STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366363	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Steubenville The	500 Stanton Boulevard Steubenville, OH 43952

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview the facility failed to ensure narcotic medication was not misappropriated. This affected one resident (#86) of three residents reviewed for pain management. Findings include:Closed record review revealed Resident #86 was admitted to the facility on [DATE] with a diagnoses including chronic pain syndrome, Parkinsonism, pain and stiffness in right and left shoulder, osteoarthritis, carpal tunnel syndrome, hereditary and idiopathic neuropathy, thrombocytopenia, metabolic encephalopathy, aphasia, and cerebral infarction. The resident was discharged to the hospice facility on 07/28/25. Review of Resident #86's significant change in status minimum data set (MDS) dated [DATE] revealed the resident was absent of spoken words and sometimes understood. The resident had severe cognition impairment and no behavioral symptoms. Resident #86 was on a scheduled pain medication regimen and could not answer the pain assessment interview questions. The staff assessment pain section was conducted and indicated the resident had non-verbal sounds and facial expression for indicators for pain. The resident had indicators of pain or possible pain observed one to two days. The resident was receiving hospice care. Review of Resident #86's plan of care dated 06/19/23 revealed the resident was at risk for pain and/or has chronic pain related to neuropathy, cerebral infarction, shoulder replacement, osteoarthritis, depression, left hip pain, bilateral lower extremities pain, and history of chronic pain. Intervention included to offer non-pharmacological interventions, administer medication as ordered and observe for ineffectiveness and side effects, report abnormal findings, anticipate the resident's need for pain relief as needed and respond immediately to any complaint of pain, identify residents' existing conditions which may increase pain and or discomfort (arthritis, neuropathy, osteoporosis) and provide appropriate pain management treatments, notify physician if interventions are unsuccessful or if current complaints was significant change from residents past experience of pain, observe and report any signs and symptoms of non-verbal pain, vocalizations, mood/behaviors (more irritable, restless, aggressive, squirmy, constant motion), eyes (tearing), body (tense, ridged, rocking, curled up, thrashing) and report abnormal findings to the physician. Review of Resident #86's risk for discomfort or adverse side effects from pain medication plan of care dated 01/25/25 revealed the resident was on pain medication therapy (Oxycodone, Tylenol, Ibuprofen, and Gabapentin) for chronic shoulder pain. Intervention included administering medication as orders and observe for altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus, respiratory distress, sedation, urinary retention, and notify physician if indicated. Review of Resident #86's risk for decline in condition, pain, depression, weight loss and other symptom related to terminal prognosis dated 05/22/25 revealed the resident was receiving hospice. Intervention included assess resident's coping strategies and respect the residents wishes, consult hospice, encourage resident/family to express feelings, observe for adverse reactions and symptoms of end of life such as nausea/vomiting, difficulty breathing, agitation, observe resident closely for signs of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain, administer pain medications as ordered, and notify physician immediately if there was breakthrough pain, refer to hospice plan of care, work cooperatively with hospice team, and work with nursing staff to provide maximum comfort for the resident.a. Review of Resident #86's narcotic control sheet dated 05/22/25 revealed the facility had received 60 Oxycodone 5 milligram (mg) tablets on 05/23/25. The sheet indicated there were 27 remaining on 06/09/25 and only one was disposed of on 06/23/25. Review of the MAR dated 06/2025 