

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Best Care Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2159 Dogwood Ridge Road Wheelersburg, OH 45694	

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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>42728</p> <p>Based on review of the Resident Council meeting minutes, staff interview, and resident interview, the facility failed to ensure concerns discussed during the meetings were adequately addressed. This had the potential to affect five facility-identified residents (#10, #27, #44, #47, #65) who consistently attended the Resident Council meetings. The facility census was 66 residents.</p> <p>Findings include:</p> <p>Review of the Resident Council meeting minutes dated 04/15/24 revealed the social worker had looked into free phones but had been unable to secure any. The department response documented on the form read the social worker would meet with the residents regarding free phones.</p> <p>Review of the Resident Council meeting minutes dated 08/26/24 revealed residents asked if there were free government phones available. There was no documented response for the concern noted on the form.</p> <p>Review of the Resident Council meeting minutes dated 09/16/24 revealed residents asked again if the social worker could check on free government phones. The department response documented on the form read the social worker had checked and was unable to find any avenues for residents to receive free government phones.</p> <p>Interview on 10/03/24 at 2:05 P.M. with Social Service Director (SSD) #75 confirmed she had been working at the facility since August 2024 and no requests from residents regarding free government phones had been brought to her attention.</p> <p>Interview on 10/03/24 at 2:20 P.M. with Activities Director (AD) #53 on 10/03/24 confirmed residents had requested information and assistance with obtaining government phones during several Resident Council meetings. AD #53 confirmed she was present at Resident Council meetings and wrote the concerns down on a piece of paper and then gave the paper to the Administrator who then typed out the meeting minutes and returned them to her. AD #53 further confirmed the Administrator was responsible to address the concerns and she was unsure how and if the residents' concerns were addressed.</p> <p>Interview on 10/03/24 at 2:30 P.M with Resident #10 on 10/03/24 confirmed residents had requested information about government phones during the last resident council meeting, but the facility had not provided with a response to the concern.</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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This deficiency represents noncompliance investigated under Complaint OH00158289.</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023</p> <p>Based on record review, observation, resident interview, ombudsman interview, and staff interview, the facility failed to ensure residents were not discharged without a justified and documented reason. This affected one (Resident #20) of three residents reviewed for discharge rights. The facility census was 66 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #20 revealed an admitted [DATE] with the diagnoses including cellulitis, Parkinson's disease, cerebral infarction, bipolar disorder, anxiety, hypertension, dementia, polyneuropathy, depression, asthma, hemiplegia and hemiparesis, hyperlipidemia, and traumatic subdural hemorrhage.</p> <p>Review of the medical record for Resident #20 revealed the resident signed a copy of the facility smoking policy upon admission on 02/29/20.</p> <p>Review of the nurse progress note for Resident #20 dated 06/10/24 revealed the resident was educated on signing himself out of the facility as he was known to leave and purchase cigarettes and lighters while he was out of the facility. The resident returned to the facility with a pack of cigarettes which were turned over to the Administrator. Resident #20 was observed sitting on the front patio smoking cigarettes.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #20 completed on 09/18/24 revealed the resident was cognitively intact.</p> <p>Review of the 30-day Notice of Discharge and Transfer of Resident #20 dated 09/27/24 revealed the resident was being discharged from the facility due to noncompliance with the facility smoking policy. The notice was sent to the resident's representative via certified mail and hand-delivered to the resident on 09/27/24. Resident #20 had signed the notice which included information regarding the resident's right to appeal.</p> <p>Interview on 10/02/24 at 10:00 A.M. with the Ombudsman confirmed she spoke to Resident #20 on 09/27/24 regarding the 30-day discharge notice. Further interview with the Ombudsman confirmed the only documented instance of Resident #20 violating the smoking policy was on 06/10/24, and she did not feel the facility had a strong case for an involuntary discharge.