| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365422 | A. Building<br>B. Wing | 03/09/2026 |

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| Brookhaven Nursing & Rehabilitation Center | One Country Lane<br>Brookville, OH 45309 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff, resident and family interviews and policy review, the facility failed to ensure care conferences were scheduled and conducted quarterly. This affected four (#36, #37, #61 and #85) out of four residents reviewed for care plans. The facility census was 84. Findings include:<br>1. Medical record review for Resident #36 revealed an admission on [DATE] with diagnosis including but not limited to cerebral atherosclerosis, stage four kidney disease, hypertension. Review of the annual Minimum Data Set for Resident #36 dated 12/29/25 revealed an impaired cognition. Resident #36 was independent for eating, supervision for toileting, transfers and bed mobility. Resident #36 was coded with application of ointments and medication other than to feet. Review of the MDS assessment schedule for Resident #36 revealed quarterly assessments were completed on 10/24/24, 01/21/25, 03/10/25, 05/19/25, 08/13/25, 11/11/25 and an annual on 12/29/25. Review of the plan of care for Resident #36 dated 08/23/24 and revised on 08/30/24 revealed resident at risk for skin breakdown or have a known area of skin breakdown. Interventions include administering treatments/medications as ordered, offloading devices as needed, monitor, document and report to the provider changes in my skin. Review of the electronic health record's interdisciplinary team meeting for Resident #36 revealed one care conference was documented dated 01/17/24. There were no other care conference documented. 2. Medical record review for Resident #37 revealed an admission on [DATE] with diagnoses including but not limited to atrial fibrillation, congestive obstructive pulmonary disease, and chronic pain. Review of the annual MDS assessment dated [DATE] for Resident #37 revealed an intact cognition. Resident #37 was coded as independent for eating and supervision for bed mobility, transfers and toileting. Resident was coded as receiving pain medication during the assessment period. Review of the MDS assessment schedule for Resident #36 revealed an admission assessment was completed on 03/25/25 and 01/30/26 and quarterly assessments were completed on 06/19/25, 08/29/25, 09/23/25, 11/06/25. Review of the plan of care for Resident #37 revealed resident is at nutritional risk due to congestive obstructive pulmonary disease, chronic pain and congestive heart failure. Interventions included monitor for signs and symptoms of dehydration, monitor laboratory results, monitor for decline in eating and assist as needed. Review of the electronic health record's interdisciplinary team meeting for Resident #36 revealed one care conference was documented dated 01/16/2026. Interview on 03/04/26 at 4:00 P.M. with Resident #37 and family verified they have not attended a care conference quarterly. 3. Medical record review for Resident #61 revealed an admission on [DATE] with diagnoses including but not limited to Alzheimer's disease, dementia, and psychotic disturbance. Review of the quarterly MDS for Resident #61 dated 01/27/26 revealed severely impaired cognition. Resident #61 was coded as independent for eating and dependent on staff for toileting, transfers and bed mobility. Review of the MDS assessment schedule for Resident #61 revealed quarterly assessments were completed on 12/17/24, 03/18/25, 09/11/25, 10/30/25, 01/27/26. An annual assessment was completed on 06/12/25. Review of the plan of care for Resident #61 revealed resident at risk for adverse effects/complications due to psychotropic medication due to major depressive disorder with<br>(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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | psychotic symptoms. Interventions include monitor behaviors and record q shift, monitor resident for side effects of medication use, notify physician of any adverse side effects and use non-pharmacological interventions and document effectiveness Review of the electronic health record's interdisciplinary team meeting for Resident #61 revealed four care conferences dated 11/08/24, 12/04/24, 03/31/25 and 02/19/26 Additionally, the assessments were noted to all to be in error status. Review of the 02/19/26 assessment revealed the assessment to be incomplete with only the restorative nursing and the nursing section signed. Interview on 03/05/25 at 8:59 A.M. with Resident #61's family verified they have not had care conferences quarterly. 