STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366123	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accord Care Community Orrville LLC	1980 Lynn Drive Orrville, OH 44667

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 - Minimal harm or potential for 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** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to develop and implement a comprehensive and effective pain management program to ensure Resident' #3's pain was adequately assessed and treated prior to treatments of multiple (vascular) wounds on her bilateral lower extremities. This affected one resident (#3) of three residents reviewed for pain. The facility census was 52. Findings include: Review of Resident #3's medical record revealed an admitted [DATE] with diagnoses including peripheral vascular disease, major depressive disorder, type two diabetes with diabetic peripheral angiopathy without gangrene and heart failure. Review of Resident #3's care plan dated 04/12/21 revealed Resident #3 was at risk for pain related to immobility, peripheral vascular disease and heart failure. The goal developed was for Resident #3 to not have an interruption in normal activities due to pain. Interventions included to administer analgesia per orders; anticipate Resident #3's need for pain relief and respond within a timely manner to any complaint of pain; monitor and record pain characteristics; treatments as ordered. Review of Resident #3's physician orders dated 03/28/24 revealed orders for Tylenol Extra Strength tablet 500 mg (acetaminophen), give two tablets by mouth every eight hours as needed for pain and fever. Reposition, rest, and offer drinks and snacks related to pain. Review of Resident #3's quarterly Minimum Data Set assessment dated [DATE] included Resident #3 was cognitively intact. Resident #3 was dependent for toileting hygiene, upper and lower body dressing and personal hygiene. Resident #3 required substantial to maximal assistance for the ability to roll from lying on back to the left and right side and return to lying on back on the bed and the ability to move from sitting on the side of the bed to lying flat in bed. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's wound notes dated 02/25/25 written by Doctor of Nursing Practice (DNP) #100 revealed the resident was being seen for an initial consult today for bilateral lower extremity wounds noted per nursing staff. Resident #3 had a history of wounds to the affected areas. Resident #3 reported discomfort to the wounds when wound care was completed. Wound one was a new wound of Resident #3's left proximal lower extremity as of 02/25/25 and was in-house acquired. Measurements were length 1.5 cm, width 1.2 cm and depth 0.1 cm. Treatment was cleanse every day and as needed, apply hydrogel, cover with adaptic, followed by non-adherent dressing, wrap with roll gauze and secure with tape. Wound two was a new wound, in-house acquired, of Resident #3's left medial lower extremity. Measurements were length 1.2 cm, width, 1.2 cm and depth 0.1 cm. Treatment was cleanse every day and as needed, apply hydrogel, cover with adaptic, followed by non-adherent dressing, wrap with roll gauze and secure with tape. Wound three was a new wound, in-house acquired of Resident #3's left medial distal lower extremity. Measurements were length 3.0 cm, width 2.8 cm, and depth 0.1 cm. Treatment was cleanse every day and as needed, apply hydrogel, cover with adaptic, followed by non-adherent dressing, wrap with roll gauze and secure with tape. Wound four was a new wound, in-house acquired of Resident #3's left distal lower extremity. Measurements were length 2.5 cm, width 4.5 cm, and depth of 0.1 cm. Treatment was cleanse every day and as needed, apply hydrogel, cover with adaptic, followed by non-adherent dressing, wrap with roll gauze and secure with tape. Wound five was a new wound, in-house acquired, of Resident #3's left lateral lower extremity. Measurements were length 1.0 cm, width 1.0, depth of 0.1 cm. Treatment was cleanse every day and as needed, apply hydrogel, cover with adaptic, followed by non-adherent dressing, wrap with roll gauze and secure with tape. Wound six was a new wound, in-house acquired of Resident #3's left lateral lower extremity. Measurements were length 2.3 cm, width, 1.8 cm, and depth was 0.1 cm. Treatment was cleanse every day and as needed, apply hydrogel, cover with adaptic, followed by non-adherent dressing, wrap with roll gauze and secure with tape. Wound seven was a new wound, in-house acquired of Resident #3's left lateral distal lower extremity. Measurements were length 1.0 cm, width 0.7 cm, depth 0.1 cm. Wound eight was a new wound, in-house acquired of Resident #3's right proximal lower extremity. Measurements were length 2.2 cm, width 1.8 cm and depth 0.1 cm. Wound nine was a new wound, in-house acquired of Resident #3's right medial lower extremity. Measurements were length 2.0 cm, width 2.4 cm, and depth of 0.1 cm. Wound ten was a new wound, in-house acquired of Resident #3's right distal lower extremity. Measurements were 2.7 cm, width 3.2 cm, and depth 0.1 cm. Wound eleven was a new wound of Resident #3's right distal lower extremity. Measurements were length 1.7 cm, 1.5 cm, 0.1 depth. Treatments for wounds seven, eight, nine, ten and eleven were cleanse every