STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365461	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muskingum Skilled Nursing & Rehabilitation	501 Pinecrest Drive Beverly, OH 45715

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on observations and interviews, the facility failed to ensure beds were the appropriate size for residents. This affected one (Resident #39) of one resident reviewed for positioning. The facility census was 46. Findings include: Record review revealed Resident #39 admitted to the facility on [DATE] with diagnoses including syncope and collapse, dementia, hyperlipidemia, and intellectual disabilities. Review of a quarterly Minimum Data Set (MDS) assessment completed on 05/03/24 revealed Resident #39 had moderately impaired cognition and was independent for bed mobility. Observation on 07/08/24 at 9:03 A.M. revealed Resident #39 was laying diagonal in bed with his feet over the edge because the bed was not long enough. Observation on 07/08/24 at 11:13 A.M. revealed Resident #39 was laying diagonal in bed with his feet over the edge. When asked if his bed was long enough, Resident #39 shook his head no. Interview on 07/09/24 at 10:26 A.M. with Resident #39 revealed he was not comfortable in his bed because he has to lay diagonal which was putting a little more pressure on his right hip. Resident #39 was positioned low in the bed, but stated moving up in bed would not help because his toes would still touch the footboard. Interview on 07/09/24 at 10:26 A.M. with State tested Nursing Assistant (STNA) #387 confirmed Resident #39 was laying diagonal in bed and confirmed if Resident #39 was moved further up in bed, his toes would still touch the footboard, which could cause pressure. Interview on 07/11/24 at 2 P.M. with Director of Nursing (DON) revealed Resident #39 always lays diagonal in bed.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review,interview, and policy review, the facility failed to ensure care conferences were offered in conjunction with minimum data set (MDS) reviews. This affected two (Resident #2 and #39) of two residents reviewed for care conferences. The facility census was 46. Findings include: 1. Record review revealed Resident #2 admitted to the facility on [DATE] with diagnoses including heart failure, atrial fibrillation, hypertension, and anemia. Review of a quarterly MDS dated [DATE] revealed Resident #2's cognition remained intact. Review of completed MDS' revealed Resident #2 had quarterly MDS assessments completed on 08/29/23, 11/27/23, 02/26/24, and 05/25/24. Review of Multidisciplinary Care Conference assessments revealed care conferences were held on 08/18/23, 02/28/24, and 04/30/24. There was no record of a care conference because held in conjunction with the MDS completed on 11/27/23. Interview on 07/08/24 at 5:23 P.M. with Resident #2 revealed the resident could not recall having care conferences. 2. Record review revealed Resident #39 admitted to the facility on [DATE] with diagnoses including syncope and collapse, dementia, hyperlipidemia, and intellectual disabilities. Review of a quarterly MDS completed on 05/03/24 revealed Resident #39 had moderately impaired cognition. Review of completed MDS' revealed Resident #39 had quarterly MDS assessments completed on 08/07/23, 11/05/23, 02/03/24, and 05/03/24. Review of Multidisciplinary Care Conference assessments revealed care conferences were held on 08/01/23, 11/09/23, 02/01/24, and 06/24/24. The care conference held on 06/24/24 was not completed in conjunction with the MDS completed on 05/03/24. Interview on 07/09/24 at 9:19 A.M. with Resident #39 revealed the resident could not recall having a care conference. Interview on 07/09/24 at 1:58 P.M. with Social Worker (SW) #345 revealed care conferences are completed when MDS' are due, about every three months. The MDS nurse will schedule the MDS, then social services schedules the care conferences. SW #345 stated she was not working at the facility in May 2024 but did confirm Resident #2 did not have a care conference documented in November 2023. SW #345 stated she thought she was waiting to schedule it when her son was available but there should have been a care conference completed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/09/24 at 3:09 P.M. with Activity Director (AD) #314 revealed she had called Resident #39's sister to schedule a care conference for June instead of when it was due in May. AD #314 was unable to provide documentation. Review of an undated policy titled Care Conference revealed the MDS nurse is responsible for coordinating the routine care conferences and social services should send out the invitations via mail two weeks prior to the care conference.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on record review, interviews, and observations, the facility failed to ensure pressure ulcer interventions were in place. This affected three (Resident #36, #26, and #12) of three residents reviewed for skin breakdown. The facility census was 46. Findings include: 1. Review of the medical record for Resident #36, revealed an admitted [DATE]. Diagnoses included but were not limited to displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing, metabolic encephalopathy, unsteady on feet and need for assistance with personal care. