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	07/31/2024

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on interviews and record reviews the facility failed to include pertinent information on the minimum data set (MDS) assessment for two residents (#15 and #26) out of 13 residents reviewed for assessment accuracy. The facility census was 44. Findings include: 1. Review of the medical record for Resident #26, revealed an admitted [DATE]. Diagnoses included but were not limited to muscle weakness, cognitive communication deficit, acute on chronic combined systolic and diastolic heart failure, major depressive disorder, end stage renal disease and chronic kidney disease, stage 4. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicated cognitive intactness. The resident was assessed to require supervision or touching assistance with shower/bathe self and independent with bed mobility and transfers. The assessment did not include hemodialysis. Review of Resident #26's active orders revealed dialysis was started on 08/01/23. Interview on 07/24/24 at 1:39 P.M. with the Director of Nursing and MDS Coordinator #411 verified Resident #26 received hemodialysis at the time of the 06/20/24 assessment and it was not indicated on the assessment. 34299 2. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, bipolar disorder, chronic obstructive pulmonary disorder, anxiety, PTSD, borderline personality disorder, panic disorder and obesity. Review of the quarterly MDS dated [DATE] indicated Resident #15 was cognitively intact with inattention and disorganized thinking. Resident #15 was independent with activities of daily living. Active diagnoses list included anxiety disorder, bipolar disorder, schizophrenia, PTSD and borderline personality disorder. The MDS did not list antianxiety or antidepressant medications. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365939	A. Building B. Wing	07/31/2024

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders dated 06/24 indicated Resident #15 received the following psychotropic medications: Venlafaxine 225 milligrams (mg) by mouth daily for depression, Fluoxetine 40 mg by mouth daily for depression related to Bipolar disorder, Lumateperone Tosylate 42 mg by mouth daily for Schizoaffective disorder,Galantamine Hydrobromide 8 mg by mouth two times daily for Schizoaffecive disorder, Carbamazepine 200 mg by mouth every 12 hours for Bipolar disorder, Brexpiprazole 1 mg by mouth daily for Schizoaffective disorder, Quetiapine Furmarate 400 mg by mouth two times daily for Schizoaffective disorder, Hydroxyzine Pamoate 50 mg by mouth three times daily for anxiety disorder and Clonazepam 1 mg by mouth three times daily for anxiety. An interview on 07/24/24 at 10:30 A.M. with the Director of Nursing (DON) #361 confirmed Resident #15 MDS was incomplete and did not include all psychotropic medications.

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	07/31/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to submit a resident review (RR) when Resident #17 received a new diagnosis. This affected one (Resident #17) of two residents reviewed for PASARRs (pre-assessment screens and resident reviews). The facility census was 44. Findings included: Record review revealed Resident #17 admitted to the facility on [DATE] with diagnoses including acute myocardial infarction, urinary tract infection, metabolic encepalopathy, type II diabetes, anemia, cognitive communication disorder, anxiety disorder, and major depressive disorder. An additional diagnosis of schizophrenia was added on 06/11/24. Review of a PASARR dated 06/06/24 revealed section E (a screen for serious mental illness) indicated Resident #17 had a mood disorder (depression) and a panic/severe anxiety disorder. The PASARR did not indicate Resident #17 had a diagnosis of schizophrenia. Interview on 07/24/24 at 8:44 A.M. with Social Worker (SW) #445 revealed she does complete PASARRs for the facility, but she just started and had not completed any yet. SW #445 stated when residents admit to the facility, the admission director reviews the PASARR to ensure accuracy but a RR should be completed when a resident has a change in mental health diagnosis or payer source. SW #445 confirmed Resident #17's PASARR did not contain a diagnosis of schizophrenia and a RR was not completed because she did not know a diagnosis of schizophrenia had been added. A request for a PASARR policy was made, but the facility did not have one.

