STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365939	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor of Wellston	405 North Park Avenue Wellston, OH 45692

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to ensure residents were free of unnecessary medications. This affected two residents (#33, #44) of four residents reviewed for unnecessary medications. The facility census was 44. Findings included: 1. Record review revealed Resident #33 admitted to the facility on [DATE] with diagnoses including atrial fibrillation, idiopathic gout, gastro-esophageal reflux disease, anemia, and acute kidney failure. Review of orders revealed Resident #33 had an order in place for tramadol oral tablet 50 mg give one tablet by mouth every 6 hours as needed for pain with a start date of 10/10/22 and an order for Tylenol tablet give 650 mg by mouth every four hours as needed for pain with a start date of 04/25/24. Review of the medication administration record (MAR) for April and May 2024 revealed there were no parameters in place to determine which PRN pain medication should be administered based on the numerical level of pain Resident #33 stated he was in. 2. Record review revealed Resident #44 admitted to the facility on [DATE] with diagnoses including ataxic cerebral palsy, hypertension, schizophrenia, paranoid personality disorder, muscle weakness, and personal history of traumatic brain injury. Review of MAR for April and May 2024 revealed Resident #44 had orders in place for acetaminophen oral tablet 325 mg give 650 mg by mouth every six hours as needed for pain dated 12/28/22 and an order for hydro-codone acetaminophen oral tablet 5-325 mg give one tablet by mouth every ix hours as needed for pain dated 12/28/22. Further review of MAR reviewed no parameters were in place to determine which PRN pain medication should be administered based on the numerical level of pain Resident #44 stated she was in. Interview on 05/03/24 at 1:49 P.M. with Licensed Practical Nurse (LPN) #137 revealed if a resident has a PRN pain medication in place such as a Tylenol and a narcotic, she would determine which one to administer based on what the resident tells her they need. LPN #137 stated they do ask for a numerical pain rating, but if they aren't alert and oriented they use a pain monitoring scale based on body language, facial grimacing and other signs of pain to determine the level of pain, then go from there. (continued on next page)

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

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/03/24 at 2:06 P.M. with LPN #156 revealed if a resident has a PRN pain medication in place, such as Tylenol and a narcotic, she determined which pain medication to administer based on the level of pain. LPN #156 stated if a resident told her the pain was mild, one through four, she would administer Tylenol then if it was a five to ten, she would give something stronger. LPN #156 stated you always start low, then go higher if needed. Interview on 05/03/24 at 3:14 P.M. with LPN #129 revealed if a resident has PRN pain medications and they state their pain is a three or four, she will ask if they think Tylenol would be effective or not, but if they stated their pain was a six to seven should would administer the stronger medication. Interview on 05/03/24 at 3:33 P.M. with the director of nursing (DON) revealed Residents #33 and #44 did not have parameters in place to determine which pain medication should be administered. DON stated pain medication should be given based on what the resident states their pain level is and as ordered by the physician. Review of a policy titled Administering Medications dated April 2019 revealed medications are to be administered in accordance with prescriber's orders, if a dosage is believed to be inappropriate or excessive for a residents or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse effects the person preparing or administering the medical will contact the prescriber to discuss concerns. This deficiency represents non-compliance investigated under Complaint Number OH00153086.