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 07 out of 15 indicating severe cognitive impairment. The resident was assessed to require setup or clean-up assistance with eating, oral hygiene, substantial/maximal assistance with toilet hygiene, bed mobility, sit to stand and dependent with bed and toilet transfers. The resident was also assessed to not have any pressure ulcer/injury on admission, but at risk for developing them. Review of Resident #36's active care plan revealed being at risk for skin integrity/breakdown with interventions including but not limited to low air mattress as ordered, elevate heels off mattress as tolerated and to turn and reposition as ordered. Further review of this resident's care plan revealed no refusals for care related to skin integrity/breakdown interventions. Review of the progress notes for Resident #36 revealed no refusals documented for care related to skin integrity/breakdown interventions since admission to the facility. Review of Resident #36's active physicians orders revealed: pressure reducing mattress to bed ordered 06/12/24, low air mattress to bed, check function with no settings ordered 06/21/24 and no order to turn and reposition. Review of a weekly skin assessment dated for 06/20/24 at 12:37 P.M. for Resident #36 revealed a pink blister noted to left heel measuring 1.5 centimeters (CM) X 1.5 CM and an open sore on right heel measuring 1.5 CM X 1.75 CM with the inside of the wound as yellow/cream color with dark redness noted in the middle of the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review for this resident revealed a skin grid pressure documentation dated 06/20/24 for both the left and right heel skin alterations noted on the weekly skin assessment. The left heel was noted to be a Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister.) pressure being 1.5 CM X 1.5 CM raised with clear fluid filled raised intact blister noted. The right heel was noted to be a Stage II pressure being 1.75 CM X 1.5 CM with open sore inside of wound is yellow/cream color with dark redness noted in the middle of the wound with scant serosanguinous drainage. Review of the unavoidable pressure injury document dated 06/20/24 2:08 P.M. for Resident #36 revealed no refusals for care related to skin integrity/breakdown interventions with interventions in place such as: elevated heels and low air loss mattress. Observation on 07/08/24 at 9:06 A.M., 10:08 A.M., 12:23 P.M. and 2:29 P.M. revealed Resident #36 in bed, heels not elevated, being on his right side each time, and his bed being on comfort level 4. Interview on 07/10/24 at 11:03 A.M. with the Assistant Director of Nursing verified Resident # 36's bed was set to comfort level 3 and the order does not specify a comfort level for the resident and it should. Also verified no orders to turn and reposition. Observation on 07/10/24 at 12:19 P.M. and 2:24 P.M. revealed Resident #36 in bed, heels not elevated, resident on his back each time and bed being on comfort level 3 at the 12:19 P.M. observation. Interview on 07/10/24 at 2:25 P.M. with State tested Nursing Assistants (STNA) #444 verified Resident #36's heels were not elevated, and the resident needed assistance to turn and reposition. Review of physician order dated 7/10/24 for Resident #36 revealed a low air mattress to bed, check function, to promote skin care and comfort and mattress to be in static mode and comfort level 5. 2. Review of the medical record for Resident #26, revealed an admitted [DATE]. Diagnoses included but were not limited to peripheral vascular disease, hemiplegia, unspecified affecting unspecified side, need for assistance with personal care and disorder of the skin and subcutaneous tissue. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 09 out of 15 indicating moderate cognitive impairment. The resident was assessed to require total dependence on all aspects of care. Resident was assessed to have 2 stage 4 pressure ulcers with one upon re-entry/admission. Review of Resident #26's active care plan revealed impaired skin integrity with interventions including but not limited to low air loss mattress. Review of physician order dated 07/09/23 at 5:03 P.M. for Resident #26 revealed low air loss perimeter mattress to bed, monitor function every shift. Observation on 07/09/24 at 7:38 A.M., 10:10 A.M., and 2:43 P.M. of Resident #26's bed with the resident in it revealed a weight of 450 pounds to the low air loss mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/10/24 at 7:21 A.M. and 12:10 P.M. of Resident #26's bed with the resident in it revealed a weight of 450 pounds to the low air loss mattress. Interview on 07/10/24 at 11:00 A.M. with the Assistant Director of Nursing verified Resident # 26's bed was set to a weight of 450 pounds and stated that the aides bump into the beds a lot and they will educate them to make sure to inform the nurses if that happens so settings are not changed. Verified Resident #26 is not over 200 pounds, and the setting was incorrect. 