STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365532	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Greenville	243 Marion Drive Greenville, OH 45331

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record reviews, staff interview, and policy review, the facility failed to ensure psychotropic medications had appropriate documentation for medical use and failed to ensure as needed (PRN) psychotropic medications had a date for re-evaluation of use or duration of use dates. This affected two (#05 and #16) residents out of three residents reviewed for medication administration. The facility census was 60. Findings include: 1. Review of the medical record for Resident #05 revealed an admission date of 01/15/25 with medical diagnoses of dysphagia, tremors, dementia, osteoarthritis, and adult failure to thrive. Review of the medical record for Resident #05 revealed an admission Minimum Data Set (MDS) assessment, dated 01/31/25, indicated Resident #05 was cognitively intact and required partial/moderate staff assistance for eating, substantial/maximum staff assistance for transfers, and was dependent upon staff for toilet hygiene and bathing. Review of the medical record for Resident #05 revealed a physician order dated 04/14/25 for Lorazepam (antianxiety medication) 0.5 milligram (mg) one tablet by mouth every 12 hours as needed (PRN) for anxiety. The order did not indicate a date for re-evaluation of use or duration use dates. Review of the medical record revealed the Lorazepam order was changed on 05/05/25 to 0.5 mg one tablet by mouth every 12 hours PRN for 14 days. Review of the medical record for Resident #05 revealed the April Medication Administration Record (MAR) which indicated Resident #05 received Lorazepam daily on 04/14/25 to 04/20/25, daily 04/22/25 to 04/26/25, and 04/28/25. Review of Resident #05's May MAR revealed Lorazepam was administered daily 05/01/25 to 05/05/25. 2. Review of the medical record for Resident #16 revealed an admission date of 03/07/25 with medical diagnoses encephalopathy, hypotension, Alzheimer's disease, and atrial fibrillation. Review of the medical record revealed a discharge date of 04/30/25. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #16 revealed an admission MDS assessment, dated 03/17/25, which indicated Resident #16 was never/rarely understood and had cognitive impairment. Review of the MDS indicated Resident #16 required supervision with eating, partial/moderate staff assistance with transfers, substantial/maximum staff assistance for bathing and bed mobility and was dependent upon staff for toilet hygiene. Review of the MDS indicated Resident #16 received antipsychotic medication daily. Review of the medical record for Resident #16 revealed a physician order dated 03/14/25 for Haloperidol (antipsychotic medication) 5 mg one tablet by mouth every eight hours PRN for agitation. The order did not indicate a date for re-evaluation of use or duration of use dates. Review of the medical record for Resident #16 revealed the March 2025 MAR revealed documentation to support Resident #16 received Haloperidol daily on 03/14/25 to 03/16/25, 03/18/25, 03/22/25, 03/23/25, 03/26/25 to 03/30/25. Further review revealed the April 2025 MAR which indicated Resident #16 received Haloperidol daily on 04/01/25, 04/02/25, 04/07/25 to 04/10/25, 04/17/25, and 04/22/25 to 04/24/25. Review of the medical record for Resident #16 revealed a pharmacy Medication Regimen Review, dated 03/17/25, recommended to re-evaluate the use of Haloperidol 5 mg one tablet by mouth every eight hours PRN to see if the medication was still needed and to consider adding a 14 day stop date. The review was signed by the physician on 04/29/25 with a note which stated the resident was discharging on 04/30/25 and would review if repeat admission. Interview on 04/29/25 at 3:26 P.M. with Director of Nursing (DON) confirmed Resident #05's order for Lorazepam was changed from routine to PRN on 04/14/25 because Resident #05 was having difficulty waking up in the morning. DON confirmed Resident #05's order dated 04/14/25 for Lorazepam 0.5 mg one tablet by mouth every eight hours PRN did not have a re-evaluation of use date or duration of use dates. DON also confirmed Resident #16's Haloperidol was ordered PRN and did not have a re-evaluation of use date or duration of use dates. DON confirmed Resident's Medication Regimen Review, dated 03/17/25, was not reviewed or signed by the physician until 04/29/25. DON also confirmed Resident #16's indication for use of haloperidol was agitation and Resident #16 did not have a medical diagnosis for use of the medication. Review of the facility policy titled, Unnecessary Medications, dated 04/28/25, stated the facility's policy that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being free from unnecessary meds. The policy stated the attending physician would assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents and/or representatives, other professionals, and the interdisciplinary team. Each resident's drug regimen would be reviewed on an ongoing basis, taking into consideration the following elements: dose, duration of use, indications and clinical need for medication, and adequate monitoring for efficacy and adverse consequences, preventing, identifying, and responding to adverse consequences. The policy also stated the resident's medical record would show adequate indications for the medication's use and the diagnosed condition for which it was prescribed.

