STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366112	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brown Memorial Home Inc	158 E Mound St Circleville, OH 43113

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41266 Based on record review, review of the facility's beneficiary notice list and notices, staff interview, and facility policy review, the facility failed to provide an Advanced Beneficiary Notice (ABN) to one resident (Resident #141) when he was discharged from Medicare part A services and remained in the facility. The deficient practice affected one resident (Resident #141) of one reviewed for beneficiary notices. The facility census was 39. Findings Include: Review of the closed record for former Resident #141 revealed an original admitted on 01/08/24, readmitted s on 04/05/24 and 06/30/24, and a discharge date on 07/13/24. Medical diagnoses included complete traumatic amputation of right midfoot, protein-calorie malnutrition, dementia with behavioral disturbance, Type II Diabetes Mellitus with diabetic polyneuropathy, non-pressure chronic ulcers of right and left feet, peripheral vascular disease, and osteoarthritis. Review of the facility's Beneficiary Notice-Residents discharged Within the Last Six Months revealed Resident #141 was discharged from Medicare Part A therapy services with benefit days still remaining and remained in the facility on 03/01/24 and 07/10/24. Review of the beneficiary notices provided to Resident #141 revealed the resident was not provided with an ABN when he was discharged from Medicare Part A therapy services on either occasion. Interview on 09/04/24 at 4:42 P.M. with Business Office Manager (BOM) #121 confirmed Resident #141 was not provided with an ABN when he was cut from Medicare Part A therapy services and remained in the facility. BOM #121 stated she was not aware the resident should have been provided with an ABN. BOM #121 stated she did not review the options listed on the ABN with Resident #141 to determine if the resident may want to continue receiving therapy services. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the document, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) Form CMS-10055, dated 2024, revealed the document stated, the skilled nursing facility must give the applicable Medicare coverage guideline(s) and a brief explanation of why the patient's medical needs or condition do not meet Medicare coverage guidelines. Example 1: Patient no longer requires daily skilled care but wants to continue residing in the skilled nursing facility. Care: Inpatient Skilled Nursing Facility stay requiring daily skilled care which includes custodial room and board charges. Reason Medicare May Not Pay: You need only assistive or supportive care. You don't require daily skilled care by a professional nurse or therapist. Medicare won't pay for your stay, including custodial care room and board charges, at this facility unless you require daily skilled care. Review of the facility policy, Advance Beneficiary Notices, undated, revealed the policy stated, it is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. Additional notices shall be issued to Medicare beneficiaries when appropriate. 1. If services are being terminated and the beneficiary wants to continue to receive the care that is no longer considered medically reasonable and necessary, the facility shall issue an ABN prior to furnishing non-covered care.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on staff interview and record review the facility failed to document a resident transfer in the medical record when Resident #23 was transferred to the hospital for a change in condition. This affected one (Resident #23) of three Residents reviewed for hospitalization . The facility census was 39. Findings include: Record review of Resident #23 revealed an admitted [DATE] with pertinent diagnoses of, fracture of unspecified part of neck of left femur, benign neoplasm of cerebral meninges, pick's disease, dementia with severe mood disturbance, anxiety disorder, seizures, atrial fibrillation, major depressive disorder, mood disorder with depressive features, anxiety disorder, and insomnia. Review of the 06/07/24 quarterly Minimum Data Set (MDS) assessment revealed the resident is rarely or never understood. The resident did not use mobility devices and wandered one to three days during the look back period. The resident was dependent for eating, oral hygiene, toileting, shower, upper body and lower body dressing, personal hygiene, rolling left and right, sit to lying, and lying to sitting. She was independent in walking up to 150 feet. The Resident was always incontinent of bladder and frequently incontinent of bowel. Review of the electronic medical record Minimum Data Set (MDS) tab revealed the Resident was discharged on [DATE] and returned on 08/22/24. Review of the medical record on 09/04/24 revealed there was no progress note about why Resident #23 discharged on [DATE] or an assessment for her condition. Interview with the Director of Nursing (DON) on 09/05/24 at 9:18 A.M. revealed Resident #23 went out the hospital on 08/21/24 and she verified there was no information in the medical record explaining the hospitalization . The DON stated she would expect staff to document why a resident went out to hospital and complete an assessment.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, staff interview, and facility policy review, the facility failed to notify the local Ombudsman when two residents (Residents #35 and #23) were transferred out of the facility and/or discharged from the facility. The deficient practice affected two residents (Residents #35 and #23) of four reviewed for hospitalization s and discharge. The facility census was 39. Findings Include: Review of the medical record for Resident #35 revealed and initial admitted on 08/08/23 and a readmitted on 04/23/24. Medical diagnoses included congestive heart failure, chronic obstructive pulmonary disease, and progressive systemic sclerosis. Review of the clinical census for Resident #35 revealed the resident was hospitalized on [DATE] and 06/24/24. Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #35 had an unplanned discharge from the facility with return anticipated. Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #35 had an unplanned discharge from the facility with return anticipated. Interview on 09/05/24 at 10:27 A.M. with the Director of Nursing (DON) confirmed Resident #35 had been hospitalized on [DATE] and 06/24/24 and returned to the facility following treatment in the hospital. The DON confirmed the local Ombudsman office should be notified of all facility-initiated transfers and discharges from the facility. The DON confirmed the facility did not have any evidence the local Ombudsman had been notified of hospitalization s or discharges. 31404 2. Record review of Resident #23 revealed an admitted [DATE] with pertinent diagnoses of, fracture of unspecified part of neck of left femur, benign neoplasm of cerebral meninges, pick's disease, dementia with severe mood disturbance, anxiety disorder, seizures, atrial fibrillation, major depressive disorder, mood disorder with depressive features, anxiety disorder, and insomnia. Review of the 06/07/24 quarterly Minimum Data Set (MDS) assessment revealed the Resident was rarely or never understood. The Resident did not use mobility devices and wandered one to three days during the look back period. The Resident was dependent for eating, oral hygiene, toileting, shower, upper body and lower body dressing, personal hygiene, rolling left and right, sit to lying, and lying to sitting. She was independent in walking up to 150 feet. The Resident was always incontinent of bladder and frequently incontinent of bowel. Review of the electronic medical record Minimum Data Set (MDS) tab revealed the Resident was discharged on [DATE] and returned on 08/22/24. The Resident was also discharged on [DATE] and returned 08/30/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 09/05/24 at 2:00 P.M. revealed Resident #23 went out to the hospital on 08/21/24 and 08/29/24. The DON stated she was unable to provide evidence the Ombudsman was notified of Resident #23 transfer on those dates. Review of the facility policy, Transfer or Discharge Notice, undated, revealed the policy stated, a copy of the (transfer) notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, staff interview, review of bed hold notices, and facility policy review, the facility failed to notify two residents (Residents #35 and #23) of the number of bed hold days each resident had remaining upon being transferred to the hospital from the facility. The deficient practice affected two residents (Residents #35 and #23) of three reviewed for hospitalization s. The facility census was 39. Findings Include: Review of the medical record for Resident #35 revealed and initial admitted on 08/08/23 and a readmitted on 04/23/24. Medical diagnoses included congestive heart failure, chronic obstructive pulmonary disease, and progressive systemic sclerosis. Review of the clinical census for Resident #35 revealed the resident was hospitalized on [DATE] and 06/24/24. Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #35 had an unplanned discharge from the facility with return anticipated. Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #35 had an unplanned discharge from the facility with return anticipated. Review of the bed hold notices dated 04/14/24 and 06/24/24 revealed the number of bed hold days Resident #35 had remaining at the time of each transfer to the hospital was not included on either of the bed hold notices. Interview on 09/05/24 at 10:27 A.M. with the Director of Nursing (DON) confirmed bed hold notices should indicate how many bed hold days a resident had remaining. The DON confirmed the bed hold notices for Resident #35's hospitalization s did not include the number of bed hold days the resident had remaining at the time of each transfer to the hospital. 31404 2. Record review of Resident #23 revealed an admitted [DATE] with pertinent diagnoses of, fracture of unspecified part of neck of left femur, benign neoplasm of cerebral meninges, pick's disease, dementia with severe mood disturbance, anxiety disorder, seizures, atrial fibrillation, major depressive disorder, mood disorder with depressive features, anxiety disorder, and insomnia. Review of the 06/07/24 quarterly Minimum Data Set (MDS) assessment revealed the Resident was rarely or never understood. The Resident did not use mobility devices and wandered one to three days during the look back period. The Resident was dependent for eating, oral hygiene, toileting, shower, upper body and lower body dressing, personal hygiene, rolling left and right, sit to lying, and lying to sitting. She was independent in walking up to 150 feet. The Resident was always incontinent of bladder and frequently incontinent of bowel. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the electronic medical record Minimum Data Set (MDS) tab revealed the Resident was discharged on [DATE] and returned on 08/22/24. The Resident was also discharged on [DATE] and returned 08/30/24. Review of the bed hold notices dated 08/21/24 and 08/29/24 revealed there was no indication of the duration of the bed hold. The notices did not show how many bed hold days were remaining for Resident #23. Interview with the Director of Nursing (DON) on 09/05/24 at 2:00 P.M. revealed Resident #23 went out to the hospital on 08/21/24 and 08/29/24. The DON verified the bed hold notices for Resident #23 did not show how many bed hold days the resident had remaining. Review of the facility policy, Bed-Holds and Returns, undated, revealed the facility policy stated, Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave).