47985 3. Record review revealed Resident #12 admitted to the facility on [DATE] with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, unspecified protein-calorie malnutrition, malignant neoplasm of bladder, and hypothyroidism. Review of orders revealed Resident #12 had an order in place for a pressure reducing mattress to his bed. There was no indication Resident #12 had a low air-loss mattress in place or which settings the mattress should be on. Review of an admission MDS completed on 05/17/24 revealed Resident #12's cognition was moderately impaired and he required maximum assistance from staff for bed mobility. Observation on 07/08/24 at 2:21 P.M. revealed Resident #12 had a low air-loss mattress in place but it was not turned on. Resident #12 was not in bed at the time of the observation. Observation on 07/10/24 at 10:49 A.M. revealed Resident #12 was resting in his bed with the low air-loss mattress in place, but the mattress was not turned on. Interview on 07/10/24 at 10:54 A.M. with STNA #362 revealed the low air-loss mattress was likely unplugged. STNA #362 informed Resident #12 she would have to move his bed slightly so she could check and see if it was plugged in. STNA #362 was not aware of how the mattress functions, but squeezed the mattress and stated it was flat. This surveyor also squeezed the mattress which was deflated and was able to feel the inner mechanisms of the bed. STNA #362 moved the bed away from the wall and determined the mattress was unplugged. STNA #362 plugged the mattress back in. Interview on 07/10/24 at 10:57 A.M. with Regional Nurse (RN) #320 confirmed the bed was not on and assisted STNA #362 with turning on the bed and setting. RN #320 stated if the bed is unplugged, there is an emergency battery which will keep the mattress inflated for a few hours, but if it's been off for two days the mattress would be flat. RN #320 confirmed the mattress should have been plugged in and turned on. RN #320 also confirmed there was no order for the low air-loss mattress in place. RN #320 stated she thinks when staff lower or raise the bed, it causes the mattress to come unplugged. This violation represents non-compliance investigated under Complaint Number OH00155264.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, observation, interview, and policy review, the facility failed to have fall interventions in place for Resident #3 and #12. This affected two (Resident #3 and #12) out of four reviewed for accidents. Facility census was 46. Findings include: 1. Review of the medical record revealed Resident #3 was admitted on [DATE] with diagnoses that included Alzheimer's disease, dementia, type 2 diabetes mellitus, hemiplegia and hemiparesis, depression, and anxiety. Review of plan of care dated 11/06/23 revealed Resident #3 was at risk for falls and potential injury related to impaired vision, psychoactive medication, vertigo, impaired balance, dementia, and syncope. Interventions included low bed and to monitor that the bed was in the low position due to Resident #3 would elevate the bed when playing with the controls. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had a brief interview for mental status (BIMS) score of 12 out of 15 which indicated cognitive impairment. Resident #3 required substantial to maximal assistance for sit to stand and transfers. Review of a nursing progress note dated 05/10/24 at 5:49 P.M. revealed Resident #3 was found sitting on the floor beside her bed with legs outstretched and crossed. Resident #3 stated she slid off the bed trying to transfer to chair. Observations on 07/09/24 at 9:06 A.M. and 10:56 A.M. revealed Resident #3 was lying in bed. The bed was not in the low position. Interview on 07/09/24 at 11:02 A.M. Licensed Practical Nurse (LPN) #100 verified Resident #3's bed was not in the lowest position. LPN #100 also verified the controller to the bed was not in Resident #3's reach and could not have been elevated by Resident #3. 47985 2. Record review revealed Resident #12 admitted to the facility on [DATE] with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, unspecified protein-calorie malnutrition, malignant neoplasm of bladder, and hypothyroidism. Review of a care plan dated 05/10/24 revealed Resident #12 was at risk for fall and potential injury related to confusion and impaired safety ability. Intervention implemented on 05/22/24 included adding a dycem (blue, non-slip fabric) to his wheelchair. Review of an admission MDS completed on 05/17/24 revealed Resident #12's cognition was moderately impaired and he required maximum assistance from staff for bed mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/08/24 at 2:21 P.M. revealed Resident #12 was resting in bed and there was no dycem noted to his wheelchair above or below his wheelchair cushion. Observation and interview with STNA #362 revealed the dycem was still not in Resident #12's wheelchair. State tested Nursing Assistant (STNA) #362 stated the dycem is usually below his cushion in his wheelchair. STNA #362 attempted to locate the dycem in Resident #12's room but was unable to find it. Review of a policy dated 02/2021 titled Fall Prevention Policy revealed appropriate interventions will be initiated to prevent falls specific to the resident assessment. 