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	12/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on medical record review, staff interview, and facility policy review, the facility failed to adequately monitor skin issues/bruising for residents know to have skin alterations. This affected one (Resident #17) of three residents reviewed for skin alterations. The census was 33. Findings Include:Resident #17 was initially admitted to the facility for respite care on 07/07/25. Her diagnoses were Alzheimer's disease, dementia, amnesia, visual hallucinations, chronic fatigue, nonrheumatic mitral valve insufficiency, and encounter for palliative care. Review of her minimum data set (MDS) assessment, dated 11/18/25, revealed she had a severe cognitive impairment.Review of Resident #17 progress notes, dated 12/04/25, revealed hospice shower aid came to the facility nurse and stated she noted some bruising and swelling on Resident #17's lower left extremity (LLE). It was noted there were two dark colored bruises, but there was no measurement, description or exact location of the skin alteration. Review of Resident #17's progress notes, dated 12/05/25 to 12/19/25, revealed no specific information as to where the bruising was located, or any other description of the bruise including size or color. Review of Resident #17's skin assessments, dated 11/25/25, 12/02/25, 12/09/25, and 12/16/25, revealed there were no skin issues documented including bruising or skin injuries, noted on any of the skin assessments. There was no documentation, including measurements, shape, or other descriptors, of the bruising on Resident #17's lower left extremity.Review of Resident #17's shower logs/documentation, dated 12/04/25 to 12/19/25, revealed no skin assessments/documentation to support monitoring of the bruising that was reported to Resident #17's lower left extremity.Review of Resident #17's hospice notes, dated 12/04/25 to 12/19/25, revealed mention of bruising that was found to her lower left extremity. However, there was no documentation or descriptors of the bruising at any point she was in the facility.Interview with current Director of Nursing (DON), new DON, Administrator, and Assistant Director of Nursing (ADON) #35 on 12/23/25 at 3:10 P.M. confirmed they have no documentation in the facility to support the bruising was monitored, measured, or described if it grew in shape/size throughout the time that Resident #17 was in the facility and the bruise had been identified. The DON, Administrator, and ADON confirmed the bruise should have been monitored after it was identified. They confirmed they will get the hospice records to determine if they monitored the bruise.Interview with current DON on 12/24/25 at 8:16 A.M. confirmed the hospice records did not have any descriptive language about the bruise on Resident #17's lower left extremity.Review of facility Skin Assessment policy, dated 2022, revealed it is the policy to perform a full body assessment as a part of the systematic approach to pressure injury and management. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, daily for three days, and weekly thereafter. The assessment may also be performed after a change in condition or after any newly identified pressure injury. This deficiency represents non-compliance investigated with complaint number 2691551.

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure gradual dose reduction (GDR) pharmacy recommendations were completed as required. This affected one (Resident #20) of five residents reviewed for unnecessary medications. The census was 33.Resident #20 was admitted to the facility on [DATE]. Her diagnoses were gastro-esophageal reflux disease, emphysema, hyperlipidemia, morbid obesity, major depressive disorder, congestive heart failure, osteoarthritis, Type II Diabetes, chronic obstructive pulmonary disease, fibromyalgia, obstructive sleep apnea, hypertension, vitamin D deficiency, and history of falling. Review of her minimum data set (MDS) assessment, dated 09/14/25, revealed she was cognitively intact. Review of Resident #20's physician orders found the following medications ordered/administered and the dates in which they were initiated: Wellbutrin (antidepressant) 150 milligrams (mg) for depression, which was initiated on 03/11/24, and Citalopram (antidepressant) 10 mg, one half tab for depression, which was initiated on 12/06/23.Review of Resident #20's monthly pharmacy reviews, dated December 2024 to December 2025, revealed no pharmacy recommendations related to a GDR for either Citalopram or Wellbutrin for the 13 months reviewed.Interview with Current Director of Nursing (DON) and new DON on 12/24/25 at 8:13 A.M. and 10:15 A.M. confirmed there were no recommendations for a GDR for Wellbutrin or Citalopram. She confirmed there should have been, but the information she received from the pharmacist was that there was no indication for a dose reduction at this time due to psychiatric notes/review. Current DON confirmed they do not have any psychiatric notes to support a recommendation or a review for a GDR in the last 12 months.