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on closed record review, policy review, and interview, the facility failed to ensure Resident #22 was free from significant medication errors. This affected one resident (#22) of four residents reviewed for unnecessary medications. The facility census was 44. Actual Harm occurred on 11/27/23 and continued through 01/29/24 when the facility failed to clarify medication orders with Resident #22's referring hospital and include the resident in an admission care plan meeting, resulting in chemotherapy medication being administered in error to Resident #22. As a result of the medication errors, Resident #22 reported and suffered increased weakness, pain, nausea, constipation, and weight loss. Findings included: Closed record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation, syncope and collapse, chronic systolic congestive heart failure, abdominal aortic aneurysm without rupture, malignant neoplasm of larynx, malignant neoplasm of liver, and malignant neoplasm of esophagus. Review of a paper copy of hospital notes dated 12/02/22 through 11/27/23 revealed the hospital's medication administration record (MAR) for Resident #22's stay from 11/24/23 through 11/27/23 did not indicate Capecitabine was an active medication. An additional medication list was provided with the dates 12/02/22 through 11/27/23 with Capecitabine listed but did not specify if it was a current order. Review of referral paperwork from the hospital dated 11/27/23 and scanned into the electronic medical record revealed an active medication list which did not include any chemotherapy medication. Additionally, a physician progress note was included dated 11/16/23 stating Resident #22 had a history of liver cancer and a history of esophageal cancer which had been treated and was in remission. Review of a fax from the Veterans Affairs on 11/29/23 revealed an updated medication list was sent to the facility for Resident #22 and had no indication Resident #22 was supposed to received any chemotherapy medication. Review of an admission history and physical completed by Physician #141 revealed hospital admission and discharge paperwork was reviewed and indicated Resident #22 had a history of liver and esophagus cancer. Review of a care plan dated 11/28/23 revealed no indication Resident #22 had a diagnosis of cancer or was receiving chemotherapy. Review of a Baseline Care Plan Review assessment dated [DATE] revealed no indication Resident #22 or a representative was invited to or participated in care planning meeting. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22's cognition was intact, he had no behaviors, had an active diagnosis of cancer and had received chemotherapy. Resident #22 discharged from the facility on 01/29/24. Review of a medication order summary revealed Resident #22 had an order dated 11/27/23 for Capecitabine (a chemotherapy medication) oral tablet 500 milligrams (mg) to give 1000 mg by mouth two times a day for 14 days on and seven days off for cancer treatment. The resident had an order dated 12/18/23 for Capecitabine oral tablet 500 mg give 1000 mg by mouth two times a day 14 days on and 7 days off for cancer treatment dated 12/18/23 (started on 12/26/23). Review of a medication administration record (MAR) for November 2023 revealed Capecitabine was administered 11/28/23 through 11/30/23. Review of the December 2023 MAR revealed Capecitabine was administered 12/01/23 through 12/18/23, stopped from 12/18/23 through 12/15/23, and administered from 12/26/23 through 12/31/23. Review of the January 2024 MAR revealed Capecitabine was administered from 01/01/24 through 01/08/24, stopped from 01/09/24 through 01/15/24, and started from 01/16/24 through 01/29/24. Review of November 2023 MAR revealed Resident #22 had an as needed (PRN) order started on 11/27/23 for acetaminophen oral tablet 500 mg give one tablet by mouth every 24 hours as needed for pain which was not administered. Review of December 2023 MAR revealed Resident #22 received a dose of acetaminophen on 12/10/23 with a pain level of 4, a dose on 12/11/23 with a pain level of 5 and then acetaminophen was discontinued on 12/13/24. A new order was given on 12/13/23 for Oxycodone HCl oral tablet 5 mg give one tablet by mouth for pain every 8 hours as needed for pain which was administered on 12/13/23 with a pain level of 6 at 4:05 P.M., 12/14/23 for pain level of 7 at 7:58 P.M.; 12/15/23 for a pain level of 5 at 11:47 P.M.; twice on 12/16/23 for pain levels of 5 at 11:26 A.M. and 2 at 9:11 P.M.; 12/17/23 for a pain level of 2 at 8:38 P.M.; on 12/18/23 three times with a pain level of 5 for each administration at 3:05 A.M., 9 A.M., and 9:04 P.M.; 12/20/23 with a pain level of 5 at 8:38 P.M.; 12/21/23 with a pain level of 6 at 8:04 P.M.; 12/23/23 with a pain level of 4 at 2:41 A.M.; 12/24/23 with pain levels of 5 at 11:33 A.M. and 8 at 7:33 P.M.; 12/25/23 with a pain level of 2 at 8:27 P.M.; 12/26/23 with a pain level of 2 at 11:45 P.M.; 12/27/23 with a pain level of 5 at 8:54 P.M.; and on 12/31/23 with a pain level of 2 at 6:58 P.M. Review of January 2024 MAR revealed Oxycodone was administered on 01/01/24 with a pain level of 3 at 7:45 P.M.; on 01/02/24 with a pain level of 5 at 2:19 P.M.; on 01/04/24 with a pain level of 4 at 8:01 P.M.; on 01/05/24 with a pain level of 5 at 7:50 P.M.; on 