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	07/31/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on interview and record review the facility failed to ensure the Pre Admission Screening and Resident Review (PASARR) was accurate upon admission for Resident #15. This affected one of two residents reviewed for PASARR. The facility census was 44. Findings include: Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, bipolar disorder, chronic obstructive pulmonary disorder, anxiety, PTSD, borderline personality disorder, panic disorder and obesity. Review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #15 was cognitively intact with inattention and disorganized thinking. Resident #15 was independent with activities of daily living. Active diagnoses list included anxiety disorder, bipolar disorder, schizophrenia, PTSD and borderline personality disorder. The MDS did not list antianxiety or antidepressant medications. Review of the physician orders dated 06/24 indicated Resident #15 received the following psychotropic medications: Venlafaxine 225 milligrams (mg) by mouth daily for depression, Fluoxetine 40 mg by mouth daily for depression related to Bipolar disorder, Lumateperone Tosylate 42 mg by mouth daily for Schizoaffective disorder,Galantamine Hydrobromide 8 mg by mouth two times daily for Schizoaffecive disorder, Carbamazepine 200 mg by mouth every 12 hours for Bipolar disorder, Brexpiprazole 1 mg by mouth daily for Schizoaffective disorder, Quetiapine Furmarate 400 mg by mouth two times daily for Schizoaffective disorder, Hydroxyzine Pamoate 50 mg by mouth three times daily for anxiety disorder and Clonazepam 1 mg by mouth three times daily for anxiety. Review of the PASARR dated 01/05/24 indicated Resident #15 had one mental health diagnosis of Mood disorder and did not receive psychotropic medications. An interview on 07/24/24 at 10:30 A.M. with the Director of Nursing (DON) #361 confirmed the PASARR for Resident #15 was not complete and did not include all of the mental health diagnoses or psychotropic medications listed in the medical chart.

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	07/31/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed develop a care plan addressing schizophrenia for Resident #17 and Post Traumatic Stress Disorder (PTSD) for Resident #15. This affected two (Resident #15 and #17) of two residents reviewed for comprehensive care plans. Findings included: 1. Record review revealed Resident #17 admitted to the facility on [DATE] with diagnoses including acute myocardial infarction, urinary tract infection, metabolic ecepalopathy, type II diabetes, anemia, cognitive communication disorder, anxiety disorder, and major depressive disorder. An additional diagnosis of schizophrenia was added on 06/11/24. Review of a care plan dated 06/27/24 revealed no evidence of a plan of care, goals, or interventions had been implemented related to the new diagnosis of schizophrenia. Interview on 07/24/24 at 10:42 A.M. with Director of Nursing (DON) confirmed there was not a care plan in place for Resident #17 related to schizophrenia. 34299 2. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, bipolar disorder, chronic obstructive pulmonary disorder, anxiety, PTSD, borderline personality disorder, panic disorder and obesity. Review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #15 was cognitively intact with inattention and disorganized thinking. Resident #15 was independent with activities of daily living. Active diagnoses list included anxiety disorder, bipolar disorder, schizophrenia, PTSD and borderline personality disorder. Review of the Trauma Informed Care assessment dated [DATE] indicated Resident #15 had experienced an event and had nightmares. Resident #15 tried hard not to think about the event, was constantly on guard and felt detached from people. Review of the nursing progress notes dated 01/07/24 through 07/24/24 were several scattered entries of verbal behaviors. There was not documentation related to PTSD. Review of the plan of care dated 01/20/24 and updated on 06/12/24 revealed no plan for PTSD indicating triggers or interventions. An interview on 07/22/24 at 2:00 P.M. revealed Resident #15 had been abused by her mother during her life at home. An interview on 07/23/24 at 1:20 P.M. with Social Services #445 confirmed she managed the psychiatric needs of the residents. Social Services #445 had no knowledge of Resident #15 PTSD plan of care. (continued on next page)

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	07/31/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 07/23/24 at 2:04 P.M. with Stated tested Nursing Assistant (STNA) #544 confirmed she was not aware Resident #15 had PTSD, what her triggers were or any interventions. STNA #544 confirmed this information would be on Resident #15 kardex (plan of care). An interview on 07/23/24 at 2:09 P.M. with STNA #448 confirmed she was not aware Resident #15 had PTSD, what her triggers were or any interventions. STNA #448 confirmed behaviors and interventions were listed on the kardex. An interview on 07/24/24 at 10:30 A.M. with the Director of Nursing (DON) confirmed Resident #15 did not have a plan of care addressing PTSD. Review of the facility policy titled Trauma Informed Care dated 03/19 indicated all staff were provided in-service training about trauma, its impact on health and PTSD in the context of the healthcare setting. The nursing staff were trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization. Caregivers were taught strategies to help eliminate, mitigate or sensitively address the resident's triggers. Review of a policy titled Care Plans, Comprehensive Person-Centered dated 12/2016 revealed a comprehensive, person-centered care plan tht includes measurable objectives and timetables to meet the resident's physical, psychosociall an functional needs is developed and implemented for each resident. The care plan will describe the services which are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, the interventions address the underlying source of the problem area, not just addressing symptoms and triggers.