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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 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. Based on medical record review, observations, staff interviews, and policy review, the facility failed to properly measure pressure ulcers and ensure treatments were completed as ordered. This affected one (#36) resident out of three residents reviewed for adequate wound care and services. The facility census was 60. Findings include: Review of the medical record for Resident #36 revealed an admission date of 08/21/2020 with medical diagnoses of multiple sclerosis (MS), myelodysplastic syndrome, quadriplegia, anxiety, and schizophrenia. Review of the medical record for Resident #36 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/17/25, which indicated Resident #36 had severely impaired cognition and was dependent for all activities of daily living. The MDS indicated Resident #36 had a Stage IV pressure ulcer which was present upon admission. Review of the medical record for Resident #36 revealed a weekly wound assessment, dated 05/01/25, which indicated Resident #36 had a pressure ulcer to her coccyx which measured 6.1 centimeters (cm) by 5.6 cm by 0.4 cm and the wound was stable. The assessment stated the wound was beefy pink and area was improving. No other documentation noted to the description of the pressure ulcer was present. The wound assessment was completed by Wound Care Clinician (WCC) #285. Review of the medical record for Resident #36 revealed a physician order dated 07/16/24 to cleanse area to right buttock/sacrum with normal saline, pat dry, apply zinc to wound bed, cover with calcium alginate with silver, cover with abdominal (ABD) pad, do not apply tape and to change daily and as needed. Review of the medical record revealed a physician order dated 05/07/25 to cleanse area to right buttock/sacrum times two with normal saline, pat dry, apply zinc to wound bed, cover with calcium alginate with silver, cover with abdominal (ABD) pad, do not apply tape and to change daily and as needed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation with interview on 05/07/25 at 9:49 A.M. of Resident #36's wound care by Licensed Practical Nurse (LPN) #247 and LPN #242 revealed LPN #242 positioned Resident #36 on her left side. LPN #247 washed her hands and applied gloves and gown prior to wound care. LPN #242 removed Resident #36's old dressing which revealed a small amount of serosanguinous drainage. LPN #242 removed gloves, washed hands, and applied new gloves. The observation revealed Resident #36 had two distinct wounds to her right buttock/sacrum area. A wound was observed to be located on Resident #36's upper right buttock which was oblong in shape, about 3 cm long and 1 cm wide with a red wound bed and small amount of yellowish substance noted in wound bed. The observation also revealed a second wound noted posterior and lateral to the oblong wound. The second wound was circular in shape, about 3 cm long by 3 cm wide with red wound bed and a small amount of yellow substance noted in wound bed. Observation revealed LPN #247 cleansed Resident #36's circular wound with normal saline, applied zinc to the wound bed, covered with calcium alginate with silver, and covered with ABD pad. The ABD pad also covered the oblong wound. LPN #247 was observed to remove her gloves and wash her hands after discarding all soiled supplies. Interview with LPN #247 confirmed Resident #36 had two distinct wounds to her right buttock/sacrum area and that she did not complete treatment to the oblong wound located on the right upper buttock. LPN #247 stated the wound documentation for Resident #36 did not indicate a second pressure ulcer to her right buttock/sacrum area, so she only completed treatment to the circular wound located posterior and lateral to oblong wound. Interview on 05/07/25 at 1:27 P.M. with WCC #285 confirmed Resident #36 did not see a wound physician per family request and the facility staff completed weekly wound measurements and treatment orders. WCC #285 stated Resident #36 admitted to the facility with multiple pressure ulcers and the pressure ulcer to right buttock/sacrum had been present since admission. WCC #285 confirmed Resident #36 had two distinct pressure ulcers to right buttock/sacrum area, but the weekly wound assessment indicated the measurements for the entire area containing both pressure ulcers. WCC #285 confirmed the weekly wound assessment did not contain descriptions of each of Resident #36's pressure ulcers to right buttock/sacrum. WCC #285 stated she was not aware that staff were only completing treatment to one of Resident #36's pressure ulcers but confirmed the pressure ulcers have been stable. Review of the facility policy titled, Pressure injury treatment, revised 04/28/25, stated residents with pressure injuries would be treated with consistent treatment protocols to aid in the healing process. The policy stated residents with pressure injuries would have an individualized treatment program that provides the appropriate treatment to facilitate healing and that assesses and addresses comorbid conditions in a systematic manner. This deficiency represents non-compliance investigated under Complaint Number OH00164283.

