| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366387 | A. Building<br>B. Wing | 02/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Darby Glenn Nursing and Rehabilitation Center | 4787 Tremont Club Drive<br>Hilliard, OH 43026 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interviews and facility policy review, the facility failed to ensure one resident (#69) received a nutritious vegetarian diet. This affected one resident (#69) of four residents reviewed for nutrition. The facility census was 93. Findings Include:Review of the medical record for resident #69 revealed an initial admission date of 02/09/17 with the diagnoses including but not limited to moderate protein calorie malnutrition, hypertension, anemia, major depression disorder, osteoarthritis, spinal stenosis, hyperlipidemia, constipation, polyneuropathy and hypothyroidism. Review of the plan of care dated 02/15/17 revealed the resident had the potential for alteration in nutrition and hydration related to at moderate risk for malnutrition, followed a vegetarian diet related to cultural patterns. Interventions included assist with set up of meal items as needed/requested, honor food preferences as able, medications as ordered, monitor consistency of diet served and resident's family provides food from home routinely along with supplement. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The resident required set-up assistance with eating. Review of the resident's monthly physician orders for January 2026 identified an order dated 01/27/26 vegetarian diet, mechanical diet soft texture. Review of the resident's meal ticket revealed the resident was to receive a vegetarian diet a magic cup, a fruit cup, six ounces of coffee with four sugar packets, eight ounces of beverage of choice and eight ounces of whole milk. Further review revealed the resident disliked cheese, eggs, pasta, grapes and butter. Review of the facility's weekly menu titled 2025-2026 Foundation Fall/Winter week three menu revealed under the vegetarian diet the resident would received one serving of vegetarian entree, however no entree was listed. On 01/27/26 at 12: 50 P.M., observation the resident's lunch revealed the meal consisted of cheesy scalloped potatoes, carrots, pears and a magic cup. The resident had no alternate protein source on her meal tray. On 01/28/26 at 11:15 A.M., interview with the Dietary Manager (DM) #166 revealed residents on a vegetarian diet would receive a protein replacement for an entree including grilled cheese, peanut butter and jelly sandwich (PBJ), yogurt, or cottage cheese. On 01/28/26 at 12:25 P.M., observation of the resident's lunch meal revealed she had a serving of carrots on her plate, a cup of yogurt, a fruit cup, a magic up and a roll. The resident voiced that she did not like what she was served. On 01/28/26 at 12:32 P.M., an interview with DM #166 revealed she was served a protein of yogurt for lunch. She said they provide grilled cheese, cottage cheese, yogurt, and PBJ for the protein entree. DM #166 was informed the resident did not like yogurt. She said she was unaware the resident did not like the yogurt. She said it was the aides responsibility to inform the kitchen the resident did not like the food sent and ask for an alternative. She was asked to walk to the resident's room. DM #166 pointed to the yogurt and said see there is her protein. The resident replied no when asked if she liked yogurt. She said dietary does not know if the resident doesn't like something unless nursing informs them. Review of the facility policy titled, Religious, Ethic and Cultural Food Preferences, dated 08/07/14 revealed the facility will identify, honor and accommodate each resident's nutritional needs, cultural practices, religious beliefs and personal food preferences as part of a resident centered approach to care. |

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 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and review of facility policy, the facility failed to ensure non-pharmacological interventions were provided prior to the administration of as needed pain medications for Resident #5, #1 and #30, this affected three of four residents reviewed for pain management. The facility failed to ensure descriptions of pain were documented for Resident #1 and #30 which affected two of four residents reviewed for pain management. The facility census was 93.Findings include:1. Review of Resident #30's medical record revealed an admission date of 08/22/25 and diagnoses including ataxia, mild neurocognitive disorder due to known physiological condition without behavioral disturbance, anxiety disorder, and major depressive disorder.<br><br>Review of Resident #30's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition.<br><br>Review of Resident #30's plan of care revised 10/15/25 revealed the resident was at risk for alteration in comfort due to diagnoses, generalized pain, and impaired mobility. Interventions included administering medications as ordered, offering backrub or warm blankets, offering nonpharmacological interventions, pain assessment according to policy, and quiet environment and rest periods as needed.