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	07/31/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on interviews, observations, record review and policy review, the facility failed to have bilateral palm protectors in place for one (Resident #10) reviewed for prevention of decrease of limited range of motion. The facility census was 44. Findings include: Review of the medical record for Resident #10, revealed an admitted [DATE]. Diagnoses included but were not limited to cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, major depressive disorder, unspecified dementia, contracture of muscle, unspecified upper arm, neuromuscular dysfunction of bladder, gastrostomy status and aphasia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident is rarely/never understood. The resident was assessed to be dependent on all aspects of care. Review of Resident #10's active care plans revealed the resident is to wear bilateral palm protectors at all times except during hygiene and range of motion for contractual management. Review of Resident #10's physician order dated 02/07/24 3:32 P.M. revealed the resident is to wear bilateral palm protectors at all times except during hygiene and range of motion for contractual management. Observation of Resident #10 on 07/22/24 at 9:47 A.M. and 1:12 P.M. revealed the resident was not wearing bilateral palm protectors, nothing was in place and the resident was not receiving hygiene and range of motion exercises. Observation of Resident #10 on 07/23/24 at 7:30 A.M., 10:06 A.M. and 3:06 P.M. revealed the resident was not wearing bilateral palm protectors, nothing was in place and the resident was not receiving hygiene and range of motion exercises. Observation of Resident #10 on 07/24/24 at 7:50 A.M. and 11:01 A.M. revealed the resident was not wearing bilateral palm protectors, nothing was in place and the resident was not receiving hygiene and range of motion exercises. Interview and Observation on 07/24/24 at 11:02 A.M. with LPN #540 verified Resident #10 was not wearing bilateral palm protectors, nothing was in place and the resident was not receiving hygiene and range of motion exercises and stated they might be in the laundry. I will get some washcloths until we can find them. Review of the facility policy titled Assistive Devices and Equipment revised January 2020 stated recommendations for the use of devised and equipment are documented in the residents care plan and staff are required to be available to assist and supervise residents as needed.

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	07/31/2024

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 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 record review, review of a facility fall report, policy review and interview, the facility failed to provide timely and necessary pain management (including the administration of effective pain medication) for Resident #23 following the identification of an injury to the resident's hip/leg. Actual Harm occurred on 05/19/24 when direct care staff identified Resident #23, who was severely cognitively impaired had increased incontinence (not his baseline) and verbal and non-verbal signs of pain including facial grimacing and grabbing his right leg during care resulting in unrelieved pain. On 05/19/24 at 11:16 A.M. nursing staff received an order for Ultram for pain. However, the medication was not administered on this date until 4:05 P.M. (almost five hours after the order was received). The resident was subsequently transferred to the emergency roiagnom on ,d+[DATE] at 8:32 P.M. for treatment of a fractured right hip. This affected one resident (#23) of one resident reviewed for pain. The facility census was 44. Findings include: Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including repeated falls, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, vascular dementia with a new diagnosis of fracture of unspecified part of neck of right femur, initial encounter for closed fracture dated 05/29/24 during stay. Review of physician's order dated 08/19/23 at 12:45 P.M. Resident #23 revealed an order for Acetaminophen (Tylenol) 500 milligrams (mg) enterally every six hours as needed for pain. Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 had severely impaired cognition and was rarely/never understood. The resident was assessed to require (staff) supervision or touching assistance with bed mobility, partial/moderate (staff) assistance with all transfers and substantial/maximal (staff) assistance with toilet hygiene. The assessment reflected Resident #23 had no falls during the look back period, was occasionally incontinent of urine and was continent of bowels. Review of the progress note dated 05/19/24 at 11:23 A.M. revealed Resident #23 was noted to be incontinent of urine which he was usually continent. The resident was holding his right leg up to his chest, and had bruises noted on right leg and right inner leg. The progress note revealed the resident was questioned if he fell and he shook his head yes. When asked when, the resident put his two fingers up. When asked two days ago, the resident shook his head yes. When asked if he got himself up, he shook his head yes. The progress note revealed the certified nurse practitioner (CNP) was notified, and an order was received for an x-ray of the hips, labs and for pain medication. Review of the progress note revealed no evidence a comprehensive pain assessment was completed at this time or evidence the facility attempted any type of non-pharmacological pain interventions for the resident. Review of the resident's nursing progress notes revealed no documentation of any type of fall sustained by the resident two days prior. There was no documentation of any type of injury or bruising to the resident's leg prior to this note on 05/19/24 . (continued on next page)