day and as needed, apply hydrogel, cover with adaptic, followed by non-adherent dressing, wrap with roll gauze and secure with tape. Wounds one through eleven were full thickness and the etiology was venous stasis. Recommendations were treatment orders per wound grid, consider medicating Resident #3 for pain prior to wound care to ease symptom burden. Review of Resident #3's medical record including progress notes dated 02/26/25 at 4:29 P.M. through 03/01/25 at 4:25 P.M. did not include documented evidence Resident #3 was evaluated/assessed for pain. However, there was no written evidence the resident had complaints of pain during this time period. Review of Resident #3's Medication Administration Audit Report dated 03/03/25 revealed orders to cleanse wounds to right lower extremity and left lower extremity with saline, pat dry, apply hydrogel to wound bed, apply adaptic to wound bed, cover with non-adherent dressing, wrap with Kerlix every night shift for vascular wounds. The report stated the scheduled time for the dressing change was 03/03/25 at 11:00 P.M. but the dressing change was not completed until 03/04/25 at 4:02 A.M. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's medical record including the Medication Administration Record (MAR) dated 03/04/25 did not reveal Resident #3 was assessed for pain or that Tylenol Extra Strength tablet 500 mg (acetaminophen), give two tablets by mouth every eight hours was administered for pain at or prior to 4:02 A. M. when Resident #3's dressing changes to her right and left lower extremities was completed. Further review revealed Resident #3 was not administered Tylenol for pain until 03/04/25 at 6:54 A.M. for a pain level of five on a zero to ten scale, zero being no pain and ten being the worst pain on this date. Review of Resident #3's Pain assessment dated [DATE] revealed Resident #3 stated she frequently had pain or hurting in the last five days and pain made it hard for her to sleep at night. Over the past five days pain limited Resident #3's day-to-day activities. Resident #3 rated her pain at a five on a scale of zero to ten, zero being no pain and ten being the worst pain. The assessment revealed Resident #3 received Tylenol 500 mg as needed. Repositioning, rest and offer drinks, snacks had been ineffective. Review of Resident #3's wound notes dated 03/04/25 written by DNP #100 revealed Resident #3 had eleven wounds of her bilateral lower extremities. The treatment ordered for wounds one through eleven was cleanse daily and as needed, apply xeroform, followed by non-adherent dressing, wrap with roll gauze and secure with tape. The note also included to consider medicating Resident #3 for pain prior to wound care to ease symptom burden. Review of Resident #3's Medication Administration Audit Report dated 03/05/25 revealed orders to cleanse wounds to left lower extremities and right lower extremities with saline, pat dry, apply xeroform, cover with non-adherent dressing, wrap with Kerlix daily for autolytic debridement every night shift for vascular wounds was scheduled for 11:00 P.M. and was not completed until 03/06/25 at 4:05 A.M. Review of Resident #3's medical record including the MAR dated 03/06/25 did not reveal Resident #3 was assessed for pain or that Tylenol was administered at or prior to Resident #3's right and left lower extremity dressing changes at 4:05 A.M. Tylenol was not administered until 03/06/25 at 9:15 A.M. for pain rated at a level of 8. Review of Resident #3's progress notes dated 03/06/25 at 9:15 A.M. revealed Resident #3 stated that her pain was rated an eight out of 10. The note included Resident #3 was resting in bed at the time. Review of Resident #3's Medication Administration Audit Report dated 03/06/25 revealed orders to cleanse wounds to left lower extremities and right lower extremities with saline, pat dry, apply Xeroform, cover with non-adherent dressing, wrap with Kerlix daily for autolytic debridement every night shift for vascular wounds was scheduled for 11:00 P.M. and was not completed until 03/07/25 at 4:46 A.M. Review of Resident #3's medical recording including the MAR dated 03/07/25 did not reveal Resident #3 was assessed for pain or that Tylenol or other pain medication was administered at or prior to 4:46 A.M. Further review did not reveal Tylenol was administered at any time on 03/07/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Medication Administration Audit Report dated 03/07/25 revealed orders to cleanse wounds to left lower extremities and right lower extremities with saline, pat dry, apply xeroform, cover with non-adherent dressing, wrap with Kerlix daily for autolytic debridement every night shift for vascular wounds was scheduled for 11:00 P.M. and was not completed until 03/08/25 at 4:23 A.M. Review of Resident #3's medical record including the MAR dated 03/08/25 did not reveal Resident #3 was assessed for pain or that Tylenol or other pain medication was administered at or prior to 4:23 A.M. Further review did not reveal Tylenol was administered at any time on 03/08/25. Review of Resident #3's Medication Administration Audit Report dated 03/08/25 revealed orders to cleanse wounds to left lower extremities and right lower extremities with saline, pat dry, apply xeroform, cover with non-adherent dressing, wrap with Kerlix daily for autolytic debridement