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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** 31404 Based on staff interview and record review the facility failed to update the Preadmission Screening Resident Review (PASRR) documents when a resident received a new mental health diagnosis. This affected two (Resident #10, and #34) of four residents reviewed for PASRR. The facility census was 39. Findings include: 1. Record review of Resident #10 revealed an admitted [DATE] with pertinent diagnoses of, vascular dementia with mild agitation, obesity, gastroenteritis and colitis, low back pain, schizoaffective disorder, bipolar disorder, abdominal distension, hyponatremia, localized edema, major depressive disorder, seasonal allergic rhinitis, age related osteoporosis, paranoid schizophrenia, pneumocystosis, extrapyramidal and movement disorder, psychosis, hallucinations, anxiety disorder, delusional disorders, type two diabetes mellitus, cerebral amyloid angiopathy, gastro-esophageal reflux disease, hypertension, insomnia, and chronic obstructive pulmonary disease. Review of the 08/06/24 annual Minimum Data Set (MDS) assessment revealed the resident was moderately cognitively impaired and does not use any devices for mobility. The resident was independent with dressing and personal hygiene and was always continent of bladder and bowel. Review of the most recent PASRR for Resident #10 revealed the document was completed on 8/02/21. Review of the medical record on 09/03/24 at 1:43 P.M. revealed Resident #10 had a new diagnosis of paranoid schizophrenia dated 09/13/22. Interview with Social Services Designee #102 (SSD) on 09/04/24 at 11:00 A.M. verified this was Resident #10 most recent PASRR and she did not have diagnosis of paranoid schizophrenia updated. 37100 3. Resident #34 was admitted to the facility on [DATE]. Her diagnoses were cervicalgia, anxiety disorder, schizoaffective disorder, chronic obstructive pulmonary disorder, bipolar disorder, hyperlipidemia, drug induced subacute dyskinesia, hypertension, osteoarthritis, and personal history of irradiation. Review of her Minimum Data Set (MDS) assessment, dated 06/01/24, revealed she was cognitively intact. Review of Resident #34's PASRR document, dated 06/29/23, revealed under Section D, the document only had personality disorder listed as a mental health diagnosis. Review of Resident #34's diagnoses list, the following diagnoses should have been indicated/updated on her PASRR document: bipolar disorder, which was added to her diagnoses list on 06/23/23, schizoaffective disorder, which were added to her diagnoses list on 10/03/23, and anxiety disorder, which was added on 03/10/24. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing (DON) on 09/04/24 at 2:52 P.M. confirmed the PASRR documents provided were the most up to date and confirmed all the diagnoses in Resident #34 medical records were not listed on her PASRR document. She confirmed she spoke about this with the social services director prior to giving the document to the surveyor, and they confirmed all the diagnoses were not listed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview, the facility failed to revise care plans when significant changes in the resident's condition occurred. This affected one (Resident #34) of 15 resident care plans reviewed. The census was 39. Findings Include: Resident #34 was admitted to the facility on [DATE]. Her diagnoses were cervicalgia, anxiety disorder, schizoaffective disorder, chronic obstructive pulmonary disorder, bipolar disorder, hyperlipidemia, drug induced subacute dyskinesia, hypertension, osteoarthritis, and personal history of irradiation. Review of her Minimum Data Set (MDS) assessment, dated 06/01/24, revealed she was cognitively intact. Review of Resident #34's current physician orders revealed she was not on hospice care at that time. Review of her previous/discontinued physician orders found she was discharged from hospice care on 02/23/24. Review of Resident #34's nutritional notes, dated 08/15/24, revealed a recommendation from the dietitian to decrease her chocolate/strawberry milk intake recommendation from eight ounces to four ounces due to her significant weight increase. Review of Resident #34's current physician orders revealed she was ordered to have four ounces of chocolate/strawberry milk. Review of Resident #34's current care plans revealed she had a care area related to Nutrition/Dehydration. The care area for this care plan stated, the resident has nutritional problem related to diagnoses, mechanically altered diet, varied intakes, significant weight loss, inadequate meal intakes, poor supplement acceptance, medications with potential side effects, and swallowing difficulty; requests texture upgrades; admit to Hospice (11/09/23). The current interventions included: honor comfort care desires per hospice protocol and add eight ounces chocolate or strawberry milk with all meals as ordered. Interview with Director of Nursing (DON) on 09/04/24 at 2:55 P.M. confirmed Resident #34 was no longer on hospice services since February 2024. Interview with Dietitian #400 on 09/05/24 at 10:30 A.M. confirmed Resident #34 graduated