revealed the resident had received Oxycodone 5 mg one tablet on 06/09/25 at 8:00 A.M. and 4:00 P.M., 06/10/25 at midnight, 8:00 A.M., and 6:00 P.M., 06/11/25 at midnight, 8:00 A.M., and 6:00 P.M., 06/12/25 at midnight at midnight, 8:00 A.M., noon, and 6:00 P.M., and two tablets on 06/13/25 at midnight and 8:00 A.M., however there was no evidence of the narcotic control sheet for the 16 doses administered from 06/09/25 to 06/13/25. A new card of Oxycodone 10 mg was received on 06/13/25 and started on 06/13/25 at 4:39 P.M. Reconciliation of the narcotic control sheet and MAR revealed there should have been 11 Oxycodone 5 mg remaining if the doses were administered per the MAR. Interview on 12/30/25 at 3:27 P.M., with the Administrator and Director of Nursing confirmed there was no narcotic control sheet to account for the 27 Oxycodone 5 mg that remained on 06/09/25. The Administrator reported the narcotic control sheet may have been double sided and the facility did not scan the other side of the control sheet. b. Review of Resident #86's orders dated 05/30/25 to 06/17/25 revealed Resident #86 was ordered Ativan 0.5 mg every six hours as needed for anxiety/restlessness. Reconciliation of the June 2025 MAR and narcotic control sheet for Ativan 0.5 mg revealed on 06/01/25 a narcotic was signed off the narcotic control sheet at 1800 (6:00 P.M.), however was not documented on the MAR. On 06/07/25 the narcotic control sheet indicated Ativan 0.5 mg was administered at 9:00 A.M. and 4:00 P.M., however was never documented on the MAR. On 06/08/25 the narcotic control sheet indicated Ativan 0.5 mg was administered at 2:00 P.M., however was never documented on the MAR. On 06/14/25 the narcotic control sheet indicated Ativan 0.5 mg was administered at 12:20 P.M., however was never documented on the MAR. Further review revealed the resident had refused Ativan 0.5 mg on 06/17/25 at 2:00 P.M., 06/17/25 at 10:00 P.M., and 06/18/25 at 6:00 P.M., the narcotics were signed off the narcotic control sheet, however no evidence the medication was wasted. c. Review of Resident #86's orders dated 07/26/25 revealed Ativan was changed to 1 mg every four hours scheduled and every hour as needed. Review of the narcotic control sheet revealed two tablets were removed at 2:45 P.M. on 07/26/25, however it was not documented on the MAR. Interview on 12/30/25 at 4:22 P.M., with the Administrator and DON reconciled Ativan with the surveyor and confirmed the above findings during the reconciliation. d. Review of Resident #86's orders dated 06/01/25 revealed Morphine Sulfate 0.25 milliliters (ml) every four hours as needed for pain. On 06/18/25 the order was changed to 0.5 ml every two hours as needed. Reconciliation of the June (2025) MAR and narcotic control sheet dated 06/2025 revealed Morphine 0.25 ml was signed off the narcotic control sheet on 05/15/25 at 10:30 A.M. and 2:30 P.M., 06/16/25 at 6:00 P.M., 06/22/25 at noon and 4:00 P.M., however not signed off on the MAR. Further review of the narcotic control sheet revealed on 07/24/25, 0.5 ml was removed at 8:00 A.M., 12:00 P.M., and 4:00 P.M., however not signed off by the nurse administering. Review of the facility policy tilted Medication Administration dated 03/01/13 and revised 10/17/23 revealed to record the dose, route, and time of medication on the Medication/Treatment Administration Record. Interview on 12/29/25 from 12:39 P.M. to 3:30 P.M. and 12/30/25 at 10:13 A.M., with anonymous staff members #103, #107, and #111 confirmed Resident #86 daughter was upset due to one nurse would not administer Resident #86's pain medication per hospice orders. Interview on 12/30/25 at 4:22 P.M., with the director of nursing (DON) and Administrator confirmed findings during reconciliation with the surveyor. The DON confirmed the nurse did not sign off the Morphine on the control (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sheets on 07/24/25. Interview on 12/30/25 at 10:00 A.M., with Resident #86's daughter confirmed her mother did not receive pain medication as ordered by hospice. This deficiency represents non-compliance investigated under Complaint Number 2614918.