2. Record review revealed Resident #12 admitted to the facility on [DATE] with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, unspecified protein-calorie malnutrition, malignant neoplasm of bladder, and hypothyroidism. Review of a care plan dated 05/10/24 revealed Resident #12 was at risk for fall and potential injury related to confusion and impaired safety ability. Intervention implemented on 05/22/24 included adding a dycem (blue, non-slip fabric) to his wheelchair. Review of an admission MDS completed on 05/17/24 revealed Resident #12's cognition was moderately impaired and he required maximum assistance from staff for bed mobility. Observation on 07/08/24 at 2:21 P.M. revealed Resident #12 was resting in bed and there was no dycem noted to his wheelchair above or below his wheelchair cushion. Observation and interview with STNA #362 revealed the dycem was still not in Resident #12's wheelchair. State tested Nursing Assistant (STNA) #362 stated the dycem is usually below his cushion in his wheelchair. STNA #362 attempted to locate the dycem in Resident #12's room but was unable to find it. Review of a policy dated 02/2021 titled Fall Prevention Policy revealed appropriate interventions will be initiated to prevent falls specific to the resident assessment.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on medical records review, emergency room records review, interview, and facility policy review, the facility failed to develop and implement a comprehensive, individualized and adequate pain management program to provide effective and timely pain relief to residents after falls with injury/fractures. Actual harm occurred on 06/22/24 at 10:31 P.M. when Resident #35 was not provided effective pain management following a fall with hip fracture on 06/22/24 with complaints of significant verbal and non-verbal indicators of pain. The resident was subsequently sent out to the emergency room for the fracture and continued pain on 06/23/24 at 7:15 P.M. (approximately 20 hours after the fall occurred). Actual harm occurred on 03/17/24 at 6:45 A.M. when Resident #22 experienced a fall that resulted in pain and a non-displaced fracture of the greater tuberosity and minimally impacted humeral neck fracture component of the left shoulder fracture. Although the resident complained of pain, pain medication was not initially provided until 03/17/24 at 11:00 A.M. (over four hours after the fall). Actual harm occurred beginning on 01/04/24 at 10:38 P.M. when Resident #24 was not provided effective pain management after a fall with a left comminuted minimally displaced fracture of the proximal humerus. Following the fall, no pharmacological or effective non-pharmacological pain interventions were provided until the resident was transferred to the emergency room (ER) on 01/05/24 at 3:42 A.M. (over five hours later). Direct care staff reported the resident voiced complaints of pain to the area following the incident and before being transferred to the ER. Upon arrival to the ER the resident was assessed to have significant pain to the area. This affected three residents (#24, #22 and #35) of four residents reviewed for pain. The facility census was 46. Findings include: 1. Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including unspecified dementia, adult failure to thrive, difficulty in walking, muscle wasting and atrophy and chronic obstructive pulmonary disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was assessed to require supervision or touching assistance with toilet hygiene and partial/moderate assistance with eating, bed mobility, and transfers. The resident was also assessed in the past 5 days to not receive any scheduled pain medication and received no non-pharmacological interventions for pain. Review of the progress note dated 06/22/24 10:31 P.M. revealed Resident #35 was found on the floor at the foot of the bed on the left side. The resident's head was bleeding, and the resident was wincing in pain when attempting to move him, and an order was obtained to send Resident #35 to the emergency department (ER). Review of Resident #35's progress note dated 06/23/24 2:10 A.M. revealed the resident returned to the facility from the ER at this time. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #35's fall report dated 06/22/24 revealed the resident was confused, found at the foot of the bed on left side with abrasion to forehead, arm and hip pain and was sent to the ER. Record review revealed no evidence the facility developed a comprehensive and individualized plan of care to address the resident's pain or that the resident was monitored/assessed for pain upon return from the ER. Review of the progress note dated 06/23/24 at 12:20 P.M. (10 hours after he returned from ER) by Licensed Practical Nurse (LPN) #100 revealed Resident #35 was assessed for left leg/hip pain after staff reported resident screamed out in pain while changing and trying to get him up for lunch. When assessing, resident yelled when leg lifted and bent at the knee and place back in bed. The resident's left hip area noted to be discolored, area palpated, and resident screamed out in pain. Resident #35's wife was at bedside and said the hospital didn't x-ray the left hip during visit on 06/22/24. A STAT x-ray of the left hip was obtained at this time. Record review revealed no evidence the physician was notified of the pain the resident was displaying at this time to provide any type of pain management/pain relief. Review of the physician's order dated 06/23/24 at 12:20 P.M. reflected the order for Resident #35 to have a STAT