</p> <p>Interview on 10/03/24 at 01:46 P.M. with Resident #20 confirmed he did not want to be discharged from the facility.</p> <p>Interview on 10/03/24 at 02:43 P.M. with Social Service Director (SSD) #75 confirmed the facility issued Resident #20 a 30-day discharge notice on 09/27/24 for noncompliance with the facility smoking policy, because the facility did not allow smoking on facility grounds. SSD #75 further confirmed the only documented instance of noncompliance with the smoking policy for Resident #20 occurred on 06/10/24. There were no instances of noncompliance noted in July, August, September, or October 2024.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299</p> <p>Based on medical record review and the staff interview the facility failed to update resident Preadmission Screening and Resident Reviews (PASARRs) for residents with new diagnoses and/or treatment with psychotropic medications. This affected two (Residents #39 and #52) of four residents reviewed for PASARR completion. The facility census was 66 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses including depression, anxiety, diabetes mellitus type two, hypertension and congestive heart failure.</p> <p>Review of the PASARR for Resident #39 dated 07/21/23 revealed the resident did not have a dementia diagnosis or any indications of serious mental illness such as psychosis, depression and anxiety and was not prescribed any psychotropic medications.</p> <p>Review of the diagnosis list for Resident #39 revealed dementia was added as a diagnosis on 08/22/23.</p> <p>Review of the diagnosis list for Resident #39 revealed psychosis was added as a diagnosis on 11/23/23.</p> <p>Review of the care plan for Resident #39 dated 08/02/24 revealed the resident had altered psychosocial needs related to dementia, depression, psychosis and anxiety. Interventions included the following: administer medications as ordered, provide nonpharmacological interventions such as redirect with an activity, offer food and or fluids, offer reassurance, offer conversation and provide one on one care.</p> <p>Review of the annual Minimum Data Set (MDS) assessment for Resident #39 dated 08/15/24 revealed the resident had cognitive impairment with no behaviors and was dependent on the staff for personal care and mobility.</p> <p>Review of the physician's orders for Resident #39 for October 2024 revealed the resident had orders for the following psychotropic medications: Seroquel (antipsychotic medication) 50 milligrams (mg) by mouth three times daily for terminal agitation, Ativan (antianxiety medication) one mg by mouth every eight hours for anxiety, Trazodone (antidepressant medication) 50 mg by mouth at bedtime for terminal agitation and sleep, Paxil (antidepressant medication) 10 mg by mouth daily for depression.</p> <p>Interview on 10/03/24 at 2:25 P.M with Social Services Director (SSD) 75 confirmed the facility should have completed a new PASARR for Resident #39 in conjunction with the new diagnoses and the addition of psychotropic medications.</p> <p>2. Review of the medical record for Resident #52 revealed an admitted [DATE] with a diagnosis of bipolar disorder.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the PASARR for Resident #52 dated 06/07/24 revealed the resident was not prescribed any antipsychotic medications.</p> <p>Review of the care plan for Resident #52 dated 08/02/24 revealed the resident had altered psychosocial needs related to bipolar disorder, trouble sleeping, feeling down at times, feeling bad about self and trouble concentrating on things. Interventions included the following: encourage the resident to attend activities of his choice, medications as ordered, monitor for behaviors every shift and document if noted, provide nonpharmacological interventions such as offer food and or fluids, offer reassurance, offer conversation, provide one on one care, offer music of choice.</p> <p>Review of the quarterly MDS assessment for Resident #52 dated 09/19/24 revealed the resident was cognitively intact with no behaviors and required supervision with activities of daily living.</p> <p>Review of the physician's orders for Resident #52 for October 2024 dated 10/24 revealed the resident had orders for the following psychotropic medications: Paxil (antidepressant medication) 40 mg by mouth daily for anxiety dated 07/12/24, Trazadone (antidepressant medication) 50 mg by mouth at bedtime for insomnia dated 07/12/24, Vraylar (antipsychotic medication to treat bipolar disorder) 1.5 mg by mouth daily dated 09/25/24.</p> <p>Interview on 10/03/24 at 2:25 P.M. with SSD #75 confirmed the facility should have completed a new PASARR for Resident #52 with the addition of psychotropic medications. SSD #75 further confirmed the facility did not have a written policy regarding PASARR completion.