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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of hospice records, review of a facility soft file, interview, and policy review the facility failed to implement an effective pain management program, including the administration of scheduled and as needed opioid medication to effectively manage Resident #86's pain.Actual Harm occurred beginning on [DATE], when Resident #86, who was identified with chronic pain and a new onset of end of life care for pain management, did not receive scheduled or as needed Oxycodone (narcotic pain medication), resulting in uncontrolled pain affecting the resident's end of life care requiring increasing and changing the residents pain medication to re-gain control of the resident's pain. This affected one resident (#86) of three residents reviewed for pain.Findings include: Review of Resident #86's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome, Parkinsonism, pain and stiffness in right and left shoulder, osteoarthritis, carpal tunnel syndrome, hereditary and idiopathic neuropathy, thrombocytopenia, metabolic encephalopathy, aphasia, and cerebral infarction. The resident was discharged to a hospice facility on [DATE].Review of Resident #86's plan of care dated [DATE] revealed the resident was at risk for pain and/or had chronic pain related to neuropathy, cerebral infarction, shoulder replacement, osteoarthritis, depression, left hip pain, bilateral lower extremities pain, and history of chronic pain. Interventions included to offer non-pharmacological interventions, administer medication as ordered and observe for ineffectiveness and side effects, report abnormal findings, anticipate the residents need for pain relief as needed and respond immediately to any complaint of pain, identify residents' existing conditions which may increase pain and or discomfort (arthritis, neuropathy, osteoporosis) and provide appropriate pain management treatments, notify physician if interventions are unsuccessful or if current complaints was significant change from residents past experience of pain, observe and report any signs and symptoms of non-verbal pain, vocalizations, mood/behaviors (more irritable, restless, aggressive, squirmy, constant motion), eyes (tearing), body (tense, ridged, rocking, curled up, thrashing) and report abnormal findings to the physician.Review of Resident #86's risk for discomfort or adverse side effects from pain medication plan of care dated [DATE] revealed the resident was on pain medication therapy (Oxycodone, Tylenol, Ibuprofen, and Gabapentin) for chronic shoulder pain. Interventions included administering medication as ordered and observe for altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritis, respiratory distress, sedation, urinary retention, and notify physician if indicated.Review of Resident #86's risk for decline in condition, pain, depression, weight loss and other symptom related to terminal prognosis dated [DATE] revealed the resident was receiving hospice services. Intervention included assess resident's coping strategies and respect the residents wishes, consult hospice, encourage resident/family to express feelings, observe for adverse reactions and symptoms of end of life such as nausea/vomiting, difficulty breathing, agitation, observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there was breakthrough pain, refer to hospice plan of care, work cooperatively with hospice team, and work with nursing staff to provide maximum comfort for the resident.Review of Resident #86's nursing progress notes revealed on [DATE] the resident had increased drowsiness, trouble with fine motor skills, and decreased appetite. Cymbalta had been increased to 60 milligrams (mg) twice daily on [DATE]. New orders to hold Cymbalta for 24 hours and restart 20 mg for two days, then start 30 mg daily was provided at this time. Review of Resident #86's nursing progress note dated [DATE] revealed the resident's daughter was aware of the resident's acute functional decline and wished to have hospice consulted. Hospice (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	in facility and consulted with daughter and daughter has decided to move forward and sign paperwork.Review of Resident #86's hospice agreement and note dated [DATE] revealed the resident's prior pain medication regime included Lidocaine patch four percent apply for 12 hours and remove for 12 hours daily for pain, Gabapentin 300 mg twice daily for neuropathy, Ibuprofen 400 mg twice daily for pain, Oxycodone 5 mg twice daily for pain, and Tylenol Extra Strength 500 mg two tablets three times daily. The resident's daughter had reported the resident had knee replacement and surgery on both shoulders and had been in constant pain and was taking Oxycodone, Tylenol, and ibuprofen scheduled. Resident grimaced any time she moves, above medications were not effective. Hospice recommended to increase Oxycodone to every eight hours and as needed. Message left with provider for approval. Review of Resident #86's hospice psychosocial admission assessment dated [DATE] revealed the resident was asleep when the social worker arrived. The resident arose easily, her speech was mumbled and she was confused and unable to answer questions appropriately. The facility nurse reported the resident had been sleeping most of the day.Review of Resident #86 hospice note date [DATE] revealed