from hospice in February 2024 due to improved health conditions, which included gaining weight. She confirmed her nutritional care plan should have reflected that. She also confirmed she made the recommendation on 08/15/24 to reduce her chocolate/strawberry milk intake from eight ounces to four ounces due to her significant weight gain. She also confirmed the care plan interventions should have been updated to reflect the current order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on observation, staff interview, and resident record review, the facility failed to ensure the care planned assistance devices were properly placed to prevent falls for one (Resident #89) of three reviewed for accident hazards. The census was 39. Findings Include: Review of the medical record for Resident #89 on 09/03/24 at 9:58 A.M. revealed an admitted [DATE] with a diagnosis of atherosclerotic heart disease of native coronary artery. Review of a skilled nurse's note dated 09/01/24 at 10:09 P.M. revealed Resident #89 had a history of falls with multiple falls within the last six months. Review of the baseline careplan dated 09/01/24 at 10:14 P.M. revealed documented fall interventions including: Non-skid footwear, parameter mattress, bed in low position, and mattress to floor. Review of a nurse's note dated 09/02/24 at 5:35 A.M. revealed that the nurse was alerted by an aide that Resident #89 was found laying on the floor by his bed on his back. Observations on 09/03/24 at 9:58 A.M. and 1:42 P.M., and again on 09/04/24 at 9:51 A.M. accompanied by the Director of Nursing (DON) revealed Resident #89 in bed wearing black sports socks without non-skid tread, without a parameter mattress in place, without the bed in low position, and no mattress on the floor. Interview with the Director of Nursing (DON) on 09/04/24 at 9:51 A.M. confirmed that the care planned interventions to prevent falls for Resident #89 were not in place.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, staff interview, and facility policy review, the facility failed to ensure Bilevel Positive Airway Pressure (BiPAP) (a machine that helps to push air into your lungs) settings were included in the physician order for one resident (Resident #35). The deficient practice affected one resident (Resident #35) of one reviewed for respiratory care. The facility census was 39. Findings Include: Review of the medical record for Resident #35 revealed and initial admitted on 08/08/23 and a readmitted on 04/23/24. Medical diagnoses included congestive heart failure, chronic obstructive pulmonary disease, secondary pulmonary arterial hypertension, and progressive systemic sclerosis. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #35 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #35 required partial to moderate assistance with tub transfers and showering but was independent with other Activities of Daily Living (ADLs). Resident #35 received oxygen therapy and used a non-invasive mechanical ventilator. Review of the physician orders dated August 2024 revealed Resident #35 had an order for a Continuous Positive Airway Pressure (CPAP) machine with home settings to be on at night (HS) and off in the morning (AM) every night shift. The order was dated 11/06/23. Review of the care plan, revised 08/22/24, revealed Resident #35 had an altered respiratory status. Interventions included CPAP with home settings on at HS and off in AM. Interview on 09/04/24 at 2:55 P.M. with Resident #35 revealed the resident used a Bilevel Positive Airway Pressure (BiPAP) machine at night as well as when needed for shortness of breath and difficulty breathing. The resident did not have or use a CPAP machine. Resident #35 stated the machine was set up for her and she did not know what settings were supposed to be used for the machine. Interview on 09/05/24 at 10:27 A.M. with the Director of Nursing (DON) confirmed Resident #35 used a BiPAP machine, not a CPAP machine at night. The DON stated the settings for the BiPAP machine should be included in the physician's order. The DON confirmed the physician's order only indicated home settings and did not provide what the specific setting for the machine should be. Interview on 09/05/24 at 10:37 A.M. with Licensed Practical Nurse (LPN) #100 revealed Resident #35's BiPAP machine was set up for her at home prior to being admitted to the facility. LPN #100 confirmed she did not know what the specific settings for the machine were supposed to be. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Verbal Orders, undated, revealed the policy stated, Verbal orders are those given to the nurse by the physician in person or by telephone, however, are not written by the physician in the medical record. Repeat any prescribed orders back to the physician or health care provider. Use clarification questions to avoid misunderstandings. Enter the order into the medical record manually or electronically. Write T.O. (telephone order) or V. O. (verbal order), including date, time, name of the resident, the complete order; and sign the name of the physician or health care provider and nurse or sign off the electronic order as per the software system guidelines.

