STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365738	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Fairfield	3801 Woodridge Boulevard Fairfield, OH 45014

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 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. Based on record review and interviews, the facility failed to ensure residents were properly transferred using a mechanical lift. This affected one (#44) out of three residents reviewed for transfers. The facility census was 66. Findings include: Review of the medical record for Resident #44 revealed an admission date of 02/15/24. Diagnoses included other sequelae of cerebral infarction, human immunodeficiency virus disease, hemiplegia unspecified affecting left nondominant side, cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery, traumatic subdural hemorrhage without loss of consciousness sequela, nontraumatic subdural hemorrhage, osteomyelitis of vertebra lumbar region, epilepsy, hyperlipidemia, paroxysmal tachycardia, nonrheumatic tricuspid stenosis, major depressive disorder, anxiety disorder, opioid abuse with withdrawal, and unspecified viral hepatitis C without hepatic coma. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/01/24, revealed Resident #44 was cognitively intact. This resident was assessed to require setup assistance for eating, and oral hygiene, substantial/maximal assistance for toileting, bathing, lower body dressing, personal hygiene, and bed mobility, partial/moderate assistance for upper body dressing, and was dependent for transfers. Review of the plan of care initiated on 03/06/24 revealed Resident #44 was at risk for a decline in activities of daily living function related to need for assistance with activities of daily living, transfers, ambulation, and toileting due to depression, anxiety, epilepsy, hemiplegia, history of stroke, hypertension, hepatitis C, and pain. Interventions included allow time for rest breaks, encourage resident participation, report declines in function to physician, staff to anticipate needs and assist as needed, and therapy to evaluate and treat as needed. Review of the progress note dated 11/03/24 revealed Resident #44 had a possible fall from a Hoyer lift and both of her shoulders landed on the floor. The note indicated no injuries were noted. Review of the Post Fall Evaluation dated 11/03/24 revealed Resident #44 was being transferred with a Hoyer lift at the time of the fall. The evaluation noted a contributing factor was Certified Nursing Assistant (CNA) transferring the resident without assistance. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation dated 11/03/24 revealed Resident #44 reported she had been dropped from the Hoyer lift to the floor where her shoulders touched the ground and was then lifted back up. Interview on 12/03/24 at 11:07 A.M. with the Director of Nursing (DON) revealed Resident #44 reported she was being lifted and then started falling backwards, which caused her to land on her shoulders. The DON stated the CNA indicated in her statement that Resident #44 was not dropped but was lowered down and readjusted before being transferred. The DON verified the CNA admitted she was alone during the transfer. Interview on 12/03/24 at 12:30 P.M. with Resident #44 revealed she was being transferred from her wheelchair to the bed. Resident #44 stated only one CNA was present and had not clipped the back part of the Hoyer pad to the lift, which caused her to fall backwards and hit her shoulders on the floor. Interview on 12/04/24 at 2:48 P.M. with the DON revealed two aides should be present for transfers using a mechanical lift. This deficiency represents non-compliance investigated under Complaint Number OH00158870.

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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 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** Based on record review, staff interview, and policy review, the facility failed to provide medication per physician orders. This affected one (#69) when the facility did not administer his prescribed Methadone (opioid) medication resulting in a significant medication error. This affected one (#69) out of three residents reviewed for medication administration. Facility census was 71. Findings include: Review of the medical record revealed Resident #69 was admitted on [DATE] with diagnoses of paraplegia, opioid abuse, auditory hallucinations, delusional disorders and congestive obstructive pulmonary disease. Review of the Minimum Data Set (MDS) discharge-return anticipated assessment dated [DATE] revealed Resident #69 had moderately impaired cognition and was always continent of bowel and occasionally incontinent of bladder. The resident required set up assistance with eating, supervision with oral hygiene and bed mobility, moderate assistance with toileting, dressing, bed mobility and transfers. Bathing was not attempted. Review of the record revealed the resident was sent to the hospital on [DATE] where he stayed until 11/22/24. On 11/22/24 he returned to the facility where he remained until 11/26/24. On 11/26/24 he was sent back to the hospital until 12/04/24 when he returned to the facility. Review of a nursing progress note dated 11/13/24 authored by Registered Nurse #242 revealed Resident #69 arrived at the facility via stretcher accompanied by two personnel. Resident #69 was escorted to his room, and self-transferred to bed. The resident had two bags, medications, and after visit summary (AVS) present with resident at time of transfer. Alert and oriented times three, oriented to room and admission assessment completed and documented. Review of physician orders revealed an order dated 11/13/24 for Resident #69 to be administered Methadone HCl (opioid)10 milligram (mg) tablet, give one tablet by mouth every 12 hours for pain. The order was discontinued on 11/22/24. Resident #69 had an order for Methadone HCL 10 mg tablet give one by mouth every 12 hours for pain, dated 11/22/24. The order was discontinued on 12/04/24 Review of the Medication Administration Record (MAR) for November 2024 revealed the facility did not administer Methadone HCl 10 mg, to Resident #69 as ordered on 11/13/24 at 9:00 P.M., 11/23/24 at 9:00 A. M. and 9:00 P.M.; 11/24/24 at 9:00 A.M. and 9:00 P.M.; and 11/25/24 at 9:00 A.M. and 9:00 P.M. Review of nursing progress notes revealed no documentation was present for Methadone HCl 10 mg., give one tablet by mouth every 12 hours for pain not being administered to Resident #69 on 11/13/24 at 9:00 P.M. Review of a nursing note dated 11/23/24 at 11:46 A.M. revealed Methadone HCl 10 mg was not available and needs a signed prescription. The prescription was sent to physician for signature. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing note dated 11/24/24 at 10:38 A.M. revealed Methadone HCl 10 mg for pain was unavailable. The prescription his been sent to the physician and awaiting signature. Resident instructed to notify Registered Nurse (RN) of any withdrawal signs and symptoms and advised that resident could go back to hospital if needed. Review of a nursing note dated 11/24/24 at 9:56 P.M. revealed Methadone HCl 10 mg was on order. Review of a nursing note dated 11/25/24 at 9:27 A.M. revealed Methadone HCl 10 mg, give one tablet by mouth every 12 hours for pain has been ordered. Review of a nursing note dated 11/25/24 at 10:05 P.M. revealed Methadone HCl 10 mg give was on order. Telephone interview on 12/06/24 at 11:13 A.M. with the Director of Nursing verified the facility did not administer Methadone HCl 10 mg as ordered by the physician, and the resident did not receive doses on 11/13/24 at 9:00 P.M., 11/23/24 at 9:00 A.M. and 9:00 P.M.; 11/24/24 at 9:00 A.M. and 9:00 P.M.; and 11/25/24 at 9:00 A.M. and 9:00 P.M. as ordered by the physician. Email response on 12/06/24 at 2:07 P.M. from the Director of Nursing (DON) revealed, when asked what the facility procedure was when medications are not available, the DON responded staff would be expected to first check to see if the medication was available in the Pyxis machine (an automated medication dispensing system). If it is a narcotic, obviously the nurse would need to have authorization to pull the medication. If the medication is not available in the Pyxis, then the practitioner would need to be notified to see if we could get a prescription, or how the resident can get the medication. When a medication is not given or available, the practitioner should be notified to see what kind of orders they would like to give. The nurse should document these actions in the resident record. This deficiency represents non-compliance investigated under Complaint Number OH00160442.