01/06/24 with a pain level of 5 at 7:14 P.M.; on 01/09/24 with a pain level of 7 at 7:52 P.M.; on 01/11/24 with a pain level of 2 at 9:29 P.M.; on 01/12/24 with a pain level of 0 at 7:46 P.M.; on 01/13/24 with a pain level of 5 at 8:13 A.M.; on 01/14/24 with a pain level of 4 at 7:28 P.M.; on 01/15/24 with a pain level of 6 at 8 P.M.; on 01/17/24 with a pain level of 7 at 8:16 P.M.; on 01/18/24 with a pain level of 0 at 11:32 P.M.; on 01/19/24 with a pain level of 6 at 8:15 P.M.; on 01/20/24 with a pain level of 4 at 8 P.M.; on 01/22/24 with a pain level of 2 at 9:39 P.M.; on 01/23/24 with a pain level of 5 at 8:34 P.M.; on 01/24/24 with a pain level of 6 at 7:50 P.M.; on 01/25/24 with a pain level of 5 at 8:15 P.M.; on 01/26/24 with a pain level of 4 at 9:14 P.M.; on 01/27/24 with a pain level of 6 at 9:02 A.M. and 4 at 8:17 P.M.; and on 01/28/24 with a pain level of 4 at 7:53 P.M. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 05/03/24 at 1:49 P.M. with Licensed Practical Nurse (LPN) #137 revealed she was not aware of any medication administration errors in the last six months. LPN #137 stated the floor nurse who was receiving the resident from the hospital would be responsible for entering orders upon admission. LPN #137 stated if an order was not clear, it should be clarified with the hospital, facility they came from, or the in-house physician who would be taking of the care of the resident. LPN #137 stated if a resident made her aware they were receiving a medication they were not supposed to receive, she would call the hospital to get the order clarified. Interview on 05/03/24 at 2:06 P.M. with LPN #156 revealed the nurse who received a resident would be responsible for entering medication orders into their chart. LPN #156 stated if an order received from the hospital was not clear, she would call the hospital to get the order clarified. LPN #156 revealed she became aware of Resident #22's medication errors after he was already discharged (from the facility in January 2024) when the facility was notified by the Veterans Affairs (VA) called after reviewing Resident #22's discharge information from the facility. Interview on 05/03/24 at 2:32 P.M. with Resident #22 revealed his chemotherapy medication had been discontinued approximately seven years ago after his cancer was in remission. Resident #22 stated he was not aware of what medications he was receiving in the facility and he had not been invited to participate in an admission care plan meeting to review the baseline care plan, medication list, or set goals for his stay at the facility. Resident #22 stated when he returned to his home, he received a call from the VA to inform him he had been taking chemotherapy medication after they reviewed the paperwork the facility sent them regarding Resident #22's stay. Resident #22 stated he had to start taking pain medications while he was at the facility due to increased pain, which he suspected was related to taking the chemotherapy medication. Resident #22 stated other side effects from the chemotherapy included nausea, constipation, weakness, loss of appetite and taste, and weight loss. Resident #22 stated he had a hard time getting up, he was staggering and required the use of a walker and would now have to start physical therapy again to regain some strength. Interview on 05/03/24 at 2:46 P.M. with Home Health Aide (HHA) #145 revealed while Resident #22 was at the facility, she had come to visit and the facility informed her Resident #22 had cancer and would not likely be leaving the facility. HHA #145 stated since leaving the facility, Resident #22 was more short-tempered, nauseated, sick to his stomach, weak and didn't eat like he used to. HHA #145 stated when Resident #22 admitted to the facility, he weight 230 pounds and was now down to 202 pounds, which was a 12.93% weight loss in two months. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 05/03/24 at 3:33 P.M. with the Director of Nursing (DON) revealed she was unable to confirm if the chemotherapy medication listed on the hospital referral dated 12/02/22 through 11/27/23 was an old order but stated it was reasonable to assume it was a current order. The DON stated the referral information faxed from the hospital on 11/27/23 with a medication list dated 11/27/23 that did not contain chemotherapy would not be a reliable source for medication orders because often times, those orders were outdated. The DON confirmed the history and physical in the hospital paperwork specified Resident #22 had a history of liver and esophageal cancer which had both been treated and were currently in remission. The DON stated since the facility received the order for chemotherapy, it was not her place to determine if Resident #22 should have received the medication. The DON confirmed none of the nurse practitioners or physicians who treated Resident #22 while at the facility were cancer specialists. The DON confirmed the baseline care plan meeting did not indicate Resident #22 or family were invited or in attendance. DON confirmed medications, care plan and goals would be reviewed at baseline care plan meetings. DON confirmed Resident #22 was alert and oriented, and would have been able to tell staff he should not have been taking chemotherapy if he had been given the chance to participate in a care plan meeting. DON also confirmed if the