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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	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to obtain proper parameters for as needed pain medications. This affected two (Residents #34 and #29) of five residents reviewed for unnecessary medications. The census was 39. Findings Include: 1. Resident #34 was admitted to the facility on [DATE]. Her diagnoses were cervicalgia, anxiety disorder, schizoaffective disorder, chronic obstructive pulmonary disorder, bipolar disorder, hyperlipidemia, drug induced subacute dyskinesia, hypertension, osteoarthritis, and personal history of irradiation. Review of her Minimum Data Set (MDS) assessment, dated 06/01/24, revealed she was cognitively intact. Review of Resident #34's medical records revealed her physician orders included Oxycodone (opioid medication for pain) five milligrams (mg) every eight hours as needed for pain and Acetaminophen (analgesic medication to relieve pain) 650 mg every four hours as needed for pain. Review of his physician orders, Medication Administration Record (MAR), and care plan revealed there were no parameters as to what pain level should be present to administer each medication. Review of Resident #34's MARs, dated May 2024 to August 2024, revealed she was administered as needed Acetaminophen 16 different times when her pain level was six and above. Also, from May 2024 to July 2024, she was administered Oxycodone 15 times when her pain level was five or below. Review of Resident #34's current care plan revealed the facility was to administer the scheduled and as needed pain medication per physician orders. Interview with Director of Nursing (DON) on 09/04/24 at 2:55 P.M. confirmed parameters should be listed on the as needed pain medications. She confirmed they will ask the resident what level of pain they have, and they will offer the lower strength (Acetaminophen) if the resident's pain level was five or below. If the resident stated they do not want the lower strength pain medication, but want the higher strength medication (Oxycodone), they will administer the higher strength medication anyway. The DON confirmed the typical parameters for as needed pain medications was pain level one to five, offer to lower strength medication and if it's pain level six to ten, they will offer the higher strength medication. 41266 2. Review of the medical record for Resident #29 revealed and original admitted on 10/18/21 and a readmitted on 08/14/22. Medical diagnoses included other chronic pain, type II diabetes mellitus, gastric ulcer, paroxysmal atrial fibrillation, rheumatoid arthritis, and osteoarthritis. (continued on next page)

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	366112	A. Building B. Wing	09/05/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #29 required varied amounts of assistance from staff to complete Activities of Daily Living (ADLs) which ranged from independence with eating to dependence on staff for showering, dressing, and shower transfers. Resident #29 received scheduled and as needed (PRN) pain medications. The resident almost constantly had pain. The resident reported a pain level of eight out of ten, where ten was the worst pain level possible. Review of the Medication Administration Records (MAR) dated July 2024 and August 2024 revealed Resident #29 had the following orders: Acetaminophen Tablet 500 mg with instructions to give one tablet by mouth every six hours as needed (PRN) for pain. Please add corresponding number for non-pharmacological interventions dated 12/14/22 and Oxycodone Hydrochloride (HCl) oral tablet 5 mg with instructions to give 0.5 tablet by mouth every six hours PRN for pain dated 05/10/24. There were no parameters added to the physician orders for Resident #29's PRN pain medications. Review of the MAR dated July 2024 revealed the PRN Acetaminophen medication had not been administered to Resident #29 at all in the month of July. The PRN Oxycodone HCl medication was administered 32 times in the month of July for pain levels which ranged from four to nine on a scale from one to ten, where ten is the worst possible pain. There was no evidence of any non-pharmacological interventions being attempted prior to administering the PRN pain medication to Resident #29. The medication was noted to be effective, except 07/01/24 at 3:51 A.M. and 07/07/24 at 2:44 P.M. where it was marked ineffective. Review of the MAR dated August 2024 revealed PRN Acetaminophen medication had not been administered to Resident #29 at all in the month of August. The PRN Oxycodone HCl medication was administered 15 times in the month of August for pain levels which ranged from five to ten, where ten is the worst possible pain. There was no evidence of any non-pharmacological interventions being attempted prior to administering