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	07/31/2024

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 0697 Level of Harm - Actual harm Residents Affected - Few	Further review of Resident #23's progress notes revealed no documentation of a pain assessment, no evidence Tylenol (for pain) was administered, and no evidence non-pharmacological pain interventions were completed. Review of Resident #23's medication administration record (MAR) for 05/19/24 revealed no documentation Tylenol was administered during the entire 24-hour period on this date. Review of a physician's order dated 05/19/24 at 11:43 A.M. revealed an order for Ultram (a narcotic-like pain reliever) 50 mg one tablet every eight hours as needed for pain. Orders were also written (at 11:45 A.M.) for an x-ray two view bilateral hips for pain related to hip and questionable fall. There was no indication the resident was provided any pharmacological or non-pharmacological pain interventions at this time. Record review revealed between 11:23 A.M. and 4:05 P.M. the facility failed to monitor the resident's pain or provide pain management. Record review revealed on 05/19/24 at 4:05 P.M. (almost five hours after the order was received) Resident #23 was administered Ultram 50 mg for what staff documented was pain rated a four on a scale of 0 to 10 with 10 being the most severe pain. Review of the progress note dated 05/19/24 at 6:57 P.M. revealed the two-view x-ray of the right hip was completed. Left hip x-ray not done due to the resident not being able to tolerate laying on his left side. CNP notified. Review of Resident #23's x-ray results dated 05/19/24 revealed the right hip demonstrated a slightly displaced fracture of the right femur in the sub capital portion. Review of the progress note dated 05/19/24 at 8:32 P.M. revealed facility staff called 911 to get Resident #23 transferred to nearest available emergency room . Resident #23 had confirmed results of fractured/broken right hip. Review of the discharge return anticipated Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had severely impaired cognition. The assessment noted Resident #23 received as needed pain medication. The assessment revealed the resident was unable to be understood, pain was determined by grimacing, groaning and guarding body part. Resident had one fall with major injury. Review of a progress note dated 05/23/24 at 10:39 A.M. written by Licensed Practical Nurse (LPN) #45 revealed Resident #23 was readmitted to the facility from a local hospital with a diagnosis of femur head fracture. The family refused to allow any surgical intervention. Review of the most recent MDS 3.0 assessment dated [DATE] revealed the resident remained rarely/never understood. The resident was assessed to require (staff) supervision or touching assistance with bed mobility, substantial/maximal (staff) assistance with toilet hygiene and staff dependence on shower/bathe. This resident was noted to take an opioid for seven out of seven of the assessment days. This resident also had a fracture related to a fall in the six months prior to reentry. (continued on next page)