<br><br>Review of Resident #30's physician order dated 01/13/26 revealed an order for Acetaminophen (analgesic) 325 milligrams (mg) two tablets by mouth every six hours as needed for mild pain or discomfort. Nonpharmalogical interventions were to be offered or attempted prior to medication administration.<br><br>Review of Resident #30's physician order dated 01/13/26 revealed an order for Roxicodone (an opioid) five mg one tablet by mouth every six hours as needed for moderate pain or discomfort. Nonpharmalogical interventions were to be offered or attempted prior to medication administration.<br><br>Review of Resident #30's physician order dated 01/13/26 revealed an order for Methocarbamol (a muscle relaxer) 500 mg, 0.5 tablet every eight hours as needed for pain, discomfort, or muscle spasms. Nonpharmalogical interventions were to be offered or attempted prior to medication administration.<br><br>Review of Resident #30's Medication Administration Record from 01/01/26 to 01/27/26 revealed Roxicodone was given on 01/02/26 for a pain of eight, on 01/08/26 for a pain of five, on 01/09/26 for a pain of six, on 01/16/26 for a pain of two, on 01/17/26 for pain of zero, and on 01/18/26 for pain of zero. Methocarbamol was administered on 01/16/26 for pain of two, on 01/17/26 for pain of zero, and on 01/18/26 for a pain of zero.<br><br>Review of Resident #30's progress notes dated 01/01/26 to 01/27/26 revealed there was no description of pain or documentation of attempted nonpharmacological interventions for the administration of as needed medications on 01/02/26, 01/08/26, 01/09/26, 01/16/26, 01/17/26, or 01/18/26.<br><br>Interview on 01/28/26 at 10:20 A.M. with Licensed Practical Nurse (LPN) #175 revealed when a resident reported pain they assessed location, type of pain, and attempted nonpharmacological interventions. She indicated all this information should be documented in the progress notes.<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of Resident #1's medical record revealed an admission date of 01/07/25 with diagnoses including parkinsonism, generalized anxiety disorder, psychotic disorder with delusions, unspecified dementia, gout, dysphagia, rheumatoid arthritis, and alcohol abuse.<br><br>Review of Resident #1's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition.<br><br>Review of Resident #1's plan of care dated 07/08/25 revealed the resident was at risk for alteration in comfort related to diagnoses and degenerative changes of the left hip. Interventions included acknowledging presence of pain and discomfort, administering medications as ordered, encouraging and assisting to maintain proper body alignment, monitoring for increased level of pain, monitoring for side effects, offering nonpharmacological interventions, and repositioning the resident for comfort.<br><br>Review of Resident #1's physician order dated 04/11/25 for Tylenol 500 mg two tablets by mouth every eight hours as needed for pain or discomfort. Nonpharmacological interventions were to be offered or attempted prior to medication administration.<br><br>Review of Resident #1's physician order dated 06/16/25 revealed an order for Oxycodone (opioid) five milligrams (mg) one tablet by mouth every four hours as needed for pain.<br><br>Review of Resident #1's Medication Administration Record (MAR) from 01/01/26 to 01/28/26 revealed Oxycodone was administered on 01/01/26 for a pain of seven, on 01/02/26 or a pain of seven, on 01/04/26 for a pain of one, on 01/06/26 for a pain of six, and on 01/06/26 for a pain of three, on 01/08/26 for a pain of six, on 01/09/26 for a pain of zero, on 01/11/26 for a pain of three, on 01/13/26 for pain of six and on 01/13/26 for a pain of five, on 01/14/26 for a pain of three, on 01/16/26 for pain of six and on 01/16/26 for a pain of zero, on 01/17/26 for a pain of zero, on 01/18/26 for a pain of zero, on 01/20/26 for a pain of three, on 01/23/26 for pain of zero, on 01/27/26 for a pain of three, and on 01/28/26 for a pain of six. Acetaminophen was given once on 01/16/26 for a pain of six.<br><br>Review of Resident #1's progress notes from 01/01/26 to 01/28/26 revealed prior to the administration of as needed pain medications there was no documented descriptions of pain or attempted nonpharmacological interventions.<br><br>Interview on 01/28/26 at 10:20 A.M. with Licensed Practical Nurse (LPN) #175 revealed when a resident reported pain they assessed location, type of pain, and attempted nonpharmacological interventions. She indicated all this information should be documented in the progress notes.<br><br>3. Review of Resident # 5's medical record revealed she was admitted on [DATE] with diagnoses that included mild protein malnutrition, bipolar disorder and restless leg syndrome. She received hospice services for a diagnosis of terminal diagnosis of protein-calorie malnutrition.<br><br>Review of Resident # 5's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 7 indicating a cognitive impairment. The assessment indicated the resident received scheduled and as needed medications, however, did not receive non-pharmacological interventions for pain. The resident required assistance from staff with eating, dressing, toileting and transfers.