hospice had met with Resident #86's daughter. The resident was alert sitting up in bed and attempted to communicate but speech was garbled, but did shake head yes and no. The daughter was grateful for support and wanted comfort for the resident. The physician approved the Oxycodone recommendation; the daughter agreed with the medication changes and the facility nurse was updated and voiced no concerns. The resident's prescription was sent to the pharmacy.Review of Resident #86's hospice physician order dated [DATE] revealed new orders for Oxycodone 5 mg every eight-hour scheduled, and every four hours as needed for pain and Zofran 4 mg every six hours as needed for nausea and vomiting. An order was also provided to discontinue the Oxycodone 5 mg twice daily. Review of the Oxycodone control sheet dated [DATE] and received on [DATE] revealed Oxycodone 5 mg every eight hours scheduled, and every four hours as needed.Review of Resident #86's medical record revealed no evidence the new orders to change the Oxycodone 5 mg to every eight hours scheduled and every four as needed and Zofran 4 mg every six hours as needed was implemented on [DATE]. The orders were not implemented until [DATE] at 7:43 P.M. (three days after medication was ordered).Review of Resident #86's hospice note dated [DATE] revealed the resident was alert and pleasant but speech was garbled. The resident had a fall yesterday which resulted in no injuries. The resident could not respond to pain questions; however, breathing was normal, no facial expressions of pain, and body was relaxed. Review of Resident #86's medication administration records (MAR) dated 05/2025 revealed the resident did not receive the scheduled Oxycodone 5 mg at 10:00 P.M. on [DATE] or the 6:00 A.M. dose on [DATE] because she was sleeping. The narcotic control sheet dated [DATE] revealed the Oxycodone 5 mg was signed out on [DATE] at 10:00 P.M. with no evidence the medication was wasted. In addition, there was no evidence the resident had received the Oxycodone as needed from [DATE] to [DATE].Review of Resident #86 significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was absent of spoken words and sometimes understood. The resident had severe cognition impairment and no behavioral symptoms. The assessment revealed Resident #86 was on a scheduled pain medication regimen and could not answer the pain assessment interview questions. The staff assessment pain section was conducted and indicated the resident had non-verbal sounds and facial expression for indicators for pain. The resident had indicators of pain or possible pain observed one to two days. The resident was receiving hospice care. Review of Resident #86's hospice note dated [DATE] revealed the resident had been anxious since this morning. Daughter pushes the resident in her wheelchair. The resident shook head yes she was having pain. The resident was tearful during visit and fidgeting. New orders received for Ativan 0.5 mg four times daily as needed and Oxycodone increased to 10 mg every six hours and discontinue 5 mg (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	every eight hours scheduled, and every four hours as needed.Review of Resident #86 narcotic control sheet and MAR dated 05/2025 revealed the Resident received the scheduled Oxycodone 5 mg on [DATE] at 2:00 P.M. per the MAR, however there was no evidence the Oxycodone 5 mg was signed off the narcotic control sheet. The MAR indicated the Oxycodone 5 mg scheduled and the as needed orders were discontinued on [DATE] at 7:43 P.M. There was no evidence that the resident had received Oxycodone 5 mg or 10 mg on [DATE] (as evidenced by the Oxycodone not being signed off on the narcotic control sheet). Review of Resident #86's orders and MAR dated [DATE] revealed the resident did not receive the Oxycodone 10 mg at midnight on [DATE] because she was sleeping.Review of Resident #86's progress notes dated [DATE] at 11:08 A.M. revealed the resident's daughter had spoken to this nurse regarding the resident's new hospice orders. Upon chart review it was discovered that the resident was historically on Oxycodone 5 mg twice daily, while reviewing the chart this nurse noted the scheduled 2:00 A.M., dose was not administered on more than one occasion with charting code sleeping. Residents' pain was well controlled with this regimen when all doses were administered. The resident's daughter was made aware of missed doses and changes in pain management routine that resulted in the resident's increased pain that hospice had noted upon assessment. At this time the resident's daughter wished to resume original order of 5 mg Oxycodone at 2:00 A.M. and 4:00 P.M. Hospice nurse made aware of the above. Physician aware of the above and agreeable to resume historical order. Review of a clarification note dated [DATE] at 11:28 A.M., revealed Oxycodone was historically scheduled at 6:00 A.M., 2:00 P.M., and 10:00 P.M., and every four hours as needed. Review of Resident #86's progress note dated [DATE] revealed the resident's daughter was very teary eyed. The daughter stated she spoke with her mom after yesterday's fall, and the resident and family wanted to start hospice end of life drugs. She (the resident) doesn't want to be in pain and suffer any longer.Review of Resident #86's hospice physician orders dated [DATE] revealed new orders for Morphine concentrated solution 20 mg/milliliter (ml) give 0.25 ml