x-ray of the left hip for pain. There was no indication the resident was provided any pharmacological or non-pharmacological pain interventions at this time. Review of the radiology report dated 06/23/24 at 5:40 P.M. for Resident #35 revealed a recent left hip fracture and a cat scan was suggested. Review of a progress note for Resident #35 revealed on 06/23/24 at 7:15 P.M. LPN #100 received the results from the x-ray. The note indicated hospice triage notified and would notify doctor for pain meds and will call back. At 7:40 P.M. the resident was sent out to the ER. Further review of Resident #35's record revealed no pharmacological, non-pharmacological pain interventions or follow-up/monitoring of the resident related to pain after the fall or after the resident's return from the ER. There was no evidence the facility developed a comprehensive and individualized plan of care to address the resident's pain upon return from the ER. Interview on 07/10/24 at 8:50 A.M. with STNA #555 revealed she was working the day of 06/23/24 and when staff would provide personal care/change Resident #35 every two hours, he would cry out in pain. STNA #555 stated she told the nurse, and they used a pillow to position him, but he would still cry out and grab at his left leg. Interview on 07/10/24 at 9:08 A.M. with LPN #100 revealed on 06/23/24, Resident #35 would cry out in pain when being changed every two hours the aides informed him of the resident being uncomfortable and crying out in pain, so a pillow was used to keep the resident propped up on his right side for comfort. The LPN verified no other non-pharmacological interventions, and no pharmacological interventions were implemented to address the resident's pain with being changed and stated the resident did receive Ativan for behaviors (previously ordered medication for anxiety) that were consistent with prior to the fall and that makes him sleepy. In addition, the LPN revealed staff did not get Resident #35 out of bed all day as a result of the pain he was experiencing status post fall. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	2. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including bipolar disorder, major depressive disorder, schizoaffective disorder, anxiety disorder, and specified disorders of bone density and structure, unspecified site. Review of Resident #22's fall report revealed that a fall occurred on 03/17/24 at 6:45 A.M. when the resident was sitting on the side of the bed and reached for a paper on the floor and fell forward. Review of Resident #22's progress notes dated 03/17/24 at 6:45 A.M. by LPN #123 revealed the resident stated that her arms hurt. Review of the Medication Administration Reconciliation (MAR) dated 03/17/24 at 6:45 A.M. for Resident #22 revealed a pain level of seven on a scale of 0 to 10 documented per LPN #123. However, no pain medication was administered at that time. Review of the progress note dated 03/17/24 at 10:30 A.M. by LPN #100 revealed Resident #22 had complaints of left arm/shoulder pain and new order was received for Ibuprofen 400 milligrams (mg) oral every 8 hours as needed for one week and an x-ray of the left shoulder and elbow. Review of the physician order dated 03/17/24 at 10:51 A.M. for Resident #22 revealed a routine x-ray of the left shoulder and left elbow. Review of the MAR for Resident #22 revealed on 03/17/24 at 11:00 A.M. the resident had pain rated an eight on a scale of 0 to 10 and the Ibuprofen 400 mg was administered was administered at this time. Further review of Resident #22's record revealed no non-pharmacological pain interventions were initiated to address the resident's pain following the fall. Review of the radiology results dated 03/17/24 at 3:17 P.M. of the left shoulder and left elbow for Resident #22 revealed a non-displaced fracture of the greater tuberosity noted and minimally impacted humeral neck fracture component is present of the left shoulder. An appointment was made for the resident to see an orthopedic physician. Record review revealed no pain plan of care was developed for the resident with comprehensive and individualized interventions to address the resident's pain following this incident. Review of the most recent MDS 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating the resident was cognitively intact. The resident was assessed to require supervision or touching assistance for toilet hygiene and transfers and independent for bed mobility. The resident was assessed to be frequently incontinent and to have had pain in the past 5 days. Interview on 07/11/24 at 9:10 A.M. with Resident #22 revealed the resident recalled the fall on 03/17/24 and stated that it really hurt. The resident also stated she had asked for pain medicine because her left arm was hurting so bad. She denied having any non-pharmacological pain interventions after the fall and stated because of the fall/injury she needed assistance in the restroom when she had not before the fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365461	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muskingum Skilled Nursing & Rehabilitation	501 Pinecrest Drive Beverly, OH 45715