the PRN pain medication to Resident #29. The medication was noted to be effective, except on 08/01/24 at 2:17 P.M. and 08/02/24 at 2:55 A.M. where it was marked as ineffective. There was no evidence the physician was notified on 07/01/24, 07/07/24, 08/01/24, or 08/02/24 when Resident #29's PRN Oxycodone HCl medication was marked ineffective. Interview on 09/05/24 at 10:46 A.M. with Licensed Practical Nurse (LPN) #100 revealed there were no parameters included in the physician's orders for any PRN pain medications. LPN #100 stated based on her nursing judgement as well as any non-verbal indicators of pain, she would administer PRN Acetaminophen for pain levels of one to five and would administer Oxycodone HCl for pain levels of six or higher (on a scale from zero to ten, where ten was the worst possible pain). LPN #100 stated non-pharmacological interventions should also be documented on the MAR. LPN #100 stated if a pain medication was ineffective for a resident, the physician should be notified in order to gain further instructions on how to proceed with addressing a resident's pain. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/05/24 at 11:26 A.M. with the Director of Nursing (DON) confirmed the above findings indicated including Resident #29's physician was not notified on days the resident's PRN pain medications were marked as ineffective, there was no evidence of any non-pharmacological interventions attempted prior to administering the medication, and there were no parameters included in the physician orders for the PRN pain medications. The DON stated the nursing staff should administer Acetaminophen for lower levels of pain and Oxycodone HCl for higher levels of pain. Review of the facility policy, Administering Pain Medications, undated, revealed the policy stated, when opioids are used for pain management, the resident is monitored for medication effectiveness and adverse effects. Conduct a pain assessment with the resident. Evaluate and document the effectiveness of non-pharmacologic interventions. Administer pain medications as ordered.

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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** 41266 Based on record review, staff interview, and facility policy review, the facility failed to administer blood pressure medication as ordered to one resident (Resident #29). The deficient practice affected one resident (Resident #29) of five reviewed for unnecessary medications. The facility census was 39. Findings Include: Review of the medical record for Resident #29 revealed an original admitted on 10/18/21 and a readmitted on 08/14/22. Medical diagnoses included essential primary hypertension, paroxysmal atrial fibrillation, morbid obesity, type II diabetes mellitus without complications, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #29 required varied amounts of assistance from staff to complete Activities of Daily Living (ADLs) which ranged from independence with eating to dependence on staff for showering, dressing, and shower transfers. Review of the Medication Administration Records (MAR) dated August 2024 revealed Resident #29 had an order for Losartan Potassium Tablet 50 milligrams (mg) with instructions to give one tablet by mouth one time a day for hypertension (HTN) and hold if systolic blood pressure (SBP) was less than 100. Review of the Medication Administration Record (MAR) dated August 2024 revealed Losartan Potassium medication was held on 08/24/24, 08/25/24, 08/26/24, and 08/27/24. Resident #29's blood pressures were 110/62, 121/74, 108/68, and 110/62. Interview on 09/05/24 at 11:26 A.M. with the Director of Nursing (DON) confirmed Resident #29's Losartan Potassium medication was held on the above dates. The DON confirmed Resident #29's blood pressure readings were within the physician ordered parameters and therefore, the medication should have been administered to the resident. A policy related to following physician orders was requested at the time of the survey. A policy titled, Verbal Orders, undated, was provided by the facility. However, the policy does not address administering medications according to the physician order.