<br><br>Review of Resident # 5's most recent care plan dated January 2026 revealed she was at risk for<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | alteration in comfort care plan related to generalized pain, restless leg syndrome, impaired mobility and disease process/condition with interventions that included administer medications, encourage and assist resident to maintain proper body alignment, encourage and assist resident to turn and reposition every two hours as needed, offer back rubs or warm blankets, reposition for comfort, offer non-pharmacological interventions ( quiet environment, repositioning, back rubs, diversional activities) and monitor for effectiveness of interventions.<br><br>Review of Resident # 5's physicians orders dated 01/27/26 revealed orders for Morphine Sulfate (Concentrate) Oral Solution (opioid pain medication) 20 milligrams/milliliter (mg/ml) administer 0.5 ml by mouth every six hours for pain, Morphine Sulfate (Concentrate) Oral Solution 20 mg/ml administer 0.5 ml by mouth every one hour as needed for pain, Acetaminophen Oral Tablet 325 mg administer three tablets by mouth three times a day for pain with the special instruction may take with Morphine, and Ropinirole HCL Oral Tablet one milligram administer one tablet by mouth at bedtime for restless leg syndrome. There was no evidence in the orders to offer non-pharmacological pain interventions.<br><br>Review of Resident # 5's Medication Administration Record (MAR) dated January 2026 revealed she received Morphine Sulfate 0.5 ml every six hours daily and Morphine Sulfate 0.5 ml as needed (PRN) on 01/03/26, 01/10/26, 01/12/26, 01/18/26 and 01/22/26 with no documented non-pharmacological interventions being attempted prior to the administration of the as needed medication.<br><br>Review of Resident # 5's progress notes revealed no documented evidence on 01/10/26, 01/12/26 or 01/18/26 related to non-pharmacological interventions being provided prior to the administration of the as needed pain medication, and a progress note dated 01/22/26 that stated the resident received scheduled pain medications. No PRN medications have been administered over the last 5 days. Non-medication interventions are in place, however the resident had received PRN medications in the last five days, and no provided non-pharmacological interventions were documented.<br><br>Interview on 01/29/2026 at 11:33 A.M. with LPN # 168 revealed any non-pharmacological interventions provided should be documented in the progress notes when giving PRN medications. Review of January 2026 Medication Administration Record (MAR) and progress notes dated 01/18/26 and 01/22/26 with LPN # 168 revealed she administered Morphine Sulfate 0.5 ml PRN on 01/18/26 and 01/22/26 and she confirmed there were no documented non-pharmacological intervention in her note.<br><br>Review of facility for titled Pain Management Program Best Practice dated July 2019 revealed under nursing actions: identify location, nature, cause and severity of pain, implement non-pharmacological interventions alone or in combinations with medication as appropriate (eg. repositioning, comfort measures, relaxation and therapy.<br><br>Review of facility titled Pain Assessment and Management Policy dated 03/31/16 revealed the alert and oriented resident may be asked to describe his/her pain status. Pertinent information may include numeric rating scale of 0-10; with zero being no pain and ten being the most severe pain the resident can imagine, verbal descriptor scale; mild, moderate, severe, very severe/horrible and the resident's expectation for pain relief is needed to live comfortably. Also, non- pharmacological methods to reduce pain in resident may be implemented and provide pharmacological interventions in accordance with physician's order (s). |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and review of facility policy the facility failed to ensure pain parameters were in place for Resident #1, #30, and #66, who received multiple as needed pain medications. This affected three of four residents reviewed for pain management. The facility census was 93. Findings include:1. Review of Resident #30's medical record revealed an admission date of 08/22/25 and diagnoses including ataxia, mild neurocognitive disorder due to known physiological condition without behavioral disturbance, anxiety disorder, and major depressive disorder.Review of Resident #30's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition.Review of Resident #30's plan of care revised 10/15/25 revealed the resident was at risk for alteration in comfort due to diagnoses, generalized pain, and impaired mobility. Interventions included administering medications as ordered, offering backrub or warm blankets, offering nonpharmacological interventions, pain assessment according to policy, and quiet environment and rest periods as needed.Review of Resident #30's physician order dated 01/13/26 revealed an order for Acetaminophen (analgesic) 325 milligrams (mg) two tablets by mouth every six hours as needed for mild pain or discomfort. Roxicodone (an opioid) five mg one tablet by mouth every six hours as needed for moderate pain or discomfort. Methocarbamol (a muscle relaxer) 500 mg, 0.5 tablet every eight hours as needed for pain, discomfort, or muscle spasms.Review of Resident #30's Medication Administration Record from 01/01/26 to 01/27/26 revealed Roxicodone was given on 01/02/26 for a pain of eight, on 01/08/26 for a pain of five, on 01/09/26 for a pain of six, on 