STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365632	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majora Lane Ctr for Rehab & Nsg Care Inc	105 Majora Lane Millersburg, OH 44654

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #31's redness and excoriation to the buttocks was documented and treated timely. This affected one resident (#31) out of three residents reviewed for incontinence care. The facility census was 64. Findings include: Review of Resident #31's medical record revealed an admitted [DATE] with diagnoses including cerebral infarction due to thrombosis of unspecified middle cerebral artery, hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the right dominant side, need for assistance with personal care, weakness, and unspecified lack of coordination. Review of Resident #31's physician orders dated 05/29/24 revealed Weekly Skin Check: complete head to toe skin assessment. Answer questions below with Y (yes) or N (no), if any skin conditions listed below were marked with yes or any other skin impairments noted, provide detailed description of your findings in a progress note and then follow facility wound policy. Remove all splints, braces, TED hose (anti-embolism stockings), Ace wraps and any other item Resident #31 might have on that was restricting your view of the skin once a day on Tuesdays 6:30 P.M. through 6:30 A.M. Review of Resident #31's physician orders dated 05/29/24 revealed Resident #31 required extensive assistance of two staff for toilet transfers, and extensive assistance of two staff for chair-to-bed to-chair transfers. Resident #31 required total assistance for toileting and hygiene. Review of Resident #31's Nursing Skin Tool dated 06/03/24 and 06/06/24 documented by State tested Nursing Assistant (STNA) #253 did not reveal evidence Resident #31 had redness to her buttocks. Review of Resident #31's Nursing Skin Tool dated 06/10/24 documented by STNA #230 revealed Resident #31's buttocks were red and painful, and extra protective ointment was applied. Review of Resident #31's Nursing Skin Tool dated 06/11/24 documented by Licensed Practical Nurse (LPN) #237 revealed Resident #31 did not have new skin issues. Review of Resident #31's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] included Resident #31 had severe cognitive impairment. Resident #31 required substantial to maximal assistance with toileting and personal hygiene. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2024

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Majora Lane Ctr for Rehab & Nsg Care Inc	105 Majora Lane Millersburg, OH 44654

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #31's care plan dated 06/04/24 included Resident #31 was incontinent of bowel and was at risk for altered dignity, skin breakdown, diarrhea, and constipation. Resident #31 would have soft bowel movements at least every three days without complications such as skin excoriation, diarrhea or constipation by the target date of 09/04/24. Resident #31 was incontinent of bladder and was at risk for altered dignity, skin breakdown and UTI (urinary tract infection). Resident #31 was not a candidate for a scheduled toileting program. Resident #31 would not develop complications related to urinary incontinence such as skin breakdown or UTI by the target date of 09/04/24. Interventions included to check and provide incontinence care as needed, apply moisture barrier cream after each incontinent episode, observe, report any noted redness, excoriation or open areas with incontinence care. Review of Resident #31's Treatment Administration Record (TAR) dated 06/04/24 and 06/11/24 revealed skin checks were completed as ordered. Review of Resident #31's progress notes dated 06/10/24 through 06/12/24 at 6:33 P.M. did not reveal evidence Resident #31 had redness and excoriation to her bilateral inner buttocks. Review of Resident #31's progress notes dated 06/12/24 at 6:33 P.M. revealed on 06/12/24 at 8:28 A.M. Registered Nurse (RN) #262 helped Resident #31 use the restroom. Resident #31 had loose stool and was incontinent of bowel at this time. Resident #31 had redness, blanchable areas of the bilateral buttocks. Resident #31 was assisted with toileting hygiene, and barrier cream was applied. Resident #31 did not voice complaints of pain or discomfort at this time. Would continue to monitor. Review of Resident #31's physician orders dated 06/12/24 at 6:36 P.M. revealed bilateral buttocks and coccyx, cleanse with soap and warm water, pat dry and apply EPC (extra protection cream) BID (twice a day) and as needed. Review of Resident #31's Medication Administration Record (MAR) revealed an order initiated on 06/12/24 and implemented on 06/13/24 revealed bilateral buttocks and coccyx, cleanse with soap and warm water, pat dry and apply EPC cream BID. There was no evidence EPC cream was applied on 06/12/24 at 8:28 A.M. Further review of the MAR did not reveal evidence EPC cream was applied until 06/13/24 between 6:30 A.M. through 6:30 P.M. Observation on 06/12/24 at 2:29 P.M. of STNA's #238 and #274 providing incontinence care for Resident #31 revealed Resident #31's incontinence brief was wet, and STNA #274 removed the brief and proceeded to clean Resident #31's perineal area. STNA's #238 and #274 assisted Resident #31 onto her right side and when STNA #238 wiped between her buttocks Resident #31 cried out in pain. STNA #238 was asked by the surveyor to spread Resident #31's buttocks and when the buttocks were spread the entire inside area of both buttocks was observed to be deep red in color, with some excoriation. Further observation of Resident #31's inner buttocks revealed several long, blanchable, dark red marks about two to three inches