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 41266 Based on observations, staff interview, and facility policy review, the facility failed to ensure pureed food items were prepared at an appropriate texture prior to surveyor intervention for one resident (Resident #17). The deficient practice affected one resident (Resident #17) of one who had a physician ordered pureed diet. The facility census was 39. Findings Include: Observation on 09/04/24 at 10:50 A.M. of pureed food items with [NAME] #120 revealed the cook added one breaded pork chop and 1/4 cup of hot water to a blender and started blending. Another 1/4 cup of hot water was added to the blender. At 10:57 A.M., [NAME] #120 chopped another breaded pork chop on a cutting board and added it to the blender. Another 1/2 cup of hot water was added to the blender and continued blending. At 11:00 A.M., [NAME] #120 stopped the blender. [NAME] #120 scraped the sides of the blender and poured the pureed pork chops into a small Styrofoam container. This surveyor observed the pureed pork chops to be visibly stringy and watery. Interview on 09/04/24 at 11:02 A.M. with [NAME] #120 confirmed she felt the pureed pork chops were an appropriate texture for serving to one resident (Resident #17) who had an ordered pureed diet. This surveyor requested to taste the pureed pork chops if she was ready to serve them to the resident. [NAME] #120 again confirmed she was ready to serve them and handed this surveyor a clean spoon. This surveyor tasted the pureed pork chops and found them to still be stringy with small gristly chunks left on tongue. The pureed pork chops were also bland and watery. [NAME] #120 confirmed the recipe for breaded pork chops stated to add 1/4 cup of hot water per pork chop but she doubled it and had added 1/2 cup of hot water per pork chop. [NAME] #120 confirmed she added approximately one cup total of hot water to the pureed pork chops. [NAME] #120 confirmed the pureed pork chops were watery and bland with not much flavor. Interview on 09/04/24 at 11:04 A.M. with [NAME] #120 revealed pureed food items should not have any shreds of meat and should be mushy or as smooth as possible. [NAME] #120 tasted the pureed pork chops and confirmed they were not an appropriate texture to serve to any residents and she would need to continue to blend the food item before safely serving it to the residents. Interview on 09/04/24 at 11:45 A.M. with Dietary Manager (DM) #106 revealed after attempting to puree the breaded pork chops with [NAME] #120 again, the pork chops would not reach an appropriate texture and DM #106 substituted the breaded pork chops for pureed chicken breasts. Review of the recipe for breaded pork chop revealed to measure one cooked chop and 1/4 cup water for each pureed serving needed. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Puree Food Preparation, undated, revealed the policy stated, the policy of this facility to provide puree food that has been prepared in a manner to conserve nutritive value, palatable flavor, and attractive appearance. Puree means that all food has been ground, pressed and/or strained to a consistency of a soft, smooth thick paste similar to a thick pudding. If the food item requires chewing, it will be excluded from the puree diet and prepared in a way that preserves vitamins and a minimum loss of nutrients.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41266 Based on observations, staff interview, and facility policy review, the facility failed to appropriately date opened food items in the refrigerator and freezer. The deficient practice had the potential to affect all 39 residents who resided in the facility. The facility did not identify any residents with a physician ordered nothing by mouth (NPO) diet. Findings Include: Observations completed during the initial tour of the kitchen on 09/03/24 at 10:20 A.M. with Dietary Manager (DM) #106 revealed the following items in the refrigerator had been opened and not dated: One large glass container of dill pickle spears One large plastic container of mayonnaise, 75% empty One plastic container of pimento cheese spread One large plastic container with a handle of Pace Picante salsa One bottle of Frank's Red Hot sauce One bottle of Siracha hot sauce Two small plastic containers of chicken base One small container of beef base One small jar of minced garlic One small jar of sliced jalapenos One large plastic container of sour cream One large plastic container of ham salad One large plastic container of vanilla yogurt One large jar of Concord grape jelly One package of sliced deli ham One package of sliced deli salami One package of sliced deli turkey breast (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interviews on 09/03/24 at 10:24 A.M. and 10:28 A.M. with DM #106 confirmed the above findings. Observation on 09/03/24 at 10:35 A.M. of the facility kitchen freezer with DM #106 revealed the following items were opened and not dated: One bag of frozen chicken tenders One bag of frozen blueberries One bag of frozen chicken breasts One bag of frozen tator tots One bag of frozen fish patties The above findings were confirmed by DM #106 at the time of the observations. Review of the facility policy, Refrigerated Storage, undated, revealed the policy stated, refrigerated food shall be stored in a manner that optimizes food safety and quality. Refrigerated items shall bear a label indicating product name and date (month, day, and year) product was received, used or first opened.