STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365422	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Nursing & Rehabilitation Center	One Country Lane 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, observation, and staff interview, the facility failed to timely address concerns with a resident's feeding tube. This affected one (#39) of two residents reviewed for feeding tubes. The census was 94. Findings include: Review of Resident #39's medical record revealed an admitted [DATE]. Diagnoses listed included abnormal weight loss, Parkinson's disease, bipolar disorder, dementia, and dysphagia. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had severe cognitive impairment, had a feeding tube, and was receiving Hospice services. Review of nursing notes revealed on 11/02/24 at 9:08 P.M. Resident #39's feeding tube was clogged. After unclogging the feeding tube it was noticed that the feeding tube was dark almost black in color and had a foul odor. Feeding tube was flushed repeatedly and a new dressing place. A note was left for physician in the physician communication book. On 11/08/24 at 5:56 A.M., Resident #39's feeding tube was black and had a foul odor even after flushing. Feeding tube was not clogged and working properly. A note would be left for physician in the physician communication book. On 11/09/24 at 1:28 A.M., Resident #39's feeding tube was black and had a foul odor even after flushing. Attempted to be flushed again with no change in appearance. A note would be left for physician again. On 11/13/24 at 4:59 A.M., Resident #39's feeding tube was black and had a foul odor. A note would be left for physician and reported to oncoming nurse. Feeding tube was flushed and feed given as ordered. On 11/13/24 at 5:01 A.M., the Hospice on call physician was notified about Resident #39's feeding tube. Further review of Resident #39's medical record revealed no documentation of feeding tube concerns being addressed by physician, Nurse Practitioner (NP), or Hospice staff. Observation of Resident #39's feeding tube on 11/20/24 at 11:49 A.M. revealed it was black in color. Interview with Licensed Practical Nurse (LPN) #185 on 11/20/24 at 11:54 A.M. revealed Resident #39's feeding tube was black in color when he was admitted . (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 11/21/24 at 9:42 A.M. confirmed concerns with Resident #39's feeding tube were not addressed by the facility physician, NP, or Hospice staff.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, staff interview, and policy review, the facility failed to administer medications per physician orders. This affected one (Resident #57) of four residents reviewed for medication administration. The facility census was 94. Findings include: Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses of malignant neoplasm of right kidney, anemia in chronic kidney disease, and unspecified atrial fibrillation. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, was independent with eating, required set-up assistance with oral hygiene, required supervision with wheelchair mobility, required partial assistance with bed mobility, and required substantial assistance with toileting hygiene, bathing, and dressing. Review of the Medication Administration Record (MAR) for Resident #57 for November 2024 revealed Potassium Chloride ER Capsule Extended Release (Potassium Chloride) 20 mEq was ordered, but the facility had Potassium Chloride ER Oral Tablet Extended Release (Potassium Chloride) 20 mEq in stock for the resident. Review of the physician orders revealed an order dated 09/09/24 to crush medications with applesauce or pudding two times a day for preventative and an order dated 10/08/24 for Potassium Chloride ER Oral Capsule Extended Release (Potassium Chloride) give 20 mEq by mouth one time a day. Observation on 11/19/24 at 8:35 A.M. with Licensed Practical Nurse (LPN) #188 confirmed during medication administration, Potassium Extended Release 20 mg 1 tab was held due to medication is not crushable. Interview on 11/19/24 at 8:35 A.M. with Licensed Practical Nurse (LPN) #188 confirmed the resident has an order to crush medications due to a swallow evaluation result. Interview on 11/19/24 at 10:02 A.M. with Licensed Practical Nurse (LPN) #188 confirmed the resident has had her medications crushed the whole month of November per the MAR and that the Potassium Chloride ER Oral Tablet Extended Release (Potassium Chloride) 20 mEq has been administered every day in November 2024, except this morning due to needing a crushable form of the medication. Interview on 11/19/24 at 10:58 A.M. with LPN #188 and Director of Nursing (DON) confirmed there was a Fax Form for Non-Emergency Communications dated 10/05/24 and signed by the Nurse Practitioner (NP) on 10/07/24 approving Potassium Chloride ER Oral Capsule Extended Release (Potassium Chloride) 20 mEq crushable, and that the order was processed but not initiated. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration - General Guidelines policy, dated 01/17/24 revealed medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube fed. Long-acting or enteric-coated dosage forms should generally not be crushed, and an alternative should be sought.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50007 Based on observation, record review, and interview, the facility failed to maintain a clean and sanitary kitchen area. This had the potential to affect 91 residents who received meals in the facility. The facility identified Resident #13, #39 and #74 as receiving no food and drink from the kitchen. The facility census was 94. Findings include: Observation on 11/18/24 at 8:58 A.M. and 11/20/24 at 11:19 A.M. revealed a tacky substance on the hoses and a dark substance on the nozzles that connect to juice boxes. Interview on 11/20/24 at 11:19 A.M. with Dietary Director #172 confirmed a tacky substance on the hoses and the presence of a dark substance on the nozzles that connect to the juice boxes. Interview on 11/20/24 at 11:19 A.M. with Corporate Dietician #135 confirmed a tacky substance on the hoses and the presence of a dark substance on the nozzles that connect to the juice boxes. Record review of document titled, Monthly Kitchen Deep Clean, not dated, revealed Dietary and Maintenance will work in combination on a pre-scheduled evening to clean equipment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on observation, staff interviews, and policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) for two residents. This affected two (Residents #75 and #138) of four reviewed for infection control. The facility census was 94. Findings include: 1. Review of the Medical Record for Resident #75 revealed an admitted [DATE] with diagnoses of Parkinsonism, dementia, and neuromuscular dysfunction of the bladder. Review of Resident #75's medical record revealed no documentation for EBP. Observation on 11/18/24 at 3:30 P.M. of Resident #75 revealed the resident had a suprapubic catheter. Observation revealed there were no gowns or gloves available, and there was no sign to advise staff resident was in EBP. Observation on 11/21/24 at 3:00 P.M. revealed Resident #75 with suprapubic catheter to abdomen, with no EBP in place. 2. Review of the Medical Record for Resident #138 revealed an admitted [DATE] with diagnoses of acute kidney failure, end stage renal disease, and dependence on renal dialysis. Review of Resident #138's medical record revealed no documentation for EBP. Observation on 11/19/24 at 8:44 A.M. of Resident #138 revealed the resident had a dialysis catheter located on the right upper chest. Observation revealed there were no gowns or gloves available, and there was no sign to advise staff resident was in EBP. Interview on 11/19/24 2:41 P.M. with Licensed Practical Nurse (LPN) Unit Manager/Infection Preventionist (IP) #212 confirmed all residents with foleys, ostomies, wounds, picc lines, and dialysis catheters should all be in EBP at a minimum. Observation on 11/21/24 at 2:58 P.M. revealed Resident #138 with dialysis catheter to right upper chest area, with no EBP in place. Interview on 11/21/24 at 3:03 P.M. with LPN/IP #212 confirmed Resident #138 had a dialysis catheter to right upper chest area, with no EBP in place. Interview also confirmed Resident #75 with suprapubic catheter to abdomen, with no EBP in place. Interview also conformed Resident #75 and Resident #138 should have been in EBP. Review of the EBP list provided to the survey team on 11/18/24, undated, revealed Resident #75 and Resident #138 were not listed on the list. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/21/24 at 3:30 P.M. with the Director of Nursing (DON) confirmed Resident #75 and #138 was not listed on the Enhanced Barrier Precautions list provided to the survey team on 11/18/24 and confirmed Residents #75 and #138 were not care planned for EBP. Review of the Enhanced Barrier Precautions policy dated 08/2022, revealed EBP may be considered for indwelling medical devices (central line, urinary catheter, feeding tube, tracheostomy /ventilator). Gloves and gowns would be utilized for residents on EBP.