STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365271	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage Inn of Steubenville	3102 St Charles Drive 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 - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of a facility self-reported incident (SRI), review of the facility investigation, facility policy review, and interview, the facility failed to ensure residents were free from misappropriation of medications. This affected 13 (Resident #1, #3, #4, #8, #12, #15, #16, #17, #18, #19, #20, #21, and #22) of 13 residents reviewed for misappropriation. The facility census was 99. Findings include: Review of the Self-Reported Incident (SRI) Tracking Number 251396, dated 08/31/24, revealed on 08/31/24, a concern was reported related to missing medications from Licensed Practical Nurse (LPN) #400's medication cart. On 08/31/24 at approximately 1:00 P.M. the Administrator was watching video cameras and noticed suspicious activity by LPN #400 while she was administering medications. LPN #400 was observed going through the narcotics drawer but not having the medication administration record (MAR) pulled up or documenting on the narcotic count sheets. LPN #400 was immediately suspended pending investigation. An immediate investigation was initiated. During a medication audit on 08/31/24 at 4:30 P.M., completed by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), it was determined that medications in the cart were unaccounted for, and several routine medications were found in the top drawer of the medication cart. These medications were identified by their imprint code on the medication and compared with resident medication profiles to establish who the medications belonged to. Routine medications in Paxits (a secure bag containing medications scheduled at a specific time of the day with clearly labeled medication information printed on the bag) were found discarded in the trash. Controlled substances were unaccounted for and not documented on MARS or on narcotic count sheets. 1. Review of the medical record for the Resident #1 revealed an admitted [DATE]. Diagnoses included dementia, psychotic disorder with hallucinations, adult failure to thrive, acute respiratory failure, and myasthenia gravis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/24/24, revealed the resident had severe cognitive impairment. (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's SRI investigation revealed Resident #1 was not administered risperidone 0.5 milligrams (mg) on 08/31/24 at 12:00 P.M. or buspirone 15 mg on 08/31/24 at 2:00 P.M. as ordered by the physician. 2. Review of the medical record for the Resident #3 revealed an admitted [DATE]. Diagnoses included dementia, muscle wasting and atrophy, depression, anxiety disorder, and irritability and anger. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/08/24, revealed the resident had severe cognitive impairment. Review of the facility's SRI investigation revealed Resident #3 was not administered Prednisone 10 mg and sertraline 25 mg on 08/31/24 at 9:00 A.M. as ordered by the physician. Further review of Resident #3's Controlled Drug Receipt/Record/Disposition Form for oxycodone 5 mg indicated there should have been 47 pills remaining, however, there were only 46 pills remaining without documentation of administration of the oxycodone. 3. Review of the medical record for the Resident #4 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, diabetes mellitus, chronic kidney disease, cerebral vascular disease, and repeated falls. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/09/24, revealed the resident had moderate cognitive impairment. Review of the facility's SRI investigation revealed Resident #4 was not administered metoclopramide 5 mg on 08/31/24 at 11:00 A.M. and gabapentin 400 mg on 08/31/24 at 2:00 P.M. as ordered by the physician. 4. Review of the medical record for the Resident #8 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, muscle wasting and atrophy, anxiety disorder, dysphagia, and repeated falls. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/08/24, revealed the resident had severe cognitive impairment. Review of the facility's SRI investigation revealed Resident #8 was not administered Depakote Sprinkle 125 mg, two tablets, on 08/31/24 at 9:00 A.M. as ordered by the physician. 5. Review of the medical record for the Resident #12 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, muscle wasting and atrophy, anxiety disorder, dysphagia, and repeated falls. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/04/24, revealed the resident had moderate cognitive impairment. Review of the facility's SRI investigation revealed Resident #12's Controlled Drug Receipt/Record/Disposition Form for oxycodone 10 mg indicated there should have been 11 pills remaining, however, there were only nine pills remaining and without documentation of administration. During interview on 08/31/24 with Resident #12, she stated she had not requested pain medication on that day. (continued on next page)

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F 0602

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

6. Review of the medical record for the Resident #15 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, adult failure to thrive, anxiety disorder, dysphagia, and unsteadiness on feet.

Review of the annual Minimum Data Set (MDS) assessment, dated 06/08/24, revealed the resident had severe cognitive impairment.

Review of the facility's SRI investigation revealed Resident #15's Controlled Drug Receipt/Record/Disposition Form for lorazepam 0.5 mg indicated there should have been 53 pills remaining, however, there were only 52 pills remaining and without documentation of administration.

7. Review of the medical record for the Resident #16 revealed an admitted [DATE]. Diagnoses included dementia, depression, catatonic disorder, anxiety disorder, morbid obesity, and weakness.

Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/30/24, revealed the resident had severe cognitive impairment.

Review of the facility's SRI investigation revealed Resident #16's Controlled Drug Receipt/Record/Disposition Form for lorazepam 0.5 mg indicated there should have been 55 pills remaining, however, there were only 52 pills remaining and without documentation of administration. Further review of Resident #16's Controlled Drug Receipt/Record/Disposition Form for Oxycodone 5 mg indicated there should have been 51 pills remaining, however, there were only 48 pills remaining without documentation of administration.

8. Review of the medical record for the Resident #17 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, anemia, heart failure, neuropathy, chronic kidney disease, and osteoarthritis.

Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/20/24, revealed the resident had intact cognition.

Review of the facility's SRI investigation revealed Resident #17 was not administered Gabapentin 800 mg on 08/31/24 at 2:00 P.M. as ordered by the physician. Further review revealed Resident #17's Controlled Drug Receipt/Record/Disposition Form for oxycodone 10 mg indicated there should have been 28 pills remaining, however, there were only 26 pills remaining without documentation of administration.

