

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER Carroll Healthcare Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 648 Longhorn Street Carrollton, OH 44615	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653</p> <p>Based on medical record review and interview, the facility failed to ensure timely notification of a physician regarding a resident's change in condition. This affected one resident (#42) of three residents reviewed for change in condition.</p> <p>Findings include:</p> <p>Review of Resident #42's closed medical record revealed diagnoses including right hip fracture, type two diabetes mellitus, protein calorie malnutrition, anxiety disorder, adjustment disorder, and hypertension. Resident #42 was hospitalized from [DATE] to [DATE] after sustaining a fall and broken hip.</p> <p>A nursing note dated [DATE] at 5:30 A.M. indicated Resident #42's respiratory rate was 48 at 2:00 A.M. Blood pressure recording was ,d+[DATE], heart rate was 82 and oxygen saturation level was 92%. The On Call service was notified but no return phone call was received. At 3:30 A.M., Resident #42's respiratory rate was 44 and her oxygen saturation was 91%. The On Call service was contacted again but never returned a call.</p> <p>A nursing note dated [DATE] at 8:04 A.M. indicated Resident #42 expired at 6:26 A.M.</p> <p>A nursing note dated [DATE] at 8:57 A.M. indicated at 2:00 A.M. a state tested nursing assistant reported Resident #42 was breathing really fast. Vital signs were obtained. Another nurse also checked Resident #42. Oxygen was increased from two liters to 3.5 liters. The note indicated the family did not want Resident #42 sent out to the hospital. At 2:15 A.M. the head of the bed was elevated higher. Resident #42's respiratory rate was 44 and her oxygen saturation was 92%. At 2:30 A.M., Resident #42 was repositioned. Respiratory rate and oxygen saturation remained the same. At 2:45 A.M., Resident #42's respiratory rate was 44 but her oxygen saturation was 93%. At 3:00 A.M., the respiratory rate was 44, oxygen saturation was 91% and resident #42 was repositioned and a cool cloth was applied to the forehead. At 3:15 A.M., Resident #42's respiratory rate was 42 and oxygen saturation was 92%. At 3:30 A.M., the respiratory rate remained 42 and the On call services was notified again. At 4:00 A.M., Resident #42's respiratory rate was 44 and oxygen saturation was 91%. At 5:00 A.M., Resident #42 was repositioned. Respiratory rate remained 42 and oxygen saturation was 91%. At 6:20 A.M., Resident #42 was absent of vital signs with a second nurse verifying. Time of death was listed as 6:26 A.M. The family and physician were notified.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:17 P.M., during interview the Director of Nursing (DON) verified on [DATE] the nurses were unable to get the On Call physician service to respond to their phone calls related to Resident #42's change in condition. The DON stated the nurse could have phoned her and she could have attempted to contact the physician. However, nurses did not notify her of the failure of the On Call services physician to return calls. The DON indicated when she spoke to the physician he let the On Call services company know it was not acceptable for nurses phone calls not to be responded to. The DON reiterated the family did not want Resident #42 sent to the hospital.</p> <p>Review of the facility's Change in a Resident's Condition or Status policy (revised [DATE]) revealed the nurse would notify the resident's attending physician or physician on call when there had been a significant change in a resident's physical condition and there was a need to alter the resident's medical treatment significantly.</p> <p>Review of the facility's Emergency and/or Alternative Physician Care policy (revised [DATE]) revealed should an emergency arise and the resident's attending physician was not available, the emergency on-call must be contacted. Back up coverage may be provided by another licensed physician or physician group or an appropriately licensed and supervised mid-level practitioner, consistent with state regulations. Staff were to use appropriate procedures to contact physicians, depending on arrangements and the urgency of a situation. If a physician and his/her back up coverage did not respond in a timely or appropriate manner to facility notification of medical issues, the nursing staff were to contact the medical director for assistance.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155390.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, review of facility-reported incident (FRI) including investigation, observations, staff and resident interviews and review of policies, the facility failed to ensure a resident's narcotic pain medication was not misappropriated. This affected one resident (#4) of one resident reviewed related to a FRI.