STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365446	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Piketon	7143 Route 23 South Piketon, OH 45661

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on record review, review of facility policy titled Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating, and interviews, the facility failed to appropriately report an allegation of resident to resident abuse to the proper agencies. This affected one resident (Resident #73) out of three reviewed for abuse. The facility census was 102. Findings include: Review of the medical record for Resident #73 revealed this resident was admitted to the facility on [DATE] with the following medical diagnoses: diabetes mellitis type II, post-traumatic stress disorder, muscle weakness, Bipolar disorder, psychoactive substance abuse, altered mental status, dysphagia, lack of coordination, low back pain, alcohol abuse, nicotine dependence, hypertension, and gastro-esophageal reflux disease. This resident is alert and oriented and has minimal cognitive deficits according to the Minimum Data Set (MDS) assessment completed on 03/22/25. Review of nursing notes from 4/12/25 at 10:35 A.M. revealed Resident #73 reported feeling threatened by the resident located across the hall. Resident #73 stated that Resident #62 had made threatening comments towards him, including saying he doesn't like him. More seriously Resident #73 claims that Resident #62 has stated there is a hit out on him and threatened to beat him up or kill him or would have his buddies do it. Resident #73 also expressed concern that Resident #62 possesses a knife. Resident #73 states this is all over him having a girlfriend and Resident #62 not having one. Activity Director #111 immediately let the I wing nurse aware of the situation, the I wing nurse and Activity Director #111 immediately went down to Resident #62's room to ask Resident #62 if he did have a knife on his person, and the resident stated no. But the nurse had seen the knife located in his basket. Nurse immediately notified the Director of Nursing of the situation and both residents are being monitored at this time. The knife was removed and locked up in the activity directors office. This was written by Activity Director #111. Review of nursing note dated 4/12/2025 at 11:35 A.M. revealed Activity Director #111 had offered to show/ move Resident #73 to a new hallway after the incident had occurred and resident stated no he did not want to move, just hope nothing happens. This was written by Activity Director #111. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #73 on 04/14/25 at 02:52 P.M. stated another resident had a knife and threatened him. Resident stated he felt afraid at the time, and is still fearful. Interview with the Director of Nursing (DON) on 04/15/25 at 02:40 P.M. verified in light of the above notes from 04/12/25, both residents were both offered a room change and both declined. She agreed this incident should have been reported as this was a qualifying event under reportable incidents by the facility. Interview with Activities Director #111 on 04/15/25 at 03:24 P.M. revealed Resident #73 reported he felt threatened by another resident who had a knife. Stated the resident was fearful after the incident so she brought him to the activities room for a few hours. She stated she had notified the DON and was told to offer both residents a room change away from each other, which both declined. Review of facility policy titled Identifying Types of Abuse last revised in September 2022, revealed mental and verbal abuse include but not limited to threatening gestures or fear of a person or place. Review of the Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigation last revised in September 2022, revealed if resident abuse is suspected it will be reported immediately as required by current regulations. Review of current Self Reported Incidents on 04/16/25 at 03:31 P.M. revealed this incident has not been created as of this time. Law Enforcement has not been notified as well.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record reviews and staff interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) was accurately completed. This affected one resident (#71) out of the six residents reviewed for PASARR during the annual survey. The facility census was 102. Findings include: Record review for Resident #71 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included epilepsy, seizures, mood disorder, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/07/25, revealed the resident was assessed to have intact cognition. Review of the residents physicians orders from 06/06/24 through 06/13/24 revealed the resident was ordered Buspar (an anti-anxiety medication) and Sertraline (an anti-depressant medication). Review of the PASARR, signed as completed on 06/13/24, revealed the resident was assessed to have not been ordered any psychotropic medications (anti-anxiety, anti-depressant, anti-psychotic, or mood stabilizers) in the past six months. Interview with the Director of Nursing (DON) on 04/16/25 at 2:40 P.M. confirmed the PASARR for Resident #71 had been completed inaccurately as the resident had been ordered psychotropic medication within the six months prior to the completion of the PASARR.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observation, interview and record review the facility failed to provide timely podiatry care and services to Resident #3. This affected one (Resident #3) of four residents reviewed for activities of daily living. The facility census was 102. Findings include: Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including infection/inflammation reaction due to internal joint prosthesis, osteoarthritis, paint in left knee and major depressive disorder. Review of the physician orders for Resident #3 revealed an order received on admission to see podiatry as needed. Review of the Medicare 5 day Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was cognitively intact and required partial to moderate assistance to complete activities of daily living. Review of the nursing progress notes for Resident #3 revealed no documentation of the condition of Resident #3 toe nails. The progress notes did not indicate Resident #3 had been seen by a podiatrist. Review of the plan of care dated 01/25/25 revealed Resident #3 required assistance with activities of daily living. Observations on 04/14/25 at 3:06 P.M. and 04/15/25 at 10:12 A.M. revealed Resident #3 toe nails (all 10) were long, yellow and thick. The toe nails were pressing against the skin of the next toe. Interview on 04/14/25 at 3:06 P.M. with Resident #3 revealed he would like to have his toe nails trimmed and treated. Resident #3 stated he had not seen the foot doctor (podiatrist) since he had been at the facility. Interview on 04/16/25 at 3:24 P.M. with Licensed Practical Nurse (LPN) #19 confirmed Resident #3 toe nails were long, yellow and thick. LPN #19 confirmed Resident #3 had not been seen by podiatry since admission.