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023</p> <p>Based on medical record review and staff interview, the facility failed to provide regular care plan conferences to residents and their representatives. This affected one (Resident #20) of three residents reviewed for care conferences and care planning. The facility census was 66 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including cellulitis, Parkinson's disease, cerebral infarction, bipolar disorder, hypertension, and dementia.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #20 dated 09/18/24 revealed the resident was cognitively intact.</p> <p>Review of the medical record for Resident #20 revealed it did not include documentation of a care conference for the resident since his admission to the facility.</p> <p>Interview on 10/02/24 at 09:46 A.M. with Social Services Director (SSD) 75 confirmed the facility had not conducted a care conference for Resident #20 since the resident's admission in 2020.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</p> <p>Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure skin alterations were adequately monitored and treated. This affected one (Residents #1) of 23 residents sampled. The facility census was 66 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including Parkinson's disease, dysphagia, and Alzheimer's disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #1 dated 07/16/24 revealed the resident was cognitively impaired.</p> <p>Review of the progress notes for Resident #1 dated 07/22/24 revealed the resident had a precancerous lesion on her forehead and the resident's representative did not want to pursue treatment of the area.</p> <p>Review of the monthly physician's orders for Resident #1 dated October 2024 revealed there were no orders for application of a bandage to the resident's forehead.</p> <p>Observation on 09/30/24 at 10:34 A.M. revealed Resident #1 had a soiled white bandage applied over a skin alteration to her forehead. The bandage was undated and there were no initials to indicate the individual who had applied it.</p> <p>Observation on 10/01/24 at 8:14 A.M. revealed Resident #1 continued to have a soiled white bandage applied over a skin alteration to her forehead.</p> <p>Observation on 10/01/24 at 1:48 P.M. revealed Resident #1 was lying in bed asleep. The soiled white bandage which had been on the resident's forehead had fallen off and was lying on the resident's left shoulder. There was a half-dollar sized lesion with dried blood to the resident's forehead.</p> <p>Interview on 10/01/24 at 1:50 P.M with Licensed Practical Nurse (LPN) 49 confirmed Resident #1 had a precancerous lesion to her forehead which frequently bled. LPN #49 confirmed staff sometimes placed a bandage over the area. Further interview with LPN #49 confirmed there was no order for a bandage to be applied to the skin alteration on the resident's forehead and the area had not been assessed since 07/22/24.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</p> <p>Based on medical record review, observation, resident interview, staff interview, and review of facility policy, the facility failed to ensure adequate care and services for residents requiring oxygen. This affected one (Resident #8) of 20 residents with orders for oxygen therapy. The facility census was 66.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes mellitus (DM), and hypertension.</p> <p>Review of the care plan for Resident #8 dated 01/12/24 revealed the resident had altered respiratory status and difficulty breathing related to COPD. Interventions included the following: administer medications as ordered, observe abnormal breathing patterns, observe for signs and symptoms of respiratory distress, report to the physician as needed.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #8 dated 09/19/24 revealed the resident had intact cognition and was coded as not having received oxygen therapy during the review period.</p> <p>Review of the monthly physician's orders for Resident #8 for October 2024 revealed there were no orders in place for the administration of oxygen.</p> <p>Review of the vital signs record for Resident #8 from June 2024 to October 2024 revealed there had been no oxygen saturation levels or respiratory rate recorded since 06/08/24.</p> <p>Observation on 10/01/24 at 3:19 P.M. revealed there was an oxygen in use sign posted on the frame of Resident #8's door. Resident #8 was lying in bed with oxygen being delivered through a nasal cannula at a rate of two liters per minute.</p> <p>Interview on 10/01/24 at 3:20 P.M. with Resident #8 confirmed she utilized oxygen when she was short of breath.