</p> <p>Findings include:</p> <p>Review of Resident #4's medical record revealed diagnoses included diabetes mellitus and chronic pain syndrome. An order with a start date of 12/25/23 was written for percocet (narcotic pain medication) 10/325 milligrams (mg) every six hours as needed for pain. The January 2024 Medication Administration Record (MAR) revealed Resident #4 was interviewed regarding pain every shift. The January 2024 MAR indicated the percocet was administered 14 times between 01/01/24 and 01/25/24. The morning of 01/26/24 a pain severity level of four on a scale of 0-10 was recorded. The MAR indicated percocet 10/325 milligrams was administered on 01/26/24 at 7:23 A.M.</p> <p>Review of facility FRI #243501 dated 01/26/24 revealed an allegation of misappropriation of Resident #4's narcotics by Licensed Practical Nurse (LPN) #150. The allegation was made by the Director of Nursing (DON) and Unit Manager #120. The report indicated there was a possible documentation discrepancy that was inconsistent with standard nursing practice.</p> <p>Review of witness statements obtained during the facility's investigation revealed Registered Nurse (RN #115) wrote he worked 01/24/24 from 6:00 A.M. to 6:00 P.M. When RN #115 administered percocet to Resident #4 at 6:45 A.M. there were more tablets remaining and the card was placed back into the medication cart. A witness statement with an illegible signature indicated the nurse worked the night of 01/25/24 and she noticed a change in the narcotic count from the day before but she did not take any cards/sheets out of the cart or the narcotic count book. When she flipped the sheet over there were several lines where LPN #150 had signed in and out several narcotic sheets. Some of the entries had the signature of another nurse who verified the information but one entry for Resident #4's percocet had a scribbly initial that was illegible. The statement indicated the nurse did not think much of it because of the second signature. The nurse indicated she did not witness removal of an narcotic sheets with LPN #150. RN #110 indicated she reported to work on 01/26/24 and did narcotic count with LPN #150 who then returned to south wing. RN #110 indicates she was questioned about the narcotic count sheet as it was missing but she reported it had been in the book when she and LPN #150 reconciled narcotics (The sheet in which the number of cards were verified.)</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/29/24 at 12:57 P.M., the DON stated on 01/26/24 it was reported to her that a narcotic count sheet was turned in for Resident #4 indicating the card had been used but there still should have been some percocet on the card. A search for the card revealed the card was gone. The narcotic count sheet was also missing. Both RN #110 and LPN #150 stated they had reconciled the narcotics and signed the sheet. During the course of the investigation it was found that LPN #150 was signing out narcotics but not documenting administration of the narcotics on the MAR on a consistent basis. The facility's cameras were reviewed. Images were not the clearest but they looked to see who might have approached the medication cart and removed the narcotic count sheet. The only one who was identified at the cart after the count was completed was LPN #150. At 1:49 P.M., the DON clarified when RN #110 counted narcotics with LPN #150 there was no percocet card in the drawer for Resident #4 and it had been signed off as removed by LPN #150 so she did not identify any discrepancies.</p> <p>Review of the facility's Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property policy (copyright 2016) indicated misappropriation of resident property was identified as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings without the resident's consent.</p> <p>Review of the facility's Controlled Substances policy revealed only authorized licensed nursing and/or pharmacy personnel should have access to Schedule II controlled drugs maintained on premises.</p> <p>Review of the facility's Controlled Substance Records for the Medication Cart (dated 01/15/24) indicated immediate reporting of any unresolved discrepancy was to be made to the DON or designee and pharmacy.</p> <p>As a result of the incident, the facility took the following actions to correct the deficient practice by 04/27/24:</p> <ol style="list-style-type: none"> 1. Immediately following the report of the missing narcotics, the DON verified the discrepancy between the narcotic count sheet and lack of percocet available. The discrepancy was reported to the Administrator. 2. On 01/26/24 at approximately 9:00 A.M., the DON initiated a review of all narcotics for availability/correct count. 3. On 01/26/24 at approximately 9:20 A.M., it was noticed there was a shift change narcotic count sheet missing from the mid-morning nurse change over on south wing between RN #110 and LPN #150. 