every night shift for vascular wounds was scheduled for 11:00 P.M. and was not completed until 03/09/25 at 1:14 A.M. Review of Resident #3's medical recording including the MAR dated 03/09/25 did not reveal Resident #3 was assessed for pain or that Tylenol or other pain medication was administered at or prior to 1:14 A.M. Further review did not reveal Tylenol was administered at any time on 03/09/25. Review of Resident #3's Medication Administration Audit Report dated 03/09/25 revealed orders to cleanse wounds to left lower extremities and right lower extremities with saline, pat dry, apply xeroform, cover with non-adherent dressing, wrap with Kerlix daily for autolytic debridement every night shift for vascular wounds was scheduled for 11:00 P.M. and was not completed until 03/10/25 at 4:10 A.M. Review of Resident #3's medical record including MAR dated 03/10/25 did not reveal Resident #3 was assessed for pain or that Tylenol or other pain medication was administered at or prior to 4:11 A.M. Further review did not reveal Tylenol was administered at any time on 03/10/25. Observation on 03/06/25 at 9:13 A.M. with Licensed Practical Nurse (LPN) #102 revealed she was administering residents their medications. Certified Nursing Assistant (CNA) #103 walked up to LPN #102 and reported that Resident #3 was asking for pain medication. LPN #102 administered two Tylenol 500 mg tablets to Resident #3 for a complaint of pain rated an eight out of 10 pain in her left leg. Interview on 03/06/25 at 3:50 P.M. with Resident #3 revealed sometimes the nurses gave her pain medication timely when she had pain and sometimes they did not. Interview on 03/10/25 at 11:30 A.M. with CNA #104 revealed Resident #3 had complaints that her left leg and knee hurt and she complained and groaned when she was moved while lying in her bed. CNA #104 stated she told the nurse when Resident #3 was in pain. CNA #104 stated the resident's pain medication helped a little bit, but the CNA did not believe the medication took the pain away completely. CNA #104 indicated Resident #3's legs were wrapped and night shift changed the wound dressings. CNA #104 stated Resident #3 was in pain this morning and she told LPN #105. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/10/25 at 12:26 P.M. of CNA #104 providing Resident #3's morning care revealed the resident had both lower extremities wrapped in Kerlix and the wounds were unable to be visualized. CNA #104 lowered the head of Resident #3's bed and Resident #3 closed her eyes and laid quietly. CNA #104 stated Resident #3 did not like to move around much because of her pain. Resident #104 confirmed she sometimes did not like to be moved because of the pain in her legs. Interview on 03/10/25 at 4:06 P.M. with Resident #3 revealed her leg wounds hurt when the nurses wrapped and unwrapped her legs and put something on the areas. Resident #3 stated it hurt a lot when the nurses changed the dressings on her legs, she told the nurses it hurt, but most of the time she was not given anything for pain when her leg dressings were changed. Resident #3 stated she had so many wounds on her legs, they hurt and she stated she wondered how she got so many wounds. Interview on 03/10/25 at 4:08 P.M. with LPN #105 revealed Resident #3 often complained of leg pain. However, LPN #105 indicated Resident #3 was quiet and did not like to complain. LPN #105 stated sometimes she felt like she was the only nurse who gave Resident #3 and other residents their pain medication. LPN #105 indicated she thought Resident #3 would do well with a scheduled pain regimen because she was so quiet and did not usually complain. LPN #105 stated she talked to the night shift nurse's about medicating Resident #3 for her pain when they did her dressing changes but she was not sure if they did. Interview on 03/10/25 at 4:30 P.M. with the Administrator and Regional Nurse #106 revealed Resident #3 was cognitively intact and stated they believed the resident could ask for pain medications if she was having pain. Review of the facility policy titled Administering Pain Medications dated 10/2010 included the purpose of the procedure was to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. Review the resident's care plan to assess for any special needs of the resident. The pain management program was based on a facility-wide commitment to resident comfort. Be familiar with the physiologic and behavioral (non-verbal) signs of pain such as verbal expressions such as groaning, crying, screaming; facial expressions such as grimacing, frowning, clenching the jaw etceteras; behavior such as resisting care, irritability, depression, decreased participation in usual activities; limitations in his or her level of activity due to the presence of pain; guarding, rubbing or favoring a particular part of the body. It was very important to recognize cognitive, cultural, familial, or gender-specific influences on a resident's ability or willingness to verbalize pain. For example some cultures value stoicism and a high threshold for pain which might influence a resident's willingness to report pain or accept pain-relieving interventions. Acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated after analgesic relief was obtained. This deficiency represents non-compliance investigated under Complaint Number OH00162597.