4. Medical record review for Resident #85 revealed an admission on [DATE] with diagnoses including but not limited to acute and chronic heart failure and vascular dementia with behaviors. Review of the quarterly MDS assessment dated [DATE] for Resident #85 revealed an impaired cognition. Resident #85 required set up for eating and moderated assist from staff members for toileting, bed mobility and transfers. Review of the MDS assessment schedule for Resident #85 revealed quarterly assessments were completed on 09/06/24, 11/29/24, 02/19/25, 08/25/25, 11/19/25 and 02/18/26. An annual assessment was completed on 05/12/25. Review of the electronic health record's interdisciplinary team meeting for Resident #85 revealed two care conferences dated 12/04/24 and 02/19/26. Additionally, the assessments were noted to all to be in error status or in progress. Review of the 02/19/26 assessment revealed the assessment to be incomplete with only the restorative nursing and the nursing section signed. Interview on 03/05/25 at 12:30 P.M. with Corporate Registered Nurse (RN) #126 verified the assessments for care conferences were in error, meaning the conference was not complete and/or lacked information and signatures. Additionally, RN #126 verified care conferences for Resident #36, #37, #61 and #85 were not conducted quarterly and should have been. Review of the facility policy titled Resident Assessment dated 11/2003 and revised on 05/2025 revealed the facility failed to implement the policy as written. Number five of the policy states that residents will have the opportunity to discuss their goals for care including their preferences for advance care planning. Number six under the policy that the care plan will include an interdisciplinary team and include the participation of the resident and or resident family. This deficiency represents non compliance investigated under Complaint Number 1321916 (OH00167273). |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interview and policy review, the facility failed to ensure activities were provided and documented in the medical record for evening hours. This affected three (#61, #43, #85) of three residents reviewed for activities. The facility census was 84. Findings include 1. Review of the medical record for Resident #61 revealed an admission on [DATE] with diagnoses including but not limited to Alzheimer's' disease, dementia and psychotic disturbances. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #61 dated 01/27/26 revealed an impaired cognition. Resident #61 was independent for eating. Resident #61 was dependent on staff for toileting, bed mobility and transfers. Review of the plan of care for Resident #61 dated 06/28/24 without revision revealed resident's interest included reading magazines, looking at picture books, being outdoors caring for flowers and televisions game shows. Interventions included activities that do not involve overly demanding cognitive tasks, assist and escort to activities, provide activity calendar, provide materials for individual activities and notify resident of any changes to the calendar. Review of the electronic health record for Resident #61 activity participation dated 02/05/26 to 03/05/26 was silent for any activities after 4:30 P.M. 2. Medical record review for Resident #43 revealed an admission date of 10/13/21 with diagnoses including but not limited to frontal lobe and executive function deficit following a stroke. Review of the quarterly MDS assessment dated [DATE] for Resident #43 revealed an impaired cognition. Resident #43 required staff assistance for meal set up and moderate assistance for toileting and transfers of one staff member. Resident #43 was limited assistance for bed mobility. Review of the plan of care for Resident #43 revealed resident was interested in reading, country music, cooking socializing with family and friends being outside in nice weather, holiday crafting and watching television. Interventions include allowing resident to help select movies, encourage participation in groups and establish and record prior levels of activity involvement and interest by talkie with the resident and the family. Review of the electronic health record for Resident #43 activity participation dated 02/05/26 to 03/05/26 was silent for any activities after 4:30 P.M. 3. Medical record review for Resident #85 revealed an admission on [DATE] with diagnoses including but not limited to acute and chronic heart failure, type two diabetes and vascular dementia. Review of the quarterly MDS assessment dated [DATE] revealed an impaired cognition. Resident #85 was not coded with behaviors or rejection of care. Resident #85 required set up assistance for eating and moderate assistance for toileting bed mobility and transfers. Review of the quarterly activity progress note dated 02/19/26 for Resident #85 revealed the resident participates in group programs daily. Resident #85 needs verbal invites and transported to activity. Resident #85 has impaired cognition, memory loss, and hallucination. Review of the electronic health record for Resident #85 activity participation dated 02/05/05 was silent for any activities after 4:30 P.M. Review of the facility March activity calendar revealed nail care was scheduled for 03/04/26 at 2:00 P.M. and snacks and hydration at 3:00 P.M. in the memory care unit. Observation on 03/04/26 at 2:35 P.M. of the memory care unit revealed no organized activity being conducted. Observation on 03/04/26 at 3:11 P.M. of the Activity Staff #151 enter the memory care and ask a resident if she would like to have her nails trimmed and painted. Interview on 03/05/26 at 10:30 A.M. with Activity Staff #152 verified the activity scheduled on the calendar was currently being organized. Activity Staff #152 stated the activity staff present in the facility usually included two staff members and they only worked until 4:30 P.M. every day, including Saturday and Sunday. Activity Staff #152 stated the facility had movies available in a drawer on the unit and snacks from the kitchen were in the unit pantry. Interview on 03/06/26 at 11:07 A.M. with Activity Staff #151 verified the schedule for activities in the memory unit were not followed on 03/04/26. Activity Staff #151 stated the snack and hydration activity was