</p> <p>Interview on 10/01/24 at 3:58 P.M with Licensed Practical Nurse (LPN) #49 confirmed Resident #8 was receiving oxygen at two liters per minute via nasal canula. LPN #49 further confirmed Resident #8 did not have a physician's order for oxygen therapy and the resident's record did not include oxygen saturation levels or respiratory rates since 06/08/24.</p> <p>Review of the facility policy titled Oxygen Administration revised October 2010 revealed the facility would follow guidelines for safe oxygen administration which included verifying there was a valid physician's order for oxygen therapy. Prior to oxygen administration, the nurse should review the resident's orders, review the facility protocol for oxygen administration, and should monitor the resident's vital signs and oxygen saturation levels in response to oxygen therapy.</p>		

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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>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</p> <p>Based on medical record review, observation, resident interview, staff interviews, and review of facility policy, the facility failed to ensure adequate monitoring of a resident pain. This affected one (Resident #45) of four residents reviewed for pain management. The facility census was 66 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #45 revealed the resident an admitted [DATE] with diagnoses including low back pain, restlessness and agitation, and need for assistance with personal care.</p> <p>Review of the admission physician's orders for Resident #45 dated 09/18/24 revealed the resident was ordered to receive the medications Zanaflex, gabapentin, and hydrocodone for pain.</p> <p>Review of the care plan for Resident #45 dated 09/18/24 revealed the resident had actual pain and potential for pain related to chronic low back pain. Interventions included the following: pain assessment quarterly and as needed, monitor for side effects of medications, monitoring what makes the pain worse.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #45 dated 09/25/24 revealed the resident had moderately impaired cognition and had daily indicators of pain during the review period.</p> <p>Review of the Resident #45's medical record revealed no pain assessments or pain levels had been obtained since 09/24/24.</p> <p>Observation on 09/30/24 at 8:40 A.M. revealed Resident #45 was yelling out loudly enough to be heard several feet from her room. The resident was lying in bed grimacing and was holding the left side of her ribcage towards her back.</p> <p>Interview on 09/30/24 at 8:41 A.M. with Resident #45 confirmed she was yelling because her back hurt.</p> <p>Interview on 09/30/24 at 8:42 A.M. with Licensed Practical Nurse (LPN) #49 confirmed Resident #49 yelled frequently throughout the day and often complained of pain to the left side of her back. LPN #49 confirmed the resident received several medications for the treatment of the pain which did not seem to help.</p> <p>Observation on 09/30/24 at 3:10 P.M. revealed Resident #45 was yelling out loudly and grimacing.</p> <p>Observation on 10/01/24 at 8:20 A.M. revealed Resident #45 was again yelling out loudly enough to be heard throughout the hallway on which she resided.</p> <p>Observation on 10/02/24 at 3:15 P.M. revealed Resident #45 was again yelling out loudly enough to be heard throughout the hallway on which she resided.</p> <p>(continued on next page)</p>		

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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 10/02/24 at 3:15 P.M. with Resident #45 confirmed she was yelling because her back hurt.</p> <p>Observation on 10/03/24 at 9:45 A.M. revealed Resident #45 was again yelling out loudly enough to be heard throughout the hallway on which she resided.</p> <p>Interview on 10/03/24 at 9:45 A.M. with Resident #45 confirmed she was yelling loudly because her back hurt.</p> <p>Interview on 10/03/24 at 10:35 A.M. with LPN #21 confirmed Resident #45 yelled out a large portion of the day and also voiced complaints of pain to the lower back. LPN #21 confirmed the resident was receiving multiple medications for the treatment of pain which seemed to have minimal effectiveness.</p> <p>Interview on 10/03/24 at 11:45 A.M. with the Director of Nursing (DON) confirmed Resident #45 yelled out frequently and complained of back pain. The DON confirmed there were no assessments of the resident's pain levels since 09/24/24 and there was no documentation of nonpharmacological interventions for Resident #45's chronic back pain.</p> <p>Review of the facility policy titled Pain Assessment and Management revised March 2020 revealed pain management was a multidisciplinary process which included recognizing the presence of pain, identifying the characteristics of pain, and monitoring the effectiveness of interventions for pain. Staff should monitor the resident by performing by performing a basic assessment with enough detail and as needed, with standardized assessment tools (approved pain scales, etc.) and relevant criteria for measuring pain management (target signs and symptoms).