long. STNA #274 stated she noticed redness between Resident #31's buttocks a couple days ago and told a nurse, but she could not remember which nurse she told. STNA #238 applied extra protection cream to Resident #31's buttocks before a clean incontinence brief was placed. Interview on 06/12/24 at 3:04 P.M. of RN #262 revealed she changed Resident #31 on 06/12/24 in the morning, saw her reddened buttocks, and applied barrier cream. RN #262 confirmed there was no documentation regarding Resident #31's reddened buttocks in the progress notes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/12/24 at 3:23 P.M. of the Director of Nursing (DON) revealed Resident #31 had intermittent redness with incontinence and no treatment was required. Interview on 06/17/24 at 9:57 A.M. of the DON revealed the STNA's did not chart resident skin issues in the electronic record. The DON stated STNA's were told to write minimal notes on shower sheets because they were supposed to tell the nurse if a resident had a skin issue, and the nurse would assess and document if there was a problem. The DON stated weekly skin assessments were not documented in resident's electronic records but were completed on paper forms. The DON indicated the nurses and STNA's used the same form which was titled Nursing Skin Tool for resident's skin assessments. The DON stated nurses would document what the skin problem was on the Nursing Skin Tool and would document in the resident's progress notes or make a skin grid depending on what the problem was. Interview on 06/17/24 at 11:06 A.M. of STNA #253 revealed Resident #31 did not have redness to her buttocks on 06/03/24 or 06/06/24 when she completed her showers. Interview on 06/17/24 at 11:51 A.M. of Licensed Practical Nurse (LPN) #237 revealed Resident #31 had no skin issues when she completed her Nursing Skin Tool on 06/11/24. LPN #237 stated no STNA's told her Resident #31 had redness to her buttocks. Review of the undated facility policy titled Wound Care included it was the facility policy to provide guidelines for the care of wounds to promote healing. Verify there was a physician's order for the procedure and review the resident's care plan to assess for any special needs of the resident. Apply ointment and or dressing per physician order. This deficiency represents non-compliance investigated under Master Complaint Number OH00154080 and Complaint Number OH00153989.

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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 0697 Level of Harm - Minimal harm or potential for 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** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #43's pain was accurately documented and treated timely. This affected one resident (#43) out of three residents reviewed for pain. The facility census was 64. Findings include: Review of Resident #43's medical record revealed an admitted [DATE] with diagnoses including unspecified fracture of the upper end of the right humerus, subsequent encounter for fracture with routine healing, major depressive disorder, and laceration of the left lower leg. Review of Resident #43's care plan dated 05/15/24 revealed Resident #43 had the potential for alteration in comfort related to pain. Resident #43 would show evidence of relief of episodes of pain AEB (as evidenced by) Resident #43 would have no episodes of breakthrough pain, would voice feelings of comfort with care and routine, would be able to sleep per normal, and would not have pain interfere with daily routine through the target date of 08/14/24. Interventions included to assess pain for possible cause, location, duration; attempt alternate relief measures; encourage Resident #43 to rate pain on a one to ten scale with ten being the worst pain; medicate per physician order for resident pain and intensity, observe for medication relief and, or response and notify physician as needed. Review of Resident #43's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] included Resident #43 had moderate cognitive impairment. Resident #43 received pain medication and had pain or hurting over the past five days. Resident #43 frequently had pain that made it hard for her to sleep at night, hard to participate in rehabilitation therapy sessions, and limited her day-to-day activities. Resident #43 rated the worst pain she had over the past five days as severe. Review of Resident #43's physician orders dated 05/27/24 revealed acetaminophen tablet 500 milligram (mg) (analgesic), give 1000 mg by mouth twice a day. Further review revealed acetaminophen 500 mg, give 500 mg by mouth twice a day as needed. Review of Resident #43's physician orders dated 05/27/24 revealed oxycodone-acetaminophen tablet 5-325 mg (opioid pain medication), give one tablet by mouth one time a day as needed. Review of Resident #43's progress notes dated 06/17/24 at 1:15 A.M. included Resident #43 requested and was given as needed pain medication with a positive effect, and she was resting quietly in bed with her eyes closed. There was no further documentation on 06/17/24 regarding Resident #43's pain, or what her pain was on a pain scale of one to ten and ten being the worst pain. Review of Resident #43's medication administration record (MAR) revealed to assess pain every shift on a scale of one to ten. On 06/17/24 day shift Resident #43's pain was documented as a zero. Review of Resident #43's MAR dated 06/17/24 revealed acetaminophen 1000 mg by mouth was not given in the morning at 7:06 A.M. because Resident #43 requested Percocet (oxycodone-acetaminophen 5-325 mg). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Majora Lane Ctr for Rehab & Nsg Care Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Majora Lane Millersburg, OH 44654	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #43's MAR dated 06/17/24 revealed oxycodone-acetaminophen tablet 5-325 mg was administered by mouth for pain at 7:06 A.M. and follow-up pain result was SE (somewhat effective). There was no documentation of Resident #43's pain level on a scale of one to ten and ten being the worst pain. Review of Resident #43's MAR dated 06/17/24 revealed acetaminophen 500 mg was administered by mouth at 12:01 P.M. for pain and the follow-up pain result was SE (somewhat effective). There was no documentation of Resident #43's pain level on a scale of one to ten. Interview on 06/17/24 at 8:15 A.M. and 10:35 A.M. revealed Resident #43 lying in bed and the head of the bed was elevated about thirty degrees. Observation on 06/17/24 at 11:47 A.M. of Resident #43 revealed she was lying in bed, leaning to the left side of the bed, and her right arm was in a sling. Resident #43 stated she was in pain, grimaced, said her arm hurt where she broke it, and while she was talking, she reached over with her right hand and rubbed her left arm. Resident #43 stated she was in a lot of pain and had not been out of her bed today. Interview on 06/17/24 at 1:48 P.M. of State tested Nursing Assistant (STNA) #250 revealed she offered to assist Resident #43 out of bed before breakfast and lunch, but she refused. Interview on 06/17/24 at 1:55 P.M. of LPN #221 revealed she evaluated Resident #43's pain a couple times today and she was in pain around lunchtime. LPN #221 stated around 12:00 P.M. Resident #43 rated her pain at an eight, Resident #43 could only receive oxycodone once a day and LPN #221 administered acetaminophen to her around 12:00 P.M. LPN #221 stated she did not contact Resident #43's physician about the pain level of eight, and Resident #43 only had acetaminophen ordered. When asked about the SE recorded on Resident #43's MAR, LPN #221 indicated the way the electronic system worked she had to click on an option for pain medication effectiveness before she could complete signing out the pain medication. LPN #221 confirmed she had to click on a follow-up pain option before she gave the pain medication, and it did not make sense. LPN #221 stated she was supposed to go back and evaluate Resident #43's pain after about one and a half hours, then go back and document the effectiveness in the electronic record. LPN #221 stated she had not gone back to Resident #43's room to check the effectiveness of the Tylenol, and it had been two hours since Resident #43's Tylenol (acetaminophen) was administered. Interview on 06/17/24 at 2:08 P.M. of the Director of Nursing (DON) revealed residents' pain was assessed on a scale of one to ten, ten being the worst pain. The DON stated if a resident requested an as needed pain medication, the nurse would give the medication, and document what the resident rated the pain on the pain scale of one to ten. The DON stated about one to two hours after the pain medication was administered the nurse would evaluate the effectiveness of the pain medication, and in the electronic record would click on the follow up option and document if the medication was effective or not. The DON indicated the nurse who put Resident #43's pain medication orders in the electronic system did not click on the option for follow-up, but instead left the option the way it was which stated before (meaning before the pain medication was given). The DON stated Resident #43's orders needed to be amended so the follow-up would be scheduled at the appropriate time to evaluate for effectiveness. The DON confirmed there was no evidence Resident #43's pain was rated on 06/17/24 when the acetaminophen and oxycodone-acetaminophen were administered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/17/24 at 2:36 P.M. of LPN #270 revealed she entered Resident #43's room and Resident #43 was lying in bed with a slight grimace on her face. When asked Resident #43 stated the Tylenol took some of the edge off her arm pain, but her arm hurt when it moved. Resident #43 stated she did not want to get out of bed today because of her pain, and she did not want to aggravate her arm. LPN #270 did not ask Resident #43 to rate her pain, but when asked by the surveyor she asked Resident #43 what her pain level was on a scale of one to ten, and Resident #43 stated her pain was an eight and a half. LPN #270 stated she would text the physician about Resident #43's pain. Interview on 06/17/24 at 4:36 P.M. of LPN #270 revealed Resident #43's physician discontinued the once-a-day oxycodone and ordered tramadol 50 mg (opioid pain medication) every six hours as needed. Review of the undated facility policy titled Pain Assessment and Management Protocol included the purpose, of the procedure was to provide guidelines for assessing resident pain, as well as ongoing monitoring, treatment and evaluation of pain to ensure appropriate pain management. It was the goal of the facility to do everything they could to manage resident's pain. Residents might be reluctant to report pain due to the belief that pain was a normal part of the aging process or because of a reluctance to bother busy staff members. When assessing a resident for pain, the nurse would evaluate resident's verbal expression of a pain score, level as well as non-verbal signs and symptoms that could reflect pain (for example, grimacing, dressing change, poor appetite etcetera). Pain management goals were to promote resident comfort, decrease pain intensity, reduce the risk of the resident from reaching the next highest pain level, using a scale of one to ten. This deficiency represents non-compliance investigated under Master Complaint Number OH00154080.