not carried out as scheduled. Activity Staff #151 stated she had to leave by 4:30 P.M. and did not have time to complete the activity. Interview on 03/06/26 at 11:38 A.M. with<br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Activity Director #160 verified the activity participation documentation was silent for any documentation after 4:30 P.M. Activity Director #160 verified the activity calendar had an activity titled sensory boxes on the March 2026 scheduled 23 times and scheduled at 6:30 P.M. and movie and snack activity was scheduled 9 times in the month of March 2026 at 6:30 P.M. No other types of activity were scheduled in the month of March 2026 for residents residing in the memory care area. Activity Director #160 stated the floor staff working in the memory care unit are assigned to complete the activity and document the participation. Activity Director #160 verified she did not monitoring the charting to ensure staff were documenting resident participation. Review of the facility policy titled Activities Policy dated 05/2003 and revised on 2017 revealed under letter f, the records are maintained by the activity coordinator to include the individual participation documentation. This deficiency represents non compliance investigated under Complaint Number 1321916 (OH00167273). |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and Nurse Practitioner (NP) interviews, and facility policy review, the facility failed to monitor and document residents' bowel movements. Additionally, the facility failed to implement their bowel protocol when a resident did not have a bowel movement. This affected one (#93) of three resident reviewed for bowel protocol procedure. The facility census was 84. Findings include: Medical record review for Resident #93 revealed and admission on [DATE] and a discharge date to the hospital on [DATE] with diagnoses including but not limited to type one diabetes, epilepsy, history of myocardial infarction, and neurocognitive disorder with Lewy body (progressive cognitive decline) dementia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed an impaired cognition. Resident #93 was coded with rejection of care one to three days during the assessment period. Resident #93 required supervision for eating, moderate assistance for bed mobility. Resident #93 is dependent for toileting and transfers. Review of the plan of care for Resident #93 revealed the resident had increased nutrition and hydration needs related to Lewy body disorder, dementia with disturbances, type one diabetes, constipation, kidney disease stage three and sepsis. Interventions include monitoring for signs and symptoms of dehydration, monitor laboratory results, monitor weights as needed, monitor for decline in eating ability, monitor and report to physician refusals to eat or signs and symptoms of difficulty swallowing. Review of the physicians' orders for Resident #93 revealed a consistent carbohydrate diet, mechanical soft texture with regular consistency dated 01/06/2026, an order for Dulcolax rectal suppository 10 milligram (mg), insert one suppository rectally every 12 hours as needed for constipation dated 12/09/25 and order for Boost glucose control nutritional supplement two times a day initiated on 12/15/25. Review of the discontinued physician orders for Resident #93 revealed an order for MiraLax oral powder 17 grams (gm) per scoop (laxative) give 1 scoop by mouth every 24 hours as needed for constipation initiated on 12/09/25 and discontinued on 01/26/26 and an order for Colace (stool softener) oral capsule 100 milligrams (mg) give one capsule by mouth every twelve hours as needed for constipation initiated on 12/09/25 and discontinued on 01/26/26, an order for Senna oral tablet 8.6 mg one tablet every 12 hours as needed for constipation initiated on 12.09/25 and discontinued on 01/26/26. Review of the Medication administration record for the month of February 2026 was silent for any medication administration for treatment of constipation. Review of the facility Certified Nursing Assistant (CNA) documentation for bowel movement monitoring dated 02/03/26 to 02/11/26 was silent for any documentation of bowel movements. Review of the progress notes for Resident #93 dated 02/03/26 to 02/11/26 was silent for any documentation of bowel movements. Review of NP #125 visit note dated 02/04/26 for Resident #93 revealed the reason for the visit was a follow up related to rash on truck. Resident #93 was nonverbal but denied any acute concerns. Resident #93 continues to intermittently refuse her accu check and insulin. Physical exam revealed no acute distress with abdomen charted as soft with positive bowel sounds in all four quadrants and without masses. Interview on 03/04/25 at 3:00 P.M. with Registered Nurse (RN) #111 verified the electronic health record was silent for any documentation for Resident #93 bowel movements after 02/03/26. RN #111 stated staff should be charting everyday if they have a bowel movement or not. RN #111 stated the electronic health record should have triggered an alert for staff to conduct an assessment and provided a laxative if needed. RN #111 verified the physician was not notified of the lack of bowel movements. Interview on 03/04/26 at 4:10 P.M. with Administrator verified the facility staff did not implement the bowel movement protocol when Resident #93 did not have a bowel movement. Additionally, the Administrator verified bowel movements were not charted in the