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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. Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure medications were available for administration. This affected one (#10) resident out of the three residents reviewed for medication administration. The facility census was 60. Findings include: Review of the medical record for Resident #10 revealed an admission date of 02/11/25 with medical diagnoses of heart disease, diabetes mellitus, atrial fibrillation, depression, and bipolar disorder. Review of the medical record for Resident #10 revealed an admission Minimum Data Set (MDS) assessment, dated 02/11/25, which indicated Resident #10 was cognitively intact and required supervision with eating, partial/moderate staff assistance with toilet hygiene and bed mobility, and substantial/maximum staff assistance with bathing and transfers. Review of the medical record for Resident #10 revealed a physician order dated 02/12/25 for Venlafaxine (antidepressant) extended release (ER) 150 milligram (mg) one tablet by mouth daily for depression. Observation with interview on 05/06/25 at 7:55 A.M. revealed Registered Nurse (RN) #236 prepared Resident #10's medications for administration. The observation revealed RN #236 was not able to locate Resident #10's Venlafaxine ER 150 mg dose due that morning in the medication cart, in medication overflow, or in the facility emergency box. Interview with RN #236 confirmed Resident #10's Venlafaxine ER 150 mg tablet was not available for administration. Review of the facility policy titled, Administering Medications, reviewed 04/28/25, stated medications shall be administered in a safe and timely manner, and as prescribed. This deficiency represents non-compliance investigated under Complaint Number OH00164459.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure insulin injector pens were dated when opened. This affected one (#09) resident out of three residents reviewed for medication administration. The facility census was 60. Findings include: Review of the medical record for Resident #09 revealed an admission date of 02/15/25 with medication diagnoses of gas gangrene, chronic osteomyelitis of right ankle/foot, diabetes mellitus (DM) , peripheral vascular disease, and hypertension. Review of the medical record for Resident #09 revealed an admission Minimum Data Set (MDS) assessment, dated 02/20/25, which indicated Resident #09 was cognitively intact and required set-up assistance with eating, partial/moderate staff assistance with showers, and substantial/maximum staff assistance with toilet hygiene, bed mobility, and transfers. The MDS indicated Resident #09 received six days of insulin injections. Review of the medical record for Resident #09 revealed a physician order dated 04/14/25 for Insulin Lispro pen to inject 10 units subcutaneous (SQ) daily for DM and an order dated 04/15/25 for Insulin Glargine SQ solution to inject 35 units SQ daily for DM. Observation on 05/06/25 at 8:08 A.M. revealed Registered Nurse (RN) #236 prepare Resident #09's medications for administration. RN #236 primed Insulin Glargine injection pen with two units of insulin and then set the pen to 35 units. RN #236 then primed Insulin Lispro injection pen with two units then set the pen to 10 units. Observation revealed neither insulin injection pen indicated a date the pens were opened. Observation revealed RN #236 administer insulin injections to Resident #09 as ordered. Interview on 05/06/25 at 8:10 A.M. with RN #236 confirmed she administered Insulin Glargine and Insulin Lispro to Resident #09 via injection pens and neither injection pen indicated a date in which the pens were opened. Review of the facility policy titled, Administering Medications, reviewed 04/28/25, stated medications shall be administered in a safe and timely manner, and as prescribed. The policy stated the expiration/beyond use date on the medication label must be checked prior to administration. When opening a multi-dose container, the date opened shall be recorded on the container.