STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365412	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Skilled Health Care	1320 Mahoning Ave NW Warren, OH 44483

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on medical record review, staff interview, review of the facility Self-Reported Incidents (SRIs), review of the facility investigation, and facility policy review, the facility failed to ensure thorough investigations were completed regarding diversion of narcotics and a resident-to-resident altercation. The facility also failed to ensure preventative and corrective measures were in place. This affected three residents (# 11, #61 and #72) of four residents who were investigated for abuse and misappropriation. The facility census was 82. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including kidney disease stage three, retention of urine, acute chronic respiratory failure, chronic obstructive pulmonary disease, anxiety, and other seizures. Significant orders included admit to hospice with a diagnosis of congestive heart failure dated 06/13/24, check fentanyl patch (opioid pain medication) placement every shift, morphine sulfate oral solution 20 milligrams (mg) per milliliter (ml) (opioid pain medication), give 0.5 ml by mouth every two hours as needed for severe pain, oxycodone 10 mg (opioid pain medication), give two tablets by mouth four times a day for pain, Ativan 1 mg (anxiety medication) four times daily for anxiety, fentanyl transdermal patch 72 Hour 50 micrograms (mcg) per hour, apply 1 patch transdermal every 72 hours for pain and remove per schedule. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively intact. Review of the care plan dated 10/10/24 revealed Resident #11 had the potential for acute and or chronic pain related to colovesical fistula chronic obstructive pulmonary disease and decreased mobility. Interventions included administering analgesia (pain medication) as ordered, monitor record and report complaints of pain, and notify the physician if interventions are unsuccessful. Review of the narcotic count sheet for Resident #11 revealed on 11/08/24 there were two missing oxycodone 10 mg tablets. Review of the facility SRI tracking number (#) 253899 revealed on 11/08/24 the narcotic count for oxycodone 10 mg was off by two pills for Resident #11. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation for SRI tracking #253899 revealed on the morning of 11/08/24 at change of shift, the narcotic count for oxycodone 10 mg was off by two pills for Resident #11. The missing medication was verified by Registered Nurse (RN) #160. The facility wanted Licensed Practical Nurse (LPN) #240 to go for a drug screen, but she refused. The investigation did not contain evidence that a police report was filed by the facility. The investigation did not contain witness statements. The investigation did not contain an assessment of Resident #11 or any other residents on narcotic pain medication. The investigation did not contain staff education regarding narcotic counts or misappropriation. On 12/09/24 at 2:22 P.M. an interview with the Director of Nursing (DON) verified the lack of witness statements, Resident #11's assessment, lack of resident assessments for residents who were on narcotics, lack of the police report and lack of staff education and no evidence that additional preventative measures were put into place. 2. Review of the facility SRI tracking #254012 revealed a resident-to-resident altercation on 11/13/24 between Residents #61 and #72. Review of the medical record for Resident #61 revealed an admitted [DATE] with diagnosis including unspecified dementia with moderate agitation. Significant orders included Depakote 125 mg (mood stabilizer) give 250 mg three times daily Ativan 1 mg give one tablet by mouth every six hours for agitation. Review of the MDS assessment completed 10/17/24 Resident #61 had severe cognitive impairment. Review of the care plan dated 10/17/24 revealed Resident #61 had behavior problems. Interventions include assessing and anticipating the resident's needs, assessing and documenting observed behavior, giving resident choices about care, and documenting and reporting to the doctor danger to self or others. Review of the progress notes for Resident #61 revealed no documented evidence of the incident with Resident #72 that occurred on 11/13/24. Review of the medical record for Resident #72 revealed a date of admission of 11/01/23 with diagnoses including alcohol dependence with alcohol induced dementia adjustment disorder with anxiety and depression. Significant orders included Depakote 250 mg give 250 mg in the morning and 500 mg at bedtime, Ativan 1 mg give 1 mg by mouth two times daily. Review of the MDS assessment dated [DATE] revealed Resident #72 had severe cognitive impairment. Review of the care plan dated 11/01/24 revealed Resident #72 was care planned for impaired cognitive function. Interventions include Resident #72 needs supervision and assistance with decision making. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 11/13/24 revealed Resident #72 was on the floor in the multipurpose room. Upon entering the unit, the nurse found Resident 72 on the floor. When the nurse asked what happened, other residents stated that Resident #72 was sitting in a chair at the table and another resident [Resident #61] came behind the resident grabbed her chair and pulled it backwards with the resident sitting in it. Resident #72 was assessed, her blood pressure was 106/46, pulse 56, oxygen saturation was 86 percent on room air, and temperature was 98.5 degrees Fahrenheit (F). Passive range of motion (PROM) was completed with no pain noted. No skin issues were noted. Staff were educated to monitor the residents' skin for bruising. Staff were educated to keep the residents separated and monitor any aggression between the two. The doctor was notified as well as the resident's sister. A review of the facility investigation for SRI tracking #254012 revealed one resident witness statement. The investigation contained no resident assessment for Resident #61. The investigation contained no interviews or assessments of other residents regarding abuse. The investigation contained no staff education or interventions put into place as preventative measures. On 12/09/24 at 2:22 P.M. an interview with the DON verified the lack of witness statements, lack of resident interviews or assessments regarding abuse, the lack of staff education or interventions put into place as preventative measures. A review of the policy titled; Abuse, Mistreatment Neglect, Misappropriation of Resident Property and Exploitation, dated 2016, revealed the person investigating the incident should generally take the following actions: Interview the residents, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard of the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. If there are no direct witnesses, then the interviews may be expanded. For example, to cover all employees on the unit, or, as appropriate, the shift. The facility should obtain written statements from the residents, if possible, the accused and each witness. The policy revealed evidence of the Investigation should be documented. In the case of resident-to-resident abuse, mistreatment, exploitation, or misappropriation of property the facility will refer the matter to Community Skilled Health Care's interdisciplinary team to determine appropriate interventions. The policy also revealed upon completion of an investigation, Community Skilled Health Care Center will determine if modifications to existing policies and procedures or new policies and procedures are needed to prevent similar incidents or injuries from occurring in the future. The quality assurance investigative materials will be reviewed by the quality assurance committee at its next regularly scheduled meeting. The committee will take all actions deemed necessary based upon the review. This deficiency represents non-compliance investigated under Self-Reported Incident, Control Number OH00159760.