

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Highland Square Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1211 W Market St Akron, OH 44313	

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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063</p> <p>Based on record review and interviews, the facility failed to ensure pain medications were available and administered as ordered by the physician. This affected one (Resident #5) of three residents reviewed for pain management. The facility census was 57.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including chronic pain.</p> <p>Review of the physician's orders for Resident #5 revealed she had an order dated 01/29/24 for Methadone HCl 80 milligrams (mg) two times a day for pain.</p> <p>Review of the care plan dated 01/30/24 for Resident #5 revealed she was on pain medication related to having pain. Interventions included to take Methadone HCl 80 mg two times a day for pain.</p> <p>Review of the Medication Administration Record (MAR) for May 2024 and June 2024 revealed Resident #5 did not receive her Methadone HCl 80 mg on 05/18/24, 06/01/24, 06/09/24, 06/20/24 and 06/21/24 in the morning and on 06/09/24 and 06/20/24 at night.</p> <p>Review of the nursing progress notes for Resident #5 revealed on 05/18/24 at 8:10 A.M. her Methadone was not able to be giving due to unavailability. The pharmacy was notified and was going to deliver that day. The physician was not updated. The nursing progress note dated 06/01/24 at 8:33 A.M. revealed nursing staff were only able to provide Methadone 40 mg to Resident #5 as that was all that was available on her medication card. The pharmacy was updated and was going to send more that day. The physician was not updated on the decreased dose provided to Resident #5. The nursing progress note dated 06/09/24 at 8:31 A.M. stated Resident #5's Methadone was not available to administer and the pharmacy was notified. The physician was not updated. The nursing progress dated 06/20/24 at 8:06 A.M. stated Resident #5's Methadone was not available. The physician was not updated. The nursing progress note dated 06/21/24 at 2:49 A.M. stated the staff were waiting for the Methadone to arrive. The physician was not updated.</p> <p>Interview on 06/26/24 at 2:10 P.M. with Registered Nurse (RN) #268 verified Resident #5 had not received her Methadone as ordered on the dates and times listed above and the physician was not updated.</p> <p>(continued on next page)</p>

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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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/27/24 at 8:45 A.M. with Resident #5 verified she had gone without her pain medication because the nursing staff did not order her medications timely. She stated she did have other as needed pain medications available during those times.</p> <p>Review of the facility policy titled, Administering Medications, revised December 2012, revealed medications were to be administered in accordance with the orders.</p>		