4. On 01/26/24 around 9:45 A.M., the DON interviewed Resident #4 to check her pain level and determine if any pain medication was needed. Resident #4 denied pain. 5. On 01/26/24 at approximately 10:00 A.M., RN #110 was interviewed regarding the missing shift change sheet. RN #110 reported she signed the shift change sheet on south wing with LPN #150 at approximately 8:50 A.M. 6. On 01/26/24 at approximately 10:03 A.M., the DON attempted to contact LPN #150 for interview. A return call was received and LPN #150 was interviewed at approximately 10:55 A.M. LPN #150 stated she signed the narcotic shift change with RN #110 before leaving. <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7. On 01/26/24 at approximately 11:15 A.M., the DON and Administrator watched camera footage showing after RN #110 and LPN #150 signed off on the narcotic count sheet on south wing at approximately 8:52 A.M. , LPN #150 returned tot he south wing med cart at 9:01 A.M. for a brief period and left the facility at approximately 9:02 A.M. It was seen on the camera footage that LPN #150 appeared to be folding a piece of paper as she was exiting the building. RN #110 did not appear to return back to the south wing med cart after the shift count. Between 9:02 A.M. and 9:18 A.M. when the missing narcotic count sheet was noticed, no other staff members had gone over to the south wing med cart.</p> <p>8. On 01/26/24 at approximately 3:00 P.M., the DON notified Resident #4's daughter-in-law to notify of possible discrepancy and get permission to test for percocet in Resident #4's system.</p> <p>9. On 01/26/24 at approximately 3:55 P.M., RN #110 submitted to a reasonable suspicion drug test. The test showed negative results.</p> <p>10. On 01/26/24 at approximately 4:00 P.M., the Corporate [NAME] President (VP) of Operations and the Corporate Clinical Director informed the pharmacy of possible discrepancy.</p> <p>11. On 01/26/24 at approximately 4:33 P.M., LPN #150 submitted to a drug test. The results were negative. LPN #150 was suspended until the conclusion of the investigation.</p> <p>12. On 01/26/24 at approximately 5:30 P.M., new narcotic count sheets were initiated on the floor and staff were educated on the Controlled Substance policy via [NAME] Learning.</p> <p>13. On 01/30/24, an audit was run for all residents on percocet. Three residents (Residents #4, #11 and #12) were identified. Resident #4 had one narcotic count sheet from 12/19/23 unaccounted for. A second sheet delivered on 12/21/23 for 30 tablets was turned in with five unaccounted pills. A third sheet was started on 01/25/24 at 2:00 P.M. by LPN #150. Resident #12's percocet counts were all accounted for with no issues identified. Resident #11 had four narcotic count sheets unaccounted for.</p> <p>14. On 01/30/24, an audit form for narcotic count sheets was initiated to be completed by the DON or designee.</p> <p>15. On 01/30/24 at approximately 1:00 P.M., LPN #150 was called in for a second interview.</p> <p>16. On 01/30/24 at approximately 2:15 P.M., LPN #150 arrived for a second interview with the Administrator, DON, Corporate VP of operations and Corporate Clinical Director.</p> <p>17. On 01/31/24 at approximately 10:45 A.M., the Administrator notified local police department of the drug discrepancy. The police office stated they would send an officer to the facility to start a report.</p> <p>18. On 01/31/24 at approximately 11:15 A.M., the DON called and spoke to Resident #11's husband and let him know there was missing documentation sheets for narcotics. The husband was told errors did exist and an investigation was completed. Resident #11's husband was informed the MAR indicated all scheduled doses of the percocet were administered.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>19. On 01/31/24 at approximately 1:40 P.M., a police officer arrived and dropped off statement sheets and asked the facility to gather all documentation the facility could provide pertaining to the incident so he could piece together his timeline and report.</p> <p>20. On 01/31/24 at approximately 1:53 P.M., the Administrator filed a complaint through the board of nursing regarding LPN #150.</p> <p>21. On 02/01/24 at approximately 9:20 A.M., LPN #150 was terminated due to nursing practices identified during the investigation.</p> <p>22. On 02/01/24 at approximately 11:24 A.M., the Administrator contacted the police department to inform him the requested information was ready for retrieval. An officer arrived at approximately 2:12 P.M. and information was provided.</p> <p>23. On 02/01/24, results from Resident #4's drug test revealed percocet was found in Resident #4's system.</p> <p>24. Review of Quality Assurance (QA) topic sheets revealed narcotics and the plan of correction was reviewed monthly from February through May 2024.</p> <p>25. Review of audit sheets revealed the narcotic audits were begun 01/28/24 three times a week to check that all narcotics were accounted for and documentation on the MARs and narcotic count sheets matched. The audits continued three times a week through the end of March 2024. On 03/31/24 the audits were decreased to weekly and continued through 04/27/24. No further discrepancies were identified.</p> <p>During the survey on 07/29/24 between 7:45 A.M. and 4:55 P.M., all narcotics were reconciled with no discrepancies identified. No residents were overheard complaining of or exhibiting signs of pain. Resident interviews with Residents #4, #22, #31, #32, #36, #37 and #41 revealed no concerns related to pain or availability of medication.</p> <p>This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00155390.</p>		