9. Review of the medical record for the Resident #18 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis, aphasia, chronic obstructive pulmonary disease, anxiety disorder, and alcohol abuse.

Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/01/24, revealed the resident had severe cognitive impairment.

Review of the facility's SRI investigation revealed Resident #18 was not administered Baclofen 20 mg on 08/31/24 at 2:00 P.M. as ordered by the physician. Further review revealed Resident #18's Controlled Drug Receipt/Record/Disposition Form for oxycodone 5 mg indicated there should have been 20 pills remaining, however, there were only 19 pills remaining without documentation of administration.

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NAME OF PROVIDER OR SUPPLIER Carriage Inn of Steubenville		STREET ADDRESS, CITY, STATE, ZIP CODE 3102 St Charles Drive Steubenville, OH 43952	

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Review of the medical record for the Resident #19 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, anemia, heart failure, neuropathy, chronic kidney disease, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/18/24, revealed the resident had moderate cognitive impairment. Review of the facility's SRI investigation revealed Resident #19 was not administered Hydralazine 50 mg on 08/31/24 at 2:00 P.M. as ordered by the physician. 11. Review of the medical record for the Resident #20 revealed an admitted [DATE]. Diagnoses included dementia, depression, anxiety disorder, dysphagia, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/09/24, revealed the resident had severe cognitive impairment. Review of the facility's SRI investigation revealed Resident #20's Controlled Drug Receipt/Record/Disposition Form for tramadol 50 mg indicated there should have been 38 pills remaining, however, there were only 37 pills remaining and without documentation of administration. 12. Review of the medical record for the Resident #21 revealed an admitted [DATE]. Diagnoses included schizophrenia, anxiety disorder, anemia, and obesity. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/23/24, revealed the resident had severe cognitive impairment. Review of the facility's SRI investigation revealed Resident #21's Controlled Drug Receipt/Record/Disposition Form for lorazepam 0.5 mg indicated there should have been 24 pills remaining, however, there were only 22 pills remaining and without documentation of administration. 13. Review of the medical record for the Resident #22 revealed an admitted [DATE]. Diagnoses included malignant neoplasm if rectosigmoid junction and lung, anxiety disorder, muscle wasting and atrophy, and anemia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/22/24, revealed the resident had intact cognition. Review of the facility's SRI investigation revealed Resident #22's Controlled Drug Receipt/Record/Disposition Form for lorazepam 0.5 mg indicated there should have been 42 pills remaining, however, there were only 41 pills remaining and without documentation of administration. Further review of Resident #22's Controlled Drug Receipt/Record/Disposition Form for oxycodone 10 mg indicated there should have been 32 pills remaining, however, there were only 30 pills remaining without documentation of administration. Further review of Resident #22's Controlled Drug Receipt/Record/Disposition Form for hydromorphone 2 mg indicated there should have been 4 pills remaining, however, there were only 3 pills remaining without documentation of administration. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation, initiated on 08/31/24, revealed LPN #400 was suspended immediately pending further investigation. LPN #400 denied misappropriating medications and resigned from employment at the facility via text messages sent to the DON. The allegation of misappropriation of medication was substantiated due to routine medications found in the trash without documentation of medication refusals (Controlled substances were also unaccounted for per SRI Tracking Number 251396). The facility could not prove without a reasonable doubt that LPN #400 had committed drug diversion. During interview on 09/19/24 at 9:39 A.M., the DON confirmed the LPN #400 did not properly administer medications and a medication cart audit revealed numerous routine pills, still in medication packets, had been thrown in the trash during LPN #400's shift, loose pills were found in the medication cart, and narcotic count sheets revealed discrepancies with unaccounted for medications. During interview on 09/19/24 at 12:39 P.M. the Administrator stated during observation of the facility's camera she noticed suspicious activity by LPN #400 during the medication administration pass. The medication cart was audited by the DON and ADON and numerous discrepancies were noted, and medications documented as having been administered were thrown in the trash. The Administrator stated LPN #400 was immediately suspended and ultimately resigned via a text message that was sent to the DON. The Administrator further stated the local police department was notified, and an investigation was initiated, incident number 24-009327. Review of the facility policy titled, Abuse, Neglect, and Exploitation, dated 06/30/23, revealed misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. As a result of the incident, the facility took the following actions to correct the deficient practice on 08/31/24: On 08/31/24, the Administrator immediately notified the Director of Nursing (DON) and Assistant Director of Nursing (ADON) of the potential misappropriation of resident medications. An SRI was filed through the Ohio Department of Health and an investigation completed. LPN #400 was immediately suspended. The investigation provided information that led the facility to believe that LPN #400 misappropriated resident medications by throwing them in the trash. On 08/31/24, the DON and ADON conducted medication cart audit for LPN #400's medication cart and found medications discarded in the trash and in top drawer of cart or not properly documented. On 08/31/24, the DON and ADON conducted physical assessments and interviews for all potentially affected residents with no negative findings. On 08/31/24, the DON and ADON reviewed medical records for discrepancies or missing medications and completed facility wide medication cart audits with no additional significant findings. On 08/31/24, all staff were educated on Abuse, Neglect, Misappropriation by the Administrator. Beginning on 08/31/24, all nursing staff had received training by the DON and/or ADON, before their shift on Medication Management, Administering Medications, Controlled Substance Administration and Accountability, and the Six Medication Rights. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/03/24, the Interdisciplinary Team (IDT) completed an Ad hoc Quality Assurance (QA) to discuss the incident and corrective action plan. DON or designee to complete random shift to shift narcotic count, random medication cart and medication administration audits daily for seven days, then weekly for three weeks, and then monthly for three months and as needed. All findings will be reviewed by the IDT weekly then reported to QAPI weekly and as needed. This deficiency represents non-compliance investigated under Complaint Number OH00157695