STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365579	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carroll Healthcare Center Inc	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility Quality Assurance plan, the facility failed to ensure resident possessions were maintained securely and treated with respect. This affected three residents (#41, #42 and #43) of three closed resident records reviewed.Findings Include:Review of the complaint log revealed the facility lockbox was misplaced affecting Resident's #41 and #42. The result stated it was believed facility lock box was thrown away when the office was cleaned. The resident's families were notified. The Police were notified. The residents' families did not state they felt anything was stolen.The facility was asked for an investigation into the missing lockbox. The paperwork provided included a progress note from Resident #41's record. Review of the progress note indicated the resident expired on [DATE] at 8:45 AM. Eyeglasses, wristwatch and a signet ring were sent with the remains at 1:30 PM. On [DATE] at 4:01 P.M. social service spoke with the resident's granddaughter and resident's son-in-law who came to collect personal belongings. On [DATE] at 11:35 A.M. there was a progress note by Registered Nurse (RN) #51. The progress note revealed:This nurse helped clean out the office when a new social service designee started towards the end of May. There was a medium size lockbox in the cabinet. I set it on top of paperwork to be stored in medical records. This week staff went to look for the lock box and it had been misplaced. I did look with the administrator for the missing lockbox and it has not been found as of now. Resident had a wallet placed in the lock box in March because he was leaving it throughout the facility. We did tell the granddaughter last evening that the lock box has been misplaced and she understood. Today the son-in-law stopped wanting the wallet and the administrator expressed to him that we are doing everything we can to find the lockbox. Son-in-law did express there was nothing significant in the wallet maybe a Social Security card but he did not know what was in there. Will continue to look for lock box.Review of the facility investigation revealed Resident #42's progress notes were included which indicated on [DATE] at 3:20 P.M. the administrator called son to inform him that the facility lockbox that contained the resident's checkbook had been misplaced when the social service designated office was cleaned out for a new social service designee to come in. Resident's son stated he would call the bank and cancel all checks for the time being until a new checkbook could be ordered. Resident's son informed that facility will reimburse for new checkbook. The investigation included a Police report that was obtained on [DATE] that revealed Resident #41's family notified the police of the missing lock box on [DATE]. The facility did not notify the police of the missing lock box. The police report dated [DATE] at 10:15 A.M. included the Administrator believed the lockbox was accidentally thrown out. The police informed the Administrator the family would like the wallet back because of sentimental value.Review of the investigation revealed Housekeeping Staff #53 had an undated written statement in the paperwork provided. The statement included she threw away office garbage, whatever management asked her to. She did not recall throwing away a lock box or brown box. She took labeled boxes for medical records to the basement. She threw away a wooden desk and old vases. She had spent the last one to two weeks looking for the lock box/brown box.Review of facility documentation revealed there was a Quality Assurance and Performance Improvement (QAPI) plan dated [DATE] that included the previous social service designee did not inform new social service designee there was a lockbox with items in it. The new social service designee did not know there was a lockbox in the office with items inside to keep track of it. Social Service office cleaned out by corporate office. No list/log kept of what was in the lock box. Box had not been used/needed in five months. The action plan was the new lock box was to be bolted down. Computerized log kept of when items go in/out, whose items go in/out, whose items are in there, date of when items go in/out, and who is putting in/taking out the items. Two keys given to social services designee and Administrator. Monthly audits of lockbox to ensure items on log are in lockbox. The QAPI plan did not include a new policy for the handling of resident items to be placed in the facility lockbox. There were no in-services to educate staff on the new process. The QAPI plan did not include verifying what is contained in a wallet or purse with the resident and witness before locking in the lock box. Further, there were no guidelines on completing a thorough investigation. Interview with [DATE] at 3:22 P.M. with RN #51 revealed she started in April (2025) cleaning out a social service office for a new hire. Social Service #52 was going to split her time between two buildings and was leaving the office she used to the new Social Service designee. There was a lot of old paperwork in the office. Registered Nurse #51 was going through the cabinets, drawers, room and removing things. She finished cleaning on the last Tuesday in May.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and policy review, the facility failed to ensure infection control protocols were maintained when performing incontinence care. This affected one resident (#28) of one resident observed for incontinence care The facility identified nine always incontinent residents.Findings Include:Observation on 09/10/25 at 11:02 A.M. of incontinence care for Resident #28 with Certified Nurse Aide (CNA) #50 revealed the CNA washed her hands, and put a barrier on the overbed table. The CNA placed a basin of warm water on the table with towels, washcloths, shampoo and body wash, barrier cream and plastic trash bags. The CNA provided privacy with the use of a bath blanket to cover the resident's pelvic area. The CNA released the incontinence brief, soaked a washcloth with water and applied a body wash. The CNA cleansed the resident from front to back appropriately, changing areas on the washcloth with each wipe and repeated the process with rinse water. The CNA dried the resident with a towel and the resident rolled to her right side and the process was repeated using the professionally accepted standard technique. Once completed, the CNA applied barrier cream, rolled the resident on to her back and fastened her clean incontinence brief. The CNA then pulled the resident's covers up to her chest, handed her the television remote control and used the bed control to lower the bed to the lowest level and elevate the bed all before removing the gloves which she had provided incontinence care with to the resident.Review of the undated facility policy for Incontinence/Perennial care included to rinse the area with warm water, pat dry, apply a small amount of lotion or prescribed ointment. Remove gloves and wash hands then return resident to clean, comfortable position. Clean the resident unit, provide clean linen as needed and return items to the appropriate place. At 11:18 AM interview with CNA #50 verified she did not remove her gloves after providing incontinence care before touching the resident's bed covers television remote control, and bed control. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2564038.