01/16/26 for a pain of two, on 01/17/26 for pain of zero, and on 01/18/26 for pain of zero. Methocarbamol was administered on 01/16/26 for pain of two, on 01/17/26 for pain of zero, and on 01/18/26 for a pain of zero.Interview on 01/28/26 at 10:20 A.M. with Licensed Practical Nurse (LPN) #175 revealed when a resident reported pain they assessed location, type of pain, and attempted nonpharmacological interventions. She indicated all this information should be documented in the progress notes. LPN #175 reported as needed pain medication was given according to resident preference and not according to the scale of the pain. 2. Review of Resident #1's medical record revealed an admission date of 01/07/25 with diagnoses including parkinsonism, generalized anxiety disorder, psychotic disorder with delusions, unspecified dementia, gout, dysphagia, rheumatoid arthritis, and alcohol abuse.Review of Resident #1's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition.Review of Resident #1's plan of care dated 07/08/25 revealed the resident was at risk for alteration in comfort related to diagnoses and degenerative changes of the left hip. Interventions included acknowledging presence of pain and discomfort, administering medications as ordered, encouraging and assisting to maintain proper body alignment, monitoring for increased level of pain, monitoring for side effects, offering nonpharmacological interventions, and repositioning the resident for comfort.Review of Resident #1's physician order dated 04/11/25 for Tylenol 500 mg two tablets by mouth every eight hours as needed for pain or discomfort.Review of Resident #1's physician order dated 06/16/25 revealed an order for Oxycodone (opioid) five milligrams (mg) one tablet by mouth every four hours as needed for pain.Review of Resident #1's Medication Administration Record (MAR) from 01/01/26 to 01/28/26 revealed Oxycodone was administered on 01/01/26 for a pain of seven, on 01/02/26 or a pain of seven, on 01/04/26 for a pain of one, on 01/06/26 for a pain of six, and on 01/06/26 for a pain of three, on 01/08/26 for a pain of six, on 01/09/26 for a pain of zero, on 01/11/26 for a pain of three, on 01/13/26 for pain of six and on 01/13/26 for a pain of five, on 01/14/26 for a pain of three, on 01/16/26 for pain of six and on 01/16/26 for a pain of zero, on 01/17/26 for a pain of zero, on 01/18/26 for a pain of zero, on 01/20/26 for a pain of three, on 01/23/26 for pain of zero, on 01/27/26 for a pain of three, and on 01/28/26 for a pain of six. Acetaminophen was given once on 01/16/26 for a pain of six.Interview on 01/28/26 at 10:20 A.M. with Licensed Practical Nurse (LPN)<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | #175 revealed when a resident reported pain they assessed location, type of pain, and attempted nonpharmacological interventions. She indicated all this information should be documented in the progress notes. LPN #175 reported as needed pain medication was given according to resident preference and not according to the scale of the pain. 3. Review of the medical record for Resident #66 revealed an initial admission date of 01/14/25 and readmission on [DATE], with diagnoses of secondary malignant neoplasm of prostate, benign prostatic hyperplasia, muscle wasting and atrophy, and primary generalized osteoarthritis.Review of Resident #66's quarterly Minimum Data Score (MDS) 3.0 completed on 12/05/25, revealed normal cognitive function.Review of Resident #66's physician order revealed an order dated 08/20/25 for Oxycodone Hydrochloride (HCl) 5 mg tablet, half a tablet by mouth every six hours as needed for pain.Review of Resident #66's physician order on 01/28/26 revealed an order dated 09/08/25 for Acetaminophen tablet 325 mg, two tablets by mouth every six hours as needed for pain/discomfort.Neither order contained parameters for administration of the pain medication.Review of Resident #66's Medication Administration Record (MAR) revealed Oxycodone was administered on 01/19/26 and 01/21/26 for a recorded pain level of five, and Acetaminophen was administered on 01/26/25 for a recorded pain level of five. Further review of the MAR also revealed Oxycodone was administered on 11/13/25 for a recorded pain level of zero.Interview on 01/29/26 at 10:25 A.M. with LPN #121 confirmed the Resident #66 is prescribed both Acetaminophen and Oxycodone as needed (PRN) for pain without parameters. LPN #121 revealed the nurse passing the medication would use their clinical judgement to decipher which medication should be given. LPN #121 reported if the pain was more severe Oxycodone may be administered instead of Acetaminophen. LPN #121 confirmed Resident #66 reported a pain of five on 01/19/26 and was administered Oxycodone but on 01/26/26 reported a pain level of five and was administered Acetaminophen. Additionally, LPN #121 confirmed a resident should not be administered as needed Oxycodone with a reported pain level of zero.Review of the facility policy with the subject Pain Assessment and Management, revised 04/02/24, revealed if more than one pain medication is prescribed as needed the nurse may consider several factors to determine which medication to administer, including the resident's current pain level and the resident's medical condition and current medication regimen. |