every four hours as needed for pain/dyspnea. There was no documented evidence to discontinue the Oxycodone 5 mg scheduled or as needed.Review of progress note dated [DATE] revealed the nurse documented the physician reviewed medication and discontinued some medications. Keep Oxycodone until morphine starts and then discontinue. The note didn't indicate which Oxycodone order to discontinue the scheduled or as needed.Review of Resident #86's Morphine (narcotic) control sheet revealed the Morphine was received on [DATE] and the first as needed dose was administered on [DATE] at 4:30 P.M.Review of Resident #86's orders revealed on [DATE] at 9:34 P.M., the three times a day scheduled and the as needed Oxycodone orders were both discontinued.Review of the hospice note dated [DATE] revealed the resident was sitting up in wheelchair, pleasant, and no signs or symptoms of distress. The daughter was tearful as it was a rough weekend. The unit manager had called the physician to ask if the new pain medication order was not being started as a medication dose was missing at 2:00 A.M. The resident was agitated Saturday ([DATE]) and had a fall Saturday afternoon and was transported to the hospital with a hematoma to the top of the head. The CT was negative. The resident's daughter stated the resident was in pain on Sunday and frustrated as the resident was suffering. New orders were obtained from hospice for Morphine 5 mg as needed every four hours. Education was provided on use of as needed Ativan for increased anxiety to nurse (Registered Nurse (RN) #113). After medical record review with RN #113 the previous Oxycodone 5 mg order (from [DATE]) was not placed in the resident orders and the resident had not received it. The previous Oxycodone 5 mg order every 8 hours scheduled was added. The resident's daughter was at the beside aware and grateful.Review of a progress note dated [DATE] revealed the hospice nurse was present and had ordered this nurse to restart the Oxycodone 5 mg every eight hours as scheduled. Review of a progress note dated [DATE] revealed (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the resident's daughter had concerns the resident was having uncontrolled pain. Hospice updated and requested we give the Morphine every four hours and keep the as needed and monitor.Review of a hospice note dated [DATE] revealed the facility had changed the resident's pharmacy. There was a new order for Oxycodone 10 mg three times daily. Resident #68 ‘s daughter reported that the resident was doing wonderful, does not want to change pain regimen at this time. Further review of Oxycodone narcotic control sheets and MAR dated 06/2025 revealed the MAR indicated Oxycodone 10 mg was administered at 8:00 A.M., on [DATE], [DATE] at midnight, 8:00 A.M., and 6:00 P.M., and [DATE] at 8:00 A.M., however the medication was not signed off on the narcotic control sheets. The control sheet indicated 20 pills were received on [DATE] of Oxycodone 10 mg. On tablet was removed on [DATE] at 4:39 P.M., one tablet on [DATE] at midnight and 11:30 P.M., no tablets were removed on [DATE], one on [DATE] at midnight and 4:00 P.M. and [DATE] at midnight. The remaining 14 tablets were destroyed on [DATE].Review of a progress note dated [DATE] revealed the resident was displaying increased signs of anxiety during medication administration, including physically grasping at this nurse's arm. Hospice contacted about increased agitation. Hospice stated they would be in today to assess resident.Review of hospice note dated [DATE] revealed the resident pain was assessed by non-verbal. The resident was tense, distressed, rubbing legs, fidgeting and refusing medication. The resident was yelling, smacking and kicking. New orders for Fentanyl patch and discontinue the scheduled Morphine order. Review of a hospice note dated [DATE] revealed the Director of Nursing (DON) called asking for Morphine to be scheduled as some facility nurses do not administer. The resident was exhibiting signs of pain. The nurse had reported prior to hospice arriving the resident was crying, moaning; morphine was administered prior to hospice arriving. Nurse reported the resident receives Morphine every four hours, she experiences good effects. Physician updated and Morphine scheduled every four hours. Review of the facility guest satisfaction concern form dated 06/2025 to 08/2025 revealed the resident had voiced concerns that she had right knee pain and the facility was aware and had not done anything. Further review revealed no documented evidence of Resident #68 family's concerns.Review of the facility's soft file for Resident #86 revealed a guest satisfaction concern form dated [DATE] indicating Resident #86 daughter called the DON down to 200 hall Unit Mangers office to voice concerns the resident's pain medication was not being administered when the resident was sleeping. She stated she wanted the resident to be woken up and given pain medication regardless. The daughter voiced a concern that RN #113 wasn't giving medication when her mom was sleeping. The investigation indicated the MAR was reviewed and medications were given as ordered. Hospice notified of daughter's concerns. The Administrator had an unsigned typed letter dated [DATE] at the top that indicated Resident #86's daughter didn't feel her mom was medicated properly. The daughter had a time of events, however never told the DON because the Unit