order for chemotherapy had been accurate, the order stated medication should be given twice daily for 14 days, then held for 7 days, and medication had been administered from 11/27/23 through 12/18/23 which added up to 22 days the medication was administered without a seven-day break. Interview on 05/03/24 at 4:46 P.M. with the Administrator confirmed Resident #22 was admitted to the facility with orders for PRN acetaminophen 500 mg which were not administered until 12/10/23 and 12/11/23, then was discontinued and a new order for PRN Oxycodone 5 mg was given for increased pain. The Administrator confirmed there was no evidence Resident #22 was invited to, attended the admission care plan meeting, or provided with a baseline care plan. Interview on 05/03/24 at 5:09 P.M. with Administrator confirmed the VA sent an updated medication list to the facility on [DATE], two days after Resident #22 admitted to the facility, and did not include chemotherapy. Interview on 05/09/24 at 9:23 A.M. with VA Privacy Officer #202 revealed Nurse Practitioner (NP) #201 was interviewed on 05/09/24 at 8:33 A.M. regarding Resident #22's symptoms being related to the chemotherapy medication. NP #201 stated Resident #22 was admitted to rehab and during the time he was receiving chemotherapy medications. Resident #22 was at the end of the 14 days off cycle for the chemotherapy pill when he came back to us at Homebase Primary Care through the VA Medical Center. He was taken off the chemotherapy drug approximately four years ago, and we realized he received the medication during his stay at the facility after reviewing his discharge records. Other medication Resident #22 had received during his stay at the facility included Percocet for hip and bone pain, Pepcid and Prilosec for acid reflux. Resident #22 reported poor taste, bitterness of food and increased heart burn. In reviewing the side effects of the drug, all his side effects including pain, heart burn, poor taste, poor appetite, and weight loss were distinct possibilities as side effects from receiving the chemotherapy drug. Review of a policy titled Administering Medications dated April 2019 revealed medications are to be administered in accordance with prescriber's orders, if a dosage is believed to be inappropriate or excessive for a residents or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse effects the person preparing or administering the medical will contact the prescriber to discuss concerns. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a policy titled Care Plans- Baseline dated December 2016 revealed a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission, the interdisciplinary team will review the healthcare practitioner's orders, and implement a baseline care plan to meet the resident's need including but not limited to initial foals based on admission orders, physician orders, dietary orders, therapy services, social services. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. The resident and their representative will be provided with a summary of the baseline care plan that includes the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility, and any updated information based on the details of the comprehensive care plan as necessary. Review of a policy titled Reconciliation of Medications on admitted d July 2017 revealed To prepare for medication reconciliation, gather the information needed to reconcile the medication list including the approved medication reconciliation form, discharge summary from the referring facility, admission order sheet, all prescription and supplement information obtained from the resident or family during the medication history, and the most recent medication administration record for readmissions. Reconciliation of medications is completed to ensure an accurate medication list and includes the drug name, dosage, frequency, route of administration, and the purpose of the medication. This helped to reduce medication errors and enhances resident safety. Medication reconciliation helps to ensure all medications, routes, and dosages on the list are appropriate for the resident and their condition, and do not interact in a negative wat with other medications or supplements on the list. Medication reconciliation also ensures correct medication information is communicated to the attending physician and care team. If medication information is not collected from the resident or family, ask the resident to list all physicians and pharmacies from which they obtained medications. The list should be reviewed carefully to determine any discrepancies or conflicts. If the dose on the discharge medication list does not match the resident's previous MAR or there is a potential medication interaction this could be a discrepancy. If there is a discrepancy, contact the nurse from the referring facility, contact the physician from the referring facility, discuss with the resident or family, contact the resident's primary care physician, contact resident's pharmacy or contact the admitting physician. Document any discrepancies on the medication reconciliation form, the actions taken to resolve the discrepancy, if left unresolved how the information was communicated to the next nurse, and if resolved document how it was resolved. This deficiency represents non-compliance investigated under Complaint Number OH00153086.