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on staff interview, record review, observation, and document review the facility failed to ensure residents were free of significant medication errors when staff failed to prime an insulin pen for Resident #90. This affected one (Resident #90) of five residents reviewed for medication administration. The facility census was 102. Findings include: Record review of Resident #90 revealed an admitted [DATE] with pertinent diagnoses of: sepsis, osteomyelitis, type two diabetes mellitus, hypertension, acquired absence of right and left lower leg below knee. Review of the 02/06/25 modification of admission and medicare five day Minimum Data Set (MDS) assessment revealed the resident is cognitively intact and uses a wheelchair to aid in mobility. Review of Physician Order dated 02/04/25 revealed Humalog injection solution 100 unit/milliliter (insulin Lispro) inject as per sliding scale if 150-200= 3 units; 201-250= 6 units; 251-300= 9 units; 301-350=12 units; 351-400=15 units; 401+= 18 units notify Nurse Practitioner, subcutaneously before meals and and bedtime for diabetes mellitus. Review of a Physician Order dated 02/04/25 revealed Insulin Lispro (one unit dial) 100 unit/milliliter solution pen injector inject seven units subcutaneously before meals and at bedtime related to type tow diabetes mellitus. Observation on 04/15/25 at 5:02 P.M. revealed Licensed Practical Nurse #11 (LPN) took Resident #90 blood sugar and it was 168 mg/Dl milligrams per deciliter. LPN #11 dialed the insulin Lispro pen to 10 units for seven units scheduled and three units for sliding scale. LPN #11 did not prime the insulin pen prior to administration to Resident #90. Interview with LPN #11 on 04/15/25 at 5:10 P.M. LPN #11 verified she did not prime the insulin pen prior to administering Resident #90 insulin. Review of the Humalog Kwikpen (insulin Lispro) instructions for use copyright 2007 revealed to prime before each injection. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select two units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with needle pointing up. Push the dose knob until it stops and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeating priming step no more than four times. If you still do not see insulin, change the needle and repeat priming.

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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** 31404 Based on staff interview, record review, observation, and document review, the facility failed to appropriately clean a blood glucose monitoring machine between patient uses. This affected one (Resident #90) of five residents reviewed for medication administration. This had the potential to affect three Residents (Resident #90, #298, and #303) who resided on the E hallway and received blood sugar glucose monitoring. The facility census was 102. Findings include: Record review of Resident #90 revealed an admitted [DATE] with pertinent diagnoses of: sepsis, osteomyelitis, type two diabetes mellitus, hypertension, acquired absence of right and left lower leg below knee. Review of the 02/06/25 modification of admission and medicare five day Minimum Data Set (MDS) assessment revealed the Resident is cognitively intact and uses a wheelchair to aid in mobility. Review of Physician Order dated 02/04/25 revealed Humalog injection solution 100 unit/milliliter (insulin Lispro) inject as per sliding scale if 150-200= 3 units; 201-250= 6 units; 251-300= 9 units; 301-350=12 units; 351-400=15 units; 401+= 18 units notify Nurse Practitioner, subcutaneously before meals and and bedtime for diabetes mellitus. Review of a Physician Order dated 02/04/25 revealed Insulin Lispro (one unit dial) 100 unit/milliliter solution pen injector inject seven units subcutaneously before meals and at bedtime related to type tow diabetes mellitus. Observation on 04/15/25 at 4:19 P.M. revealed Licensed Practical Nurse #11 (LPN) took Resident #303 blood sugar with an Assure Platinum blood glucose monitoring machine. LPN #11 used an alcohol wipe to clean the glucose machine. Observation on 04/15/25 at 4:45 P.M. revealed LPN #11 went into Resident #90 room to take his blood sugar. The Surveyor intervened and had her clean the blood glucose machine with a bleach wipe prior to taking Resident #90 blood glucose level. Interview with LPN #11 on 04/15/25 at 4:47 P.M. verified she was unaware that shared use glucose machines should be cleaned with bleach prior to Resident use to prevent blood borne pathogen transmission. The facility identified there was no blood borne communicable diseases for the Resident receiving blood glucose monitoring on the E Hall. Review of the revised 09/24 facility provided Arkray technical brief cleaning and disinfecting the assure platinum blood glucose monitoring system revealed the machine may only be used for testing multiple patients when standard precautions and the manufacturers disinfecting procedures are followed. The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arkray has tested and validated the durability and functionality of the Assure Platinum meter with the most commonly used EPA-registered wipes. Our testing confirmed the wipes listed below will not damage the functionality or performance of the meter through 3,650 cleaning and disinfecting cycles. ARKRAY recommends using these wipes to clean and disinfect the Assure Platinum meter: Clorox Germicidal Wipes, Dispatch Hospital Cleaner Disinfectant Towels with Bleach, Super Sani-Cloth Germicidal Disposable Wipe, CaviWipes, or Microdot Bleach Wipe.