electronic health record on a daily basis for Resident #93, and after three consecutive days the facility failed to administer any as needed laxatives. Interview on 03/05/25 at 2:11 P.M. with NP #125 stated she was not notified that Resident #93 was not having bowel movements. Review of the facility policy titled<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Bowel Movement Protocol dated 04/2025 revealed the facility failed to implement the policy as written. The policy states bowel movements are documented every shift in point of care, bowel movements are monitored daily and as needed, if a resident does not have a bowel movement for three consecutive days, consider an ass needed or notification to the physician. This deficiency represents non compliance investigated under Complaint Number 2790056. |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations and staff interviews, the facility failed to ensure foot care was routinely provided for a diabetic resident. This affected one (#85) of three residents reviewed for foot care. The facility census was 84. Findings included: Medical record review for Resident #85 revealed an admission on [DATE] with diagnoses including but not limited to acute and chronic heart failure, type two diabetes and vascular dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed an impaired cognition. Resident #85 was not coded with behaviors or rejection of care. Resident #85 required set up assistance for eating and moderate assistance for toileting bed mobility and transfers. Review of the plan of care for Resident #85 dated 06/21/24 revealed resident had diabetes mellitus and was insulin dependent. Interventions include blood glucose monitoring as ordered, diet as ordered, administer medication as ordered, check all of body for breaks in skin and treat promptly as ordered by physician. Review of the physicians' orders for Resident #85 for the month of March 2026 was silent for any orders related to nail care. Review of the facility podiatry services consent dated 01/22/25 revealed Resident #85 did not authorize podiatry services to be completed. Review of the weekly nursing skin and body review dated 02/28/26 Resident #85 was assessed from head to toes with no new skin areas noted. Review of the facility podiatry services authorization form dated 03/05/26 revealed Resident #85's durable power of attorney consented for podiatry services to be completed. Observation on 03/04/26 at 3:10 P.M. of Resident #85 attempted to propel herself in a wheelchair in the dining room and bumped into her foot and stating that her foot hurt. Observation on 03/05/26 at 2:00 P.M. of Resident #85's left foot revealed overgrown nails on the third and fourth digit. The nails extended past the end of the toe and curled towards the toe beside them leaving reddened indentions where the nails were touching the opposite toe. Additionally, the great toe was observed to have white colored tissue at the end of the toe, between the great toes and the second digit and along the side of second digit. During the observation staff present questioned Resident #85 and she complained of pain to the area. Interview on 03/05/26 at 4:00 P.M. with Licensed Practical Nurse (LPN) #130 stated an appointment was made for an emergency visit for Resident #85 by the podiatry services. Interview on 03/05/26 at 4:38 P.M. with Administrator verified the facility was unable to locate any documentation that nail care had been provided for Resident #85. This deficiency is based on incidental findings discovered during the course of this complaint investigation. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure appropriate urinary catheter care was provided. This affected one (#34) of three residents reviewed for catheter care. The facility census was 84. Findings include: Medical record review for Resident #34 revealed an admission on [DATE] with diagnoses including but not limited to neuromuscular dysfunction of the bladder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #34 revealed an intact cognition. Resident #34 required set up assistance from staff for eating and dependent on staff for toileting, transfers and bed mobility. Resident #34 was coded for urinary catheter use. Review of the plan of care for Resident #34 revealed resident had a indwelling catheter due to bladder neuromuscular dysfunction. Interventions include catheter care every shift, changing catheter bag as needed and changing catheter per physicians' orders. Observation on 03/03/26 at 4:17 P.M. of Certified Nurse Assistant (CNA) #107 revealed urinary catheter care was provided and on completion of that task CNA #107 gathered a urinal to empty the drainage bag. CNA #107 informed the resident of the task, completed hand hygiene and applied gloves. CNA #107 removed the drainage tubing from the storage sleeve, opened the clamp and drained the contents of the urinary drainage bag into a urinal. CNA #107 then reinserted the tip of the drainage tubing back into the storage sleeve on the urinary catheter bag and emptied the urinal into the commode. The observations revealed CNA #107 did not use an alcohol pad to clean the end of the urinary drainage tubing before reinserting the tubing back into the storage sleeve on the urinary drainage bag. Interview on 03/03/26 at 4:25 P.M. with CNA #107 stated he did not use an alcohol pad to clean the end of the drainage tubing before reinserting the tubing back into the storage sleeve on the urinary drainage bag. Interview on 03/03/26 at 4:30 P.M. with Registered Nurse (RN) #111 verified the CNA should be using an alcohol pad to clean the end of the tubing prior to re-inserting the tubing back into the storage sleeve after emptying the drainage system. Review of the facility skill check list titled Catheter Care and Measuring Urinary Output dated 2009 revealed staff closes drainage outlet and wipes with alcohol pad then reinserted into catheter bag without contaminating it. This deficienc is based on incidental findings discovered during the course of this complaint investigation. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interviews and policy review, the facility failed to ensure medications were not left at bedside and unsupervised. This affected two (#36 and #37) out of three residents reviewed for medication storage. The facility census was 84. Findings include: 1. Medical record review for Resident #36 revealed an admission on [DATE] with diagnosis including but not limited to cerebral atherosclerosis, stage four kidney disease, hypertension. Review of the annual Minimum Data Set (MDS) for Resident #36 dated 12/29/25 revealed an impaired cognition. Resident #36 was independent for eating, supervision for toileting, transfers and bed mobility. Resident #36 was coded with application of ointments and medication other than to feet. Review of the plan of care for Resident #36 dated 08/23/24 and revised on 08/30/24 revealed resident at risk for skin breakdown or have a known area of skin breakdown. Interventions include administering treatments/medications as ordered, offloading devices as needed, monitor, document and report to the provider changes in my skin. Review of the physician orders for Resident #36 revealed an order for Triamcinolone Acetonide external cream 0.1 % (Topical steroid) apply to affected area lower legs topically two times a day for stasis dermatitis dated 09/13/25. Observation on 03/05/26 at 11:15 A.M. of Resident #36 room revealed a large tub of ointment and two bottles of roll on bio freeze with pharmacy labels on them. Interview on 03/05/26 at 11:21 A.M. with Corporate Registered Nurse (RN) #126 verified the observations and removed the medications from the room. Corporate RN #126 verified the medication should not be in the room unsupervised. 2. Medical record review for Resident #37 revealed an admission on [DATE] with diagnoses including but not limited to atrial fibrillation, congestive obstructive pulmonary disease, and chronic pain. Review of the annual MDS assessment dated [DATE] for Resident #37 revealed an intact cognition. Resident #37 was coded as independent for eating and supervision for bed mobility, transfers and toileting. Resident was coded as receiving pain medication during the assessment period. Review of the plan of care for Resident #37 revealed resident at risk for pain. Interventions include administer medication as ordered, pain assessment as needed and provide non-pharmacological interventions. Review of the physicians' orders for Resident #37 revealed an order dated 02/27/26 for Potassium Chloride extended release oral tablet 20 milliequivalent (meq) give one tablet by mouth one time a day for supplement and an order dated 05/22/25 for hydrocodone-acetaminophen oral tablet 7.5-325 milligram (mg) give 1 tablet by mouth every 6 hours for pain Observation on 03/04/26 at 12:40 P.M. of Resident #37 revealed resident sitting in her room in her wheelchair looking a mobile phone without staff present. Observation on her bedside table revealed a medication cup with two oval white pills and her lunch tray. Interview on 03/04/26 at 12:40 P.M. with Resident #37 stated the pills were left in her room for her to talk with her lunch. Resident #37 stated the medication included a pain pill and a potassium pill. Observation and interview on 03/04/26 at 12:51 P.M. of Corporate RN #126 removed the unsecured medication from the room. RN #126 verified the medication should not be in the room unsupervised and included hydrocodone-acetaminophen oral tablet 7.5-325 milligram (narcotic) pain medication. Review of the narcotic count sheet for resident #37 revealed the hydrocodone-acetaminophen oral tablet 7.5-325 milligram tablet had not been signed out by the nurse at the time of the observation. Interview on 03/04/26 at 12:55 P.M. with Corporate RN #126 verified that the facility staff did not sign out the hydrocodone-acetaminophen oral tablet 7.5-325 milligram on the controlled count sheet and should have. Review of the facility policy titled Medication Storage in the Facility dated March 1996 revealed under number two states only licensed nurses and those lawfully authorized to administer medication are allowed access to medication. Medications are locked or attended by persons with authorized access. This deficiency is based on incidental findings discovered during the course of this complaint investigation. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365422 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brookhaven Nursing & Rehabilitation Center | One Country Lane<br>Brookville, OH 45309 |