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	07/31/2024

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 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 07/24/24 at 9:57 A.M. with Registered Nurse (RN) #512 revealed he was the nurse assigned to Resident #23 and working on 05/19/24. The RN revealed he was assisting another resident, so LPN #442 addressed the concerns with Resident #23 as well as calling the CNP to get orders. The RN revealed throughout his shift, Resident #23 had a flat effect but did not think the resident had verbal indicators of pain directly to him; however, the State tested Nursing Assistant (STNA) staff working with the resident did come to him to inform him of the resident's pain during incontinence care. The RN was unable to recall the times staff reported the resident's pain to him and verified he did not implement any non-pharmacological interventions during the day. The resident was transferred to the emergency room that evening and was treated for a hip fracture. The RN was unable to recall what pain medication was provided to the resident and was also unable to recall most events for this shift. Interview on 07/24/24 at 10:33 A.M. with STNA #332 revealed she was assigned to work the hall Resident #23 was on and was working the day of 05/19/24. The STNA stated, I had to assist STNA #537 several times to clean up Resident #23 as he was incontinent and in bed and you could see on his face, he was not comfortable. We cleaned him up every two hours and for the first couple of changes, he would shake his head yes to being in pain and would resist rolling and being cleaned up. I told RN #512 as did STNA #537 and it wasn't until the early evening he wasn't as resistive to care but was still in pain. The STNA revealed no non-pharmacological pain interventions were attempted for the resident when staff were providing incontinence care. Interview on 07/24/24 at 10:50 A.M. with STNA #537 revealed she was assigned to work the hall Resident #23 was on and was working the day of 05/19/24. The STNA stated, I had to get STNA #332 to assist me to do incontinence care on him as he would make faces and hold his right leg and make sounds. He is usually continent, and I never need anyone to help me with him, so I knew something was wrong with him when we would do our changes every two hours. I reported this to RN #512 several times that he was in pain because I would ask him as well and he would shake his head yes to being in pain. The STNA verified no non-pharmacological pain interventions were attempted by staff when they were providing incontinence care. Interview on 07/24/24 at 11:25 A.M. with LPN #442 revealed on 05/19/24 she was not the nurse on Resident #23's hall, but stated she had responded after being told the resident was on his floor mat . The LPN revealed she assessed the resident and stated he was definitely in pain at the time, I didn't ask him what his pain was, but he was grimacing and holding his right leg to his chest and would not let us touch him, it was hard to get him back into bed. The LPN revealed no immediate non-pharmacological interventions were attempted at this time, other than placing the resident back in bed and calling the doctor. The LPN revealed she also told RN #512 the resident was in pain as the resident resided on the hall the RN was assigned for the shift. Interview on 07/24/24 at 2:59 P.M. with the Director of Nursing (DON) revealed on 05/19/24, a pain assessment should have been completed with the incident report completed for Resident #23 at the time of the incident. The DON verified the resident was not provided any of the ordered Tylenol as noted on the administration record. The DON also verified the lack of timely and effective pain management (pharmacological and non-pharmacological) during the shift as noted above. The DON verified the resident was transferred to the emergency room after x-ray results showed the hip fracture. The DON revealed the expectation of the nursing staff was to implement both pharmacological and non-pharmacological pain interventions when pain was indicated. (continued on next page)

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	07/31/2024

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 0697 Level of Harm - Actual harm Residents Affected - Few	Attempts to interview Resident #23 related to the incident and/or pain during the investigation were unsuccessful due to the resident's cognitive status. Attempts to reach the resident's wife were also unsuccessful. Review of the facility policy titled Pain Assessment and Management revealed acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief was obtained. The pain management interventions shall be consistent with the resident's goal for treatment. Such goals would be specifically defined and documented. Non-pharmacological interventions may be appropriate alone or in conjunction with medications.

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	07/31/2024

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on interviews, record reviews, and facility policy review, the facility failed to ensure an order and care plan interventions were in place for a dialysis site for one resident (#26) of one reviewed for dialysis. The facility census was 44. Findings include: Review of the medical record for Resident #26, revealed an admitted [DATE]. Diagnoses included but were not limited to muscle weakness, cognitive communication deficit, acute on chronic combined systolic and diastolic heart failure, major depressive disorder, end stage renal disease and chronic kidney disease, stage 4. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicating cognitive intactness. The resident was assessed to require supervision or touching assistance with shower/bathe self and independent with bed mobility and transfers. Review of Resident #26's active care plans revealed a care plan for hemodialysis related to chronic kidney disease stage 4 with the resident having a left arm arteriovenous (AV) fistula with no intervention for the care and condition of the dressing. Review of the physician order dated 04/12/24 at 2:55 P.M. for Resident #26 for the left AV fistula revealed no intervention for the care and condition of the dressing, only to remove the bandage at night after dialysis on Monday, Wednesdays and Fridays. Interview on 07/23/24 at 10:15 A.M. with Licensed Practical Nurse (LPN) #540 revealed if Resident #26's fistula site starts to bleed or gets contaminated she would reapply the dressing, but there was no order to do that, so she would call the doctor and verify. Interview on 07/23/24 at 1:32 P.M. with Assistant Director of Nursing (ADON) #339 revealed for Resident #26's left AV fistula there are no physician orders and care plan interventions for the dressing care to left AV fistula site prior to removing it in the evening after dialysis and stated well they would put another on, but I will call and clarify what to do if it comes off or gets soiled before it is to be removed in the evening. Interview on 07/23/24 at 2:07 P.M. with ADON #339 verified and stated, the order for the left AV fistula is clarified and fixed to include dressing care. Review of the facility policy titled Hemodialysis Access Care revised September 2010 stated, the general medical nurse should document in the residents' medical record every shift as follows: the condition of dressing (interventions if needed) and if the dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure.