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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** Based on medical record review and staff interview, the facility failed to monitor the use of blood pressure medication appropriately. This affected two (Residents #11 and #5) of five residents reviewed for unnecessary medications. The census was 33.Findings Include: 1. Resident #11 was admitted to the facility on [DATE]. Her diagnoses were other long term drug therapy, anxiety disorder, Alzheimer's disease, dementia, repeated falls, hyperlipidemia, orthostatic hypotension, personal history of other diseases, visual hallucinations, cardiac murmur, restless leg syndrome, osteoporosis, neurocognitive disorder with Lewy bodies, and Parkinson's disease. Review of her minimum data set (MDS) assessment, dated 09/06/25, revealed she was cognitively intact. Review of Resident #11's current physician orders revealed an order for Midodrine HCl (used to treat low blood pressure) oral tablet 2.5 milligrams (mg), one tablet daily for hypotension. There were parameters documented to hold the medication if the systolic blood pressure (SBP) was greater that 90 mm hg (millimeters of mercury), and the diastolic blood pressure (DBP) was greater than 50 mm hg. This order was initiated on 03/12/25. Review of Resident #11's medication administration records (MAR), dated July 2025, revealed the following dates Midodrine was held and did not have a blood pressure taken or proper justification at the time the medication was to be given (8:00 A.M.): 07/07/25, 07/17/25, 07/20/25, 07/21/25, 07/22/25, 07/26/25, 07/27/25, and 07/31/25. The following dates the Midodrine was documented as administered when the blood pressure was above the ordered parameter and should have been held: 07/12/25, 07/13/25, 07/16/25, and 07/18/25. Review of Resident #11's medication administration records (MAR), dated September 2025, revealed the following dates Midodrine was held and did not have a blood pressure taken or proper justification at the time the medication was to be given (8:00 A.M.): 09/02/25, 09/06/25, 09/07/25, 09/08/25, 09/09/25, 09/10/25, 09/11/25, 09/14/25, 09/18/25, 09/19/25, 09/20/25, 09/21/25, 09/25/25, 09/27/25, 09/28/25, 09/29/25, and 09/30/25. The following dates the Midodrine was documented as administered when the blood pressure was above the ordered parameter and should have been held: 09/01/25, 09/03/25, 09/04/25, 09/12/25, 09/15/25, 09/16/25, 09/23/25, and 09/26/25. Review of Resident #11's medication administration records (MAR), dated October 2025, revealed the following dates midodrine was held and did not have a blood pressure taken or proper justification at the time the medication was to be given (8:00 A.M.): 10/01/25, 10/02/25, 10/03/25, 10/04/25, 10/05/25, 10/06/25, 10/07/25, 10/08/25, 10/09/25, 10/12/25, 10/13/25, 10/14/25, 10/17/25, 10/18/25, 10/19/25, 10/20/25, 10/21/25, 10/22/25, 10/23/25, 10/26/25, 10/27/25, 10/28/25, and 10/31/25. The following dates the Midodrine was documented as administered when the blood pressure was above the ordered parameter and should have been held: 10/10/25, 10/11/25, 10/15/25, 10/16/25, 10/24/25, 10/25/25, 10/29/25, and 10/30/25. Review of Resident #11's medication administration records (MAR), dated November 2025, revealed the following dates Midodrine was held and did not have a blood pressure taken or proper justification at the time the medication was to be given (8:00 A.M.): 11/06/25, 11/11/25, 11/14/25, 11/15/25, 11/16/25, 11/18/25, 11/20/25, 11/25/25, 11/26/25, 11/27/25, and 11/29/25. The following dates (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Midodrine was documented as administered when the blood pressure was above the ordered parameter and should have been held: 11/01/25, 11/02/25, 11/03/25, 11/04/25, 11/07/25, 11/08/25, 11/09/25, 11/12/25, 11/13/25, 11/17/25, 11/19/25, 11/22/25, 11/23/25, and 11/28/25. Review of Resident #11's medication administration records (MAR), dated December 2025, revealed the following dates Midodrine was held and did not have a blood pressure taken or proper justification at the time the medication was to be given (8:00 A.M.): 12/08/25, 12/09/25, 12/12/25, 12/17/25, and 12/21/25. The following dates the Midodrine was documented as administered when the blood pressure was above the ordered parameter and should have been held: 12/02/25, 12/06/25, 12/07/25, 12/14/25, and 12/18/25. Interview with Current Director of Nursing (DON) and New DON on 12/24/25 at 8:16 A.M. and 9:57 A.M. confirmed Midodrine was held and not administered to Resident #11 without blood pressure or vital signs were being taken or documented at the time the medication was to be administered. They confirmed the vital signs should have been taken to determine if the medication should or should not have been given. Also, they confirmed that Midodrine was administered outside the parameters written by the physician. They have contacted the physician to clarify the parameters for that medication. 2. Review of the medical record for Resident #5, revealed an admission date of 11/26/25. Diagnoses included but were not limited to myocardial infarction, chronic respiratory failure, Alzheimer's disease, major depressive disorder, emphysema, insomnia, bipolar disorder, vascular dementia, extrapyramidal and movement disorder, schizoaffective disorder, bipolar disorder, congestive heart failure, Type II Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), and schizophrenia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 indicating intact cognition. The resident was assessed to have received seven days of insulin during the look back period, antipsychotics, antidepressants, anticoagulant, diuretic, antiplatelet, hypoglycemic, and anticonvulsant medications with indications documented. On 11/26/25 the provider ordered Midodrine HCL oral tablet 10 milligrams (mg) every eight hours as needed for hypotension. Administer if the systolic blood pressure is less than 100 millimeters of mercury (mm hg). Review of documented blood pressures revealed Resident #5 had documented systolic blood pressures less than 100 mm hg. 11/29/25 at 8:30 P.M. Resident #5's blood pressure was 95/57, on 11/30/25 at 8:32 P.M. Resident #5's blood pressure was 98/56, on 12/04/25 at 8:00 P.M. Resident #5's blood pressure was 98/74, on 12/15/25 at 8:30 A.M. Resident #5's blood pressure was 98/48, and on 12/23/25 at 8:55 A.M. Resident #5's blood pressure was 95/53. Review of the MAR for Resident #5 from 11/26/25 until 12/24/25 reveled Midodrine HCL oral tablet 10mg had not been administered to Resident #5 when the systolic blood pressure was less than 100mm hg as ordered. Interview on 12/24/25 at 10:21 A.M. with the DON confirmed the medication Midodrine ordered for Resident #5 had never been administered and the physician order was not followed.