STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365961	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piketon Nursing Center	300 Overlook Drive Piketon, OH 45661

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** 33023 Based on record reviews and interviews, the facility failed to ensure a resident with Post Traumatic Stress Disorder (PTSD) was appropriately assessed to identify the cause of the residents PTSD and minimize triggers and/or re-traumatization. This affected two residents (#7 and #18) out of two residents identified by the facility as having PTSD/trauma. The facility census was 43. Findings include: 1. Record review for Resident #7 revealed the resident was admitted to the facility on [DATE] and had diagnoses including partial intestinal obstruction, edema, ilius, hypertension, atrial fibrillation, Parkinson's disease, depression, anxiety, chronic post-traumatic stress disorder(on admitted [DATE]), schizoaffective disorder, and chronic kidney disorder. Review of the admission Minimum Data Set (MDS) assessment, dated 03/11/25, revealed this resident was assessed to have intact cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15. This resident was assessed to have an active diagnosis of PTSD. Review of the active care plans for Resident #7 revealed no plan of care was in place addressing the cause of PTSD, triggers which may cause re-traumatization, or interventions to reduce the risk of re-traumatization and provide care for PTSD. Review of six Trauma Informed Care Evaluations revealed no determination had been completed to identify the cause of PTSD for Resident #7 and to identify potential triggers which may cause re-traumatization. Interview with Resident #7 on 04/22/25 at 02:09 P.M. revealed this resident has a history of post-traumatic stress disorder because she had been sexually abused as a child. Resident stated she cannot recall anyone ever asking her about this from the facility staff. Interview with Social Services #570 on 04/23/25 at 09:58 A.M. verified the assessments did not capture actual cause of trauma and care plan did not accurately reflect triggers for recurrence. 2. Record review for Resident #18 revealed the resident was admitted to the facility on [DATE] and had diagnoses including dementia, cognitive communication deficit, chronic obstructive pulmonary disease, hypertension, diabetes mellitus type II, hyperlipidemia, PTSD(active diagnosis since 08/18/22), edema, anxiety, depression, and unspecified psychosis. (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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Minimum Data Set (MDS) assessment, dated 01/20/25, revealed this resident was assessed to have severely impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 7 out of 15. This resident was assessed to have an active diagnosis of PTSD. Review of the active care plans for Resident #18 revealed no plan of care was in place addressing the cause of PTSD, triggers which may cause re-traumatization, or interventions to reduce the risk of re-traumatization and provide care for PTSD. Review of two Trauma Informed Care Evaluations revealed no determination had been completed to identify the cause of PTSD for Resident #18 and to identify potential triggers which may cause re-traumatization. Interview with Social Services #570 on 04/23/25 at 11:00 A.M. verified the assessments did not capture actual cause of trauma and care plan did not accurately reflect triggers for recurrence.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure a medication was administered according to physicians order. This affected one resident (#31) out of the five residents reviewed for unnecessary medications. The facility census was 43. Findings include: Record review for Resident #31 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included chronic pain due to trauma, anxiety disorder, depression, and diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/27/25, revealed the resident was assessed to have intact cognition. Review of the active physicians order, dated 12/24/24, revealed Resident #31 was to be administered one milliliter (ml) of Morphine Sulfate (an opioid medication) Oral Suspension 20 milligrams (mg) per five ml's (which was equivalent to four mg's per dose administered) every two hours as needed for breakthrough pain. Review of the facility Controlled Drug Receipt Record/Disposition Forms, dated 12/24/24 through 04/22/25, revealed bottles of Morphine Sulfate Oral Suspension supplied to the facility for administration to Resident #31 were 100 mg's per five ml's (which was equivalent to 20 mg per one ml). One ml of Morphine Sulfate Oral Suspension 100 mg's per five ml's (equaling 20 mg) was documented to have been removed from the bottles by multiple nurses over 300 times for administration to Resident #31. Review of the Medication Administration Records (MAR's) for Resident #31, dated 12/24/24 through 04/22/25, revealed one ml of Morphine Sulfate Oral Suspension 20 mg's per five ml's (equaling four mg's) was documented to have been administered to Resident #31 at each dose. Further record review for Resident #31 revealed the resident had not experienced any episodes of respiratory depression, oversedating, or other adverse side effects of medications between 12/24/24 and 04/22/25. Observation and interview with Licensed Practical Nurse (LPN) #290 on 04/22/25 at 3:45 P.M. confirmed the bottle of Morphine Sulfate Oral Suspension contained in the narcotic lock box on the medication cart used for Resident #31 was a strength of 100 mg's per five ml's which was equal to 20 mg's per one ml. LPN #290 confirmed one ml of the Morphine Sulfate Oral Suspension was removed from the bottle at each dose and administered to Resident #31 so the resident received 20 mg each time. LPN #290 further confirmed the physicians order for Resident #31 was for one ml of Morphine Sulfate Oral Suspension at a strength of 20 mg's per five ml's which was only equivalent to four mg's to be administered at each dose. LPN #290 confirmed the amount administered to the resident at each dose did not match the amount ordered by the physician. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #31 on 04/22/25 at 4:05 P.M. revealed the resident was lying in bed eating grapes and watching television and did not appear to be exhibiting signs or symptoms of pain. Interview with Resident #31 at the time of the observation confirmed facility staff administered pain medication which kept the residents pain at a manageable level and denied any concerns with adverse side effects from medications. Review of the facility policy titled Administering Medications, revised 04/2019, revealed medications are administered in accordance with prescriber orders, including any required time frames. The individual administering the medication checks the label THREE times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.