</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023</p> <p>Based on medical record review and staff interview, the facility failed to ensure a resident with post-traumatic stress disorder (PTSD) were appropriately assessed to identify the cause of the residents PTSD and minimize triggers and/or re-traumatization. This affected one (Resident #5) of one resident identified by the facility as having PTSD. The facility census was 66 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including cirrhosis of the liver, acute and chronic respiratory failure, diabetes mellitus type two, chronic obstructive pulmonary disease, congestive heart failure, Crohn's disease, chronic kidney disease, depression, and PTSD.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #5 dated 09/17/24 revealed the resident was cognitively intact and had a diagnosis of PTSD.</p> <p>Review of the care plan for Resident #5 initiated 09/25/23 revealed the plan did not address the following: the cause of the resident's PTSD, triggers which might cause re-traumatization, interventions to reduce the risk of re-traumatization, how to provide care for a resident with PTSD.</p> <p>Review of the medical record for Resident #5 revealed the record did not include an assessment to identify the cause of the resident's PTSD and the potential triggers which might cause re-traumatization.</p> <p>Interview on 10/02/24 at 12:16 P.M. with the Director of Nursing (DON) confirmed Resident #5 was admitted with a diagnosis of PTSD on 09/25/23, but the facility had not completed an assessment of the cause of the PTSD and the possible triggers which could cause re-traumatization. The DON further confirmed Resident #5's care plan did not address the following: the cause of the resident's PTSD, triggers which might cause re-traumatization, interventions to reduce the risk of re-traumatization, how to provide care for a resident with PTSD.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299</p> <p>Based on medical record review, staff interview, review of the facility policy, the facility failed to ensure residents were free of significant medication errors. This affected one (Resident #228) of 13 facility-identified newly admitted residents and one (Resident #45) of five residents reviewed for unnecessary medications. The facility census was 66 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #228 revealed an admitted [DATE] with diagnoses including end stage renal disease, diabetes mellitus type two, chronic obstructive pulmonary disorder and fracture of right lower leg.</p> <p>Review of the admitting physician orders for Resident #228 dated 09/13/24 revealed Resident #228 was ordered Admelog insulin inject 30 units subcutaneously before meals and Tresiba inject 80 units subcutaneously two times daily.</p> <p>Review of the care plan for Resident #228 dated 09/13/24 revealed the resident had diabetes mellitus. Interventions included the following: administer medications as ordered, dietary consultation for nutritional regimen as needed, observe for any signs and symptoms of hyperglycemia and hypoglycemia, obtain blood sugars as ordered, notify physician of abnormal blood sugars as indicated.</p> <p>Review of the Medication Administration Record (MAR) for Resident #228 dated September 2024 revealed the resident should have received Admelog insulin before meals on 09/14/24, but the resident did not receive his first dose of Admelog insulin until 8:00 P.M. on 09/14/24. Resident #228 should have received Tresiba at 8:00 A.M. on 09/14/24, but he did not receive his first dose of Tresiba until 8:00 P.M. on 09/14/24.</p> <p>Interview on 09/30/24 at 2:28 P.M. with Resident #228 confirmed he was admitted to the facility on [DATE] but he missed two doses of Admelog insulin and one dose of Tresiba on 09/14/24 because the medications were not available.</p> <p>Interview on 10/3/24 at 10:02 A.M. with Registered Nurse (RN) #120 confirmed Resident #228 missed two doses of Admelog insulin and one dose of Tresiba for treatment of diabetes mellitus on 09/14/24 because the medications were not available.</p> <p>Interview on 10/04/24 at 9:00 A.M. with the Director of Nursing (DON) confirmed Resident #228 arrived at the facility on new insulins which the facility did not keep in emergency stock. DON confirmed Resident #228 missed two doses of his Admelog insulin and one dose of Tresiba on 09/14/24.</p> <p>42728</p> <p>2. Review of the medical record for Resident #45 revealed the resident was admitted on [DATE], transferred to the hospital on 06/19/24, was discharged from the facility on 07/03/24 and was readmitted to the facility on [DATE] with diagnoses including low back pain, seizures, and restlessness and agitation.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Best Care Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2159 Dogwood Ridge Road Wheelersburg, OH 45694	

