

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2025
NAME OF PROVIDER OR SUPPLIER  Alpine Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  164 Office Park Drive Xenia, OH 45385	

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 - Few	Protect each resident from the wrongful use of the resident's belongings or money.  (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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff interview, review of Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to prevent the misappropriation of resident medications. This affected one (Resident #35) of three residents reviewed for misappropriation. The facility census was 72 residents. Findings include: Review of the medical record for Resident #35 revealed an admission date of 10/31/22 with diagnoses including congestive heart failure, schizoaffective disorder bipolar type, generalized anxiety disorder, and chronic pain syndrome. Review of the Minimum Data Set (MDS) assessment for Resident #35 dated 07/18/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of the controlled substance administration record for Resident #35 revealed 30 hydrocodone-acetaminophen 5-325 milligrams (mg) tablets were dispensed on 05/16/25. The administration record indicated there should be 19 doses remaining. Review of the record of disposal for controlled substances revealed the hydrocodone-acetaminophen tablets dispensed for Resident #35 on 05/16/25 with an original quantity of 30 tablets indicated 15 tablets had been destroyed on 06/13/25. Review of the facility SRI regarding Resident #35 dated 06/13/25 revealed a blister pack of the resident's hydrocodone-acetaminophen which was scheduled to be destroyed had gone missing. The facility began an investigation, and the blister pack was found in Resident #18's room with 15 pills remaining. Resident #18 reported he was unaware how the medication ended up in his room. The SRI indicated the Director of Nursing (DON) had removed multiple controlled substances from a locked drawer and had them on her desk to destroy when Housekeeping Supervisor (HS) #300 came to the office to vacuum. The DON walked to the front side of the desk while HS #300 vacuumed. The DON and additional nursing staff then began wasting the controlled substances and discovered the blister pack was missing. Interview on 08/05/25 at 10:33 A.M. via telephone with HS #300 confirmed she had been terminated because of a failed drug test. HS #300 stated she found a plastic bag in the conference room with the blister packs of medication and removed one from the plastic bag. HS #300 reported she opened four pills from the pack and took them before discarding the blister pack with the remaining pills in Resident #18's room because it was across the hall from the conference room. HS #300 stated she then pretended to have found the blister pack in Resident #18's room. Interview on 08/05/25 at 3:04 P.M. with Human Resources Director (HRD) #12 confirmed HS #300 admitted to taking Resident #35's medication. HRD #12 confirmed HS #300 was terminated. Review of the undated facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property undated revealed the facility would not tolerate the misappropriation of resident property. The deficient practice was corrected on 06/19/25 when the facility implemented the following corrective actions: On 06/13/25, the DON and/or designee investigated and determined Resident #35 had not missed any doses of medication as the medication had been discontinued. On 06/13/25, the DON and/or designee completed initial audits of residents on controlled substances with no other discrepancies identified. By 06/19/25, the Administrator, the DON, and Assistant Director of Nursing (ADON) #14 educated all staff on the abuse, neglect, exploitation, and misappropriation policy. On 06/19/25, HS #300 was terminated. Starting on 08/05/25, the DON and/or designee will monitor/audit residents on controlled substances once weekly as an ongoing part of the facility's performance improvement plan. This deficiency represents noncompliance investigated under Self-Reported Incident Control Number OH00167073 (iQIES Number 1359708.)</p>		