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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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview and policy review, the facility failed to ensure staff followed enhanced barrier precautions as required. This affected one (#34) out of three resident reviewed for infection control. The facility census was 84. Findings include: Medical record review for Resident #34 revealed an admission on [DATE] with diagnoses including but not limited to osteomyelitis of sacral vertebra (spine), peripheral vascular disease and neuromuscular dysfunction of the bladder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #34 revealed an intact cognition. Resident #34 required set up assistance from staff for eating and was dependent on staff for toileting, transfers and bed mobility. Resident #34 was coded for urinary catheter use. Resident #34 was coded as receiving applications of ointment and medications to areas other than the feet during the assessment period. Review of the plan of care for Resident #34 dated 11/18/24 revealed resident at risk for infection related to wounds. Interventions include bag and transport used linen according to facility protocol, preventing skin exposure or contamination, enhanced barrier precautions, and medications and treatments as ordered. Review of the current physicians' orders for Resident #34 revealed an order to cleanse chest wound with saline, apply hydrocolloid paste to wound bed, place alginate over wound the cover with gauze dressing daily dated 11/21/25, an order to cleanse left calf wound with normal saline, apply hydrocolloid paste to wound bed, top with xeroform (non-adhering dressing), secure with abdominal dressing (ABD) pad, and wrap with kerlix dressing daily and as needed dated 02/17/26, cleanse right calf wound with normal saline, apply hydrocolloid paste to wound bed, top with xeroform, secure with ABD pad, and wrap with kerlix dressing daily and as needed dated 02/17/26, cleanse right heel wound with normal saline, apply alginate (debridement dressing) to wound bed and cover with gauze island dressing daily and as needed dated 09/29/25. Observation on 03/03/26 at 4:17 P.M. of door signage from the Center of Disease Control (CDC) on wall beside Resident #34's room revealed one sheet of paper with two stop signs in each corner. Large black lettering in between the stop signs revealed enhanced barrier precautions. Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high contact resident care activities including dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting and device care (central line, urinary catheter, feeding tube, tracheostomy, and wound care to any wound requiring a dressing. Observation on 03/03/26 at 4:17 P.M. of Certified Nurse Assistant (CNA) #107 enter room for Resident #34 without putting on a gown before providing urinary catheter care. CNA #107 explained task to resident, completed hand hygiene and donning gloves. CNA #107 gathered a plastic basin with warm soapy water and placed it on the bedside table without a barrier between the two surfaces. CNA #107 completed urinary catheter care without concerns but laid a cloth towel on the floor and when completed with catheter care tossed the dirty washcloth onto the towel on the floor. CNA #107 emptied the basin with soapy water, completed hand hygiene and donned new gloves. CNA #107 collected a urinal to empty the urinary drainage bag. CNA #107 removed the drainage tubing from the storage sleeve, opened the clamp and drained the contents into a urinal. CNA #107 then reinserted the tip of the drainage tubing back into the storage sleeve on the urinary catheter bag without cleaning the end of the tubing with alcohol. CNA #107 emptied the urinal and storing the urinary in the bathroom. CNA #107 then proceeded to pick up the towel and dirty washcloths from the floor and put them in a plastic bag. CNA #107 then removed a bath blanket from Resident #34's bed that had stains on it from a draining wound dressing and place it into the same bag. The bed clothing came in contact with the CNA #107's uniform. Interview on 03/03/26 at 4:35 P.M. with CNA #107 stated the enhanced barrier sign was not for Resident #34 as there was not a three-drawer chest beside the door with supplies in it for usage. CNA #34 verified there were two red laundry barrels with lids on them and supplied with red bags that<br>(continued on next page) |

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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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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | were from a previous resident in the other side of the room. CNA #107 verified that he did not use a gown when providing care for Resident #34's catheter linen came in contact with his uniform when he was handling the blanket from the bed. Interview on 03/03/26 at 4:40 P.M. with Registered Nurse (RN) #111 confirmed Resident #34 was on enhanced barrier precautions for wounds and urinary catheter. RN #111 stated the staff should be using gowns when providing catheter care. Observation on 03/03/26 at 4:45 P.M. with RN #111 of the back of Resident #34's door revealed a bag hanging with washable gowns for staff to use for care. Review of the facility policy titled Enhanced Barrier Precautions dated 08/2022 stated staff providing care for residents on enhanced barrier precautions will wear an impervious gown when high contact resident care activities are being performed. High contact areas include bathing, showering, providing hygiene, changing linens, changing attends or assisting with toileting and device care (urinary catheter and wound care). This deficiency is based on incidental findings discovered during the course of this complaint investigation. |