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission Minimum Data Set (MDS) assessment for Resident #45 dated 09/25/24 revealed the resident had moderately impaired cognition.</p> <p>Review of the active and discontinued physician's orders for Resident #45 revealed there were no orders for the administration of naloxone (an opioid antagonist).</p> <p>Review of the nurse progress note for Resident #45 dated 06/19/24 and timed 6:26 P.M. revealed Resident #45 was found on her bed, nonresponsive but breathing, and was barely able to be roused with a sternal rub. The resident's blood pressure and pulse were elevated, and the nurse administered a 0.4 milligram (mg) dose of naloxone. Resident #45's responsiveness was somewhat increased after naloxone administration, and the resident was sent to the hospital for an evaluation.</p> <p>Interview on 10/03/24 at 11:45 A.M with the Director of Nursing confirmed Resident #45 did not have an order to be administered naloxone on 06/19/24 and there was no documented history of substance abuse for the resident indicating the need for naloxone to be administered on 06/19/24. The DON confirmed the medication was administered in error for Resident #45.</p> <p>Review of the facility policy titled Medication Administration dated 6/21/17 revealed medications were to be administered in accordance to applicable state, local, and federal laws and consistent with accepted standards of practice and per the prescriber's order.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>34299</p> <p>Based on observation, staff interview and review of the facility policy, the facility failed to ensure medication carts on the front hall were locked and secured. This had the potential to affect seven facility-identified cognitively impaired and independently mobile residents of 22 residents residing on the front hall. The facility census was 66 residents.</p> <p>Findings include:</p> <p>Observation on 09/30/24 at 8:05 A.M. revealed the two medication carts on the front hall were unlocked and unattended by staff.</p> <p>Interview on 09/30/24 at 8:14 A.M. with Licensed Practical Nurse (LPN) #49 confirmed the front hall medication carts were unlocked and left unattended. LPN #49 confirmed the medication carts should be locked when not attended by staff.</p> <p>Review of the facility policy titled Storage of Medications dated November 2020 revealed drugs and biologicals used in the facility should be stored in locked compartments under proper temperature, light and humidity controls and unlocked medication carts should not be left unattended.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</p> <p>Based on record review, staff interview, review of online resources per the Centers for Disease Control (CDC) regarding pneumococcal vaccinations, and review of facility policy, the facility failed to ensure residents were offered and received up to date pneumococcal vaccinations. This affected two (Residents #3 and #43) of five residents reviewed for vaccinations. The facility census was 66 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including hypertension, presence of cardiac pacemaker, and intellectual disabilities.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #43 dated 08/19/24 revealed the resident had intact cognition.</p> <p>Review of the vaccination record for Resident #43 revealed the resident received one dose of Pneumovax 23 on 10/01/18. No other pneumococcal vaccines were documented as being offered or administered.</p> <p>2. Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease and muscle weakness.</p> <p>Review of the quarterly MDS assessment for Resident #3 dated 09/02/24 revealed the resident had moderately impaired cognition.</p> <p>Review of the vaccination record for Resident #3 revealed the resident had received one dose of Pneumovax 23 on 09/08/14. No additional pneumococcal vaccines were documented as being offered or administered.</p> <p>Interview with the Director of Nursing on 10/04/24 at 10:45 A.M. confirmed Residents # had been offered or received PCV15 or PCV20.</p> <p>Review of online guidance per the CDC updated 09/12/24 at https://www2a.cdc.gov/vaccines/m/pneumo/pneumo.html revealed residents should be offered and receive one dose of PCV15 (a pneumococcal vaccine) or PCV 20 (a pneumococcal vaccine) at least one year after the last dose of Pneumovax 23.</p> <p>Review of the facility policy titled Pneumococcal Vaccine revised March 2022 revealed administration of the pneumococcal vaccines were made in accordance with the CDC recommendations in place at the time of the vaccination.</p>