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	07/31/2024

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on interview, medical record review and policy review the facility failed to ensure Resident #15 was not appropriately assessed to identify the cause of the residents' Post Traumatic Stress Disorder (PTSD), how to minimize triggers and or re-traumatization. This affected one of two residents identified as having PTSD. The facility census was 44. Findings include: Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, bipolar disorder, chronic obstructive pulmonary disorder, anxiety, PTSD, borderline personality disorder, panic disorder and obesity. Review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #15 was cognitively intact with inattention and disorganized thinking. Resident #15 was independent with activities of daily living. Active diagnoses list included anxiety disorder, bipolar disorder, schizophrenia, PTSD and borderline personality disorder. Review of the Trauma Informed Care assessment dated [DATE] indicated Resident #15 had experienced an event and had nightmares. Resident #15 tried hard not to think about the event, was constantly on guard and felt detached from people. Review of the Admission Psychosocial assessment dated [DATE] indicated Resident #15 was feeling down, depressed and hopeless. Review of the nursing progress notes dated 01/07/24 through 07/24/24 were several scattered entries of verbal behaviors. There was not documentation related to PTSD. Review of the plan of care dated 01/20/24 and updated on 06/12/24 revealed no plan for PTSD. An interview on 07/22/24 at 2:00 P.M. revealed Resident #15 had been abused by her mother during her life at home. An interview on 07/23/24 at 1:12 P.M. with Licensed Practical Nurse (LPN) # 540 confirmed the LPN had no knowledge of Resident #15 PTSD, triggers, or interventions. LPN #540 denied she received any education related to Resident #15 PTSD. An interview on 07/23/24 at 1:20 P.M. with Social Services #445 confirmed she managed the psychiatric needs of the residents. Social Services #445 had no knowledge of Resident #15 PTSD. An interview on 07/23/24 at 2:04 P.M. with Stated tested Nursing Assistant (STNA) #544 confirmed she was not aware Resident #15 had PTSD, what her triggers were or any interventions. STNA #544 confirmed this information would be on Resident #15 kardex (plan of care). (continued on next page)

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	07/31/2024

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 07/23/24 at 2:09 P.M. with STNA #448 confirmed she was not aware Resident #15 had PTSD, what her triggers were or any interventions. STNA #448 confirmed behaviors and interventions were listed on the kardex. An interview on 07/24/24 at 10:30 A.M. with the Director of Nursing (DON) confirmed Resident #15 had diagnosis of PTSD with no triggers identified or interventions in place. Review of the facility policy titled Trauma Informed Care dated 03/19 indicated all staff were provided in-service training about trauma, its impact on health and PTSD in the context of the healthcare setting. The nursing staff were trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization. Caregivers were taught strategies to help eliminate, mitigate or sensitively address the resident's triggers.

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	07/31/2024

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on interviews and record reviews, the facility failed to identify specific target behaviors related to major depressive disorder with implementation of a care plan for one resident (#26) of seven residents reviewed. The facility census was 44. Findings include: Review of the medical record for Resident #26, revealed an admitted [DATE]. Diagnoses included but were not limited to muscle weakness, cognitive communication deficit, acute on chronic combined systolic and diastolic heart failure, major depressive disorder, end stage renal disease and chronic kidney disease, stage 4. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicating cognitive intactness. The resident was assessed to require supervision or touching assistance with shower/bathe self and independent with bed mobility and transfers. This resident was assessed to also have little interest or pleasure in doing things, feeling down, depressed, or hopeless and trouble falling asleep 12-14 days with no physical and verbal behavioral symptoms during the assessment. Review of Resident #26's active care plans revealed none for major depressive disorder that would include target behaviors with interventions. Review of Resident #26's medical record revealed no documented assessment or questionnaire as to what the target behaviors are with the diagnosis of major depressive disorder. Further review of this residents medical record revealed no documentation of identifying behaviors exhibited by the resident per the MDS assessment of mood. Interview on 07/24/24 at 11:09 A.M. with Licensed Practical Nurse (LPN) #540 verified Resident #26 had moments of moods that were indicated on the MDS assessment, but were not documented in the chart and was unsure if that was a specific target behavior related to his depression diagnosis. Interview on 07/24/24 at 1:19 P.M. with the Director of Nursing verified no assessment was completed to identify specific behaviors as well as no care plan was initiated for the diagnosis of major depressive disorder for Resident #26.