pain was difficult to manage. The physician revealed he had spoken with the resident's family about concerns that staff were not offering pain medications timely and discussed options for pain control. The physician stated he wanted to slowly adjust medications due to side effects in the elderly population. The physician revealed his expectations that staff offer medication timely and check back to ensure the interventions were effective. Interviews on 04/08/24 from 1:30 P.M. to 2:30 P.M. with the Administrator and Director of Nursing stated the MAR included documentation of the pain medication effectiveness. The DON confirmed the scheduled medications dated 11/08/23 to 11/15/23 had no notation in the MAR if the medication was effective for Resident #35. The DON stated the facility identified an issue with order transcription and found orders were being put in without having the effectiveness notation. The DON and Administration acknowledged the importance for staff to check back in after giving pain medication. The DON stated I don't have the staffing to do that but at the same time acknowledged if the orders were transcribed incorrectly, the expectation was that staff should verify if pain levels had improved after interventions or medications were given. The DON and Administrator confirmed Resident #35 was hospitalized from complications with pain during a follow up visit with the surgery team on 11/15/23. Review of the facility policy titled Pain Management Program, dated 01/2016, revealed each resident's response to pain is different and resident should be monitored for pain. The facility shall use a pain scale to determine the effectiveness of intervention. The facility shall address goals and reduce pain through assessment, implementation of interventions and through monitoring the resident's response to interventions. This deficiency represents non-compliance investigated under Complaint Number OH00152034.