Manager told her that they wouldn't get addressed. The daughter felt staff could benefit from Hospice training and the Administrator agreed and set up empathy training for staff with Hospice. Included in the soft file was an email from the [NAME] President of Operations dated [DATE] that himself and Division Director of Clinical Service reviewed the medical record (of Resident #86). It was his understanding the that the Ohio Department of Health had been into the facility to investigate the same concerns. Information contained in the soft file revealed the [NAME] President of Operations indicated that appropriate actions had been taken with the facility staff to address (family) concerns and provide education as necessary.The soft file included staff education on hospice services on [DATE] and all staff meeting in June (2025) that included notifying hospice of change of condition and when to administer as needed medication. Review of the facility policy titled Pain Management dated [DATE] and revised [DATE] revealed the facility would evaluate and identify residents' (continued on next page)

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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 Note: The nursing home is disputing this citation.	pain, determine the type, location, severity, and develop a care plan for pain management. If a resident who has dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behavior such as calling out of help, facial expression, refusing to eat, striking out when moved or touched, and increased confusion.Interview on [DATE] from 12:39 P.M. to 3:30 P.M. and [DATE] at 10:13 A.M., with anonymous staff members #103, #107, and #111 confirmed Resident #86's daughter was upset due to a facility nurse not administering Resident #86 medication per hospice orders. The nurse didn't believe in hospice.Interview on [DATE] at 3:19 P.M., with the Administrator revealed Resident #86's daughter had voiced concerns to the corporate office, and they completed an investigation and had no negative findings related to the daughters' concerns. The daughter had voiced concerns to the Unit Manager; however, the Unit Manager did not forward the concerns to the DON or herself. The Unit Manager was no longer employed by the facility. The Administrator reported the DON was not aware of the family's concerns until the end of July (2025) after the resident had expired. Resident #86 had gone to the hospice house around [DATE] and expired a few days later. The Administrator reported she would have to see if the DON completed a concern form. Interview on [DATE] at 10:00 A.M., with Resident #86's daughter revealed in [DATE] she had consulted Hospice for pain management for her mother. There was one nurse who would refuse to medicate her mother per hospice orders and plan of care. She (the daughter) visited her mother daily. Her mom was not able to speak but showed non-verbal cues of pain. When she (the daughter) would request pain medication the nurse would say She doesn't need it or She has been fine and been sleeping. The nurse told hospice once she didn't agree with their orders. On [DATE]th (2025) the daughter had spoken to the DON and was assured staff would be educated on pain management and as needed orders including the nurse that refused to medicate her mother. (See above hospice note dated [DATE] that the DON called hospice requesting scheduling Morphine due some facility nurses don't administer medication). Resident #86's daughter reported she could not continue to arrive for routine visit daily to find her mother in severe pain and distress. She moved her mom to the hospice house where she had expired a few days later. Interview on [DATE] at 3:27 P.M., with the DON and Administrator confirmed the hospice order on [DATE] to increase the Oxycodone 5 mg to every eight hours schedule and every four hours as needed, and Zofran was not implemented until [DATE] because the facility was not aware of the new orders on [DATE]. The Administrator reported the facility had changed pharmacies on [DATE] and she would have to call the previous pharmacy for records. The Administrator received a printout; the records were not legible, however the narcotic control sheet indicated the new order was received by the facility on [DATE]. The DON confirmed Resident #86 did not receive scheduled Oxycodone on [DATE] at 10:00 P.M. and [DATE] at 6:00 A.M., per the MAR because the resident was sleeping. The DON reported nurses use their assessment skills to determine if it was safe to administer medications. The DON confirmed there was some confusion regarding the Oxycodone and Morphine order that was received on [DATE], however the hospice nurse clarified on [DATE] the scheduled Oxycodone should have been given resulting in the resident missing two doses of Oxycodone the morning of [DATE]. The DON confirmed there were no narcotic control sheets to prove the resident had received Oxycodone 10 mg on 8:00 A.M., on [DATE], [DATE] at midnight, 8:00 A.M., and 6:00 P.M., and [DATE] at 8:00 A.M. per the MAR. The medication was not removed from the emergency contingency machine either per the DON. Another resident had concerns on [DATE] that pain medication was not provided upon request timely. This residents' concerns were not identified as part of the facility's investigation. This deficiency represents non-compliance investigated under Complaint Number 2614918.