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 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 07/11/24 at 9:17 A.M. with LPN #123 via telephone revealed when Resident #22 fell on [DATE] at 6:45 A.M. she reported the pain to her left arm was rated a seven on a pain scale of 0 to 10 as documented and put her back in bed and passed it along to LPN #100 in shift change that the resident had fallen and had some pain. The LPN verified no non-pharmacological or timely pharmacological interventions were provided for Resident #22. Interview on 07/11/24 at 10:50 A.M. with LPN #100 revealed he was the nurse that came on shift after Resident #22 had fallen on 03/17/24. LPN #100 indicated the resident did not ask for pain medication until 10:30 A.M. and he was not aware of the pain level of seven out of 10 documented by LPN #123 after the fall therefore, no follow-up assessment or evaluation was completed. The LPN verified no timely follow up was completed and stated the resident went to breakfast, so he didn't think she was in pain or needed anything for it. The LPN verified Resident #22's pain was rated an eight on a 0 to 10 scale when he received an order to medicate. The LPN also verified no non-pharmacological interventions were initiated for the resident after the fall to address her pain. Interview on 07/11/24 at 11:02 A.M. with STNA #555 revealed after Resident #22 had fallen on 03/17/24, she would need assistance to the restroom and was babying her left arm and stated that she never needed assistance before and would make faces if staff accidentally touched her left arm and would say it was hurting. The STNA verified the facility had not implemented any type of non-pharmacological interventions for Resident #22 following the fall/fracture. 3. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including generalized anxiety disorder, obsessive-compulsive personality disorder, dementia, Alzheimer's with late onset and unspecified osteoarthritis. Review of Resident #24's progress note dated 01/05/24 at 10:38 P.M. by Licensed Practical Nurse (LPN) #666 revealed the residents call light was on and the resident asked to be helped off the floor but was on the bed side. Upon assessment, this resident had left shoulder swelling and was painful to the touch, Resident #24 stated it hurt when moving it. LPN #666 obtained a STAT x-ray order for the left shoulder. Record review revealed no additional nursing progress notes were completed to indicate the resident was assessed/monitored for pain or evidence of any type of pain management being completed following the above note documented on 01/05/24 at 10:38 P.M. Review of Resident #24's fall report for 01/05/24 at 10:38 P.M. revealed the resident wanted help getting off the floor even though she wasn't on the floor. The report indicated Resident #24 had slipped on a wash rag on the floor per resident. Review of the radiology report dated 01/05/24 2:18 A.M. for Resident #24 revealed a left comminuted minimally displaced fracture of the proximal humerus. Further review of Resident #24's record revealed no pharmacological or non-pharmacological pain interventions were provided as follow up to the resident's pain after the fall. Review of the emergency room visit for Resident #24 revealed an arrival time of 3:42 A.M. with a pain level of six on a scale of zero to 10 scale with 10 being the most severe pain. (continued on next page)

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	365461	A. Building B. Wing	07/15/2024

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Muskingum Skilled Nursing & Rehabilitation	501 Pinecrest Drive Beverly, OH 45715

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 07 out of 15 indicating the resident had cognitive impairment. The resident was assessed to be independent with toilet hygiene, bed mobility, and transfers. The resident was assessed to always be continent and in the last five days the resident received scheduled pain medications and non-pharmacological pain interventions with an interview with having pain in the past 5 days. Interview on 07/10/24 at 10:41 A.M. with State tested Nursing Assistant (STNA) #875 revealed after Resident #24 had fallen, she was the one who completed the vitals and stated Resident #24 would not let her do anything to her left arm and she was making faces when they tried to touch it. STNA #875 stated she had to help her until she went out and she was babying her left arm and said it was painful especially when helping to get her dressed to go to the emergency room . The STNA verified the resident had used the call light after the fall to indicate pain to the left arm which she stated was relayed to LPN #666 and only a pillow was utilized for a non-pharmacological intervention with no effectiveness. Attempts to reach LPN #666 during the survey were unsuccessful. In addition, attempts to interview Resident #24 related to the incident and/or pain were also unsuccessful due to the resident's cognitive impairment. Review of the facilities undated Pain Management policy revealed the facility will recognize the needto identify pain and its underlying cause, as able, that will allow for a prompt response to pain. The healthcare facility will assess, monitor, intervene, and re-evaluate the resident's pain, while updating the necessary documentation routinely. The resident will be encouraged to participate in pain relief and management, as able.