

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365629	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2024
NAME OF PROVIDER OR SUPPLIER  Dixon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  135 Reichart Avenue Wintersville, OH 43953	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26706</p> <p>Based on interview, activity calendar review, and record review, the facility failed to ensure residents right to self determination when the facility van was not available to transport residents to the bank, appointments and community activities. This affected two residents (#2,#10) of three residents reviewed for banking transportation and one resident (#6) of three residents reviewed for medical appointment transportation.</p> <p>Findings include:</p> <p>1. Record review of Resident #6 revealed a [DATE] admission with diagnoses including major depressive disorder, Vitamin D deficiency, muscle weakness, alcoholic polyneuropathy, iron deficiency anemia, and anxiety disorder.</p> <p>Review of the [DATE] Quarterly Minimum Data Set Assessment included the resident was independent for daily decision making, and walked with supervision.</p> <p>Review of [DATE], 2:50 P.M. nurse note entered by Registered Nurse (RN) #146 revealed the resident had new appointments for a mammogram on [DATE] at 12:45 P.M. and the Pain Center on [DATE] at 8:48 A.M. The appointments were placed in the appointment book and the resident was aware.</p> <p>Interview on [DATE] at 9:01 A.M. with Resident #6 revealed the resident had a mammogram scheduled for [DATE] and the facility did not arrange transportation for her despite her giving them a week notice and inquiring the day prior to the test. The nurse tried to arrange the day prior and all the transport companies were booked. She indicated she took a taxi and paid 25 dollars for transportation.</p> <p>Interview on [DATE] at 9:42 A.M. with State tested Nurse Aide (STNA) #132 included she knows she told the nurse a week ahead of time of Resident #6's mammogram. The day before the mammogram she checked to see if transportation was arranged and it was not.</p> <p>Interview on [DATE] at 9:47 A.M. with the Administrator revealed the facility does not have a company van to use for transportation. They had not had a functioning van for about a year. They use three outside agencies for transports. She did not know why the facility did not arrange transportation but she would reimburse the resident for the cost of the taxi. There</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 9:47 A.M. with the Director of Nursing revealed the mammogram appointment was on the books. She verified there was no transportation arranged by the facility.</p> <p>2. Review of Resident #2's medical record revealed a [DATE] admission with diagnoses including type 2 diabetes, hypertension, hyperlipidemia, chronic atrial fibrillation, stimulant abuse, gastro-esophageal reflux disease, cerebral vascular disease, and retention of urine.</p> <p>Review of the [DATE] Admission MDS included the resident was severely impaired for daily decision making, and had not attempted to walk.</p> <p>A [DATE] 1:44 P.M. Social Service Designee (SSD) #105 note included the resident assisted Resident #2 with calling Huntington Banking. Huntington confirmed a new debit card was sent to resident's previous address. Writer called son who reportedly will collect the mail and send it here.</p> <p>Interview on [DATE] at 5:13 P.M. with Social Services Designee (SSD) #105 revealed she had several residents who needed van transportation to the bank. Since the facility did not have a van it has been difficult getting them there. They did borrow a sister van to transport one resident.</p> <p>Interview on [DATE] at 4:57 P.M. with SSD #105 revealed Resident #2 needs to go to the bank because his debit card is expired and he did not receive a new one in the mail. What mail he did receive forwarded from his son, did not have a new debit card from Huntington bank. She helped facilitate a call to the bank knowing they would want to specifically speak with him. He had the ability to get a debit card from mobile banking but he did not know what the answers to the security questions were so he was locked out. The bank would not put the request for a debit card through over the phone. He had no one on the account with him who could change things on his behalf. He would put his son on the account but he lived four hours from his son and they both have to be at the bank. They could not do a change of address over the phone because he could not tell them his last deposits or withdraws so he needs to go in person. He needs to go in a van. Two of the transport companies only transport for medical needs. They do not have a facility van to take him.</p> <p>Interview on [DATE] at 9:47 A.M. with the Administrator revealed the facility does not have a company van to use for transportation. They had not had a functioning van for about a year.</p> <p>An email dated [DATE] from the Administrator revealed she made arrangements for Resident #2 to be transported to the bank on [DATE].</p> <p>3. Review of Resident #10's medical record revealed a [DATE] admission with diagnoses including type 2 diabetes, chronic kidney disease, gastroesophageal reflux disease, hypertension, obstructive sleep apnea, neuromuscular dysfunction of bladder, hemiplegia and hemiparesis, hyperlipidemia, major depressive disorder, epilepsy, disorder of the thyroid, benign prostatic hyperplasia with lower urinary tract symptoms, schizoaffective disorder and sleep disorder.</p> <p>Review of the [DATE] MDS included the resident was independent for daily decision making, no behaviors, had functional impairment upper and lower extremities bilaterally, utilized the wheelchair and did not attempt to walk.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A SSD #105 note dated [DATE] at 11:23 A.M. included she spoke to the residents' family and his checks were being directed to PNC bank. A [DATE] SSD#105 note included Resident #10's brother had no bank statements, social security card or birth certificate.</p> <p>A [DATE] SSD note included she called PNC bank services to order a new debit card. The resident was to be receiving a new debit card in the mail to the facility within eight business days.</p> <p>A [DATE] SSD #105 note included the writer assisted the resident with calling PNC bank to reorder a debit card. PNC Bank stated it would be delivered here between [DATE] and [DATE].</p> <p>A [DATE] SSD note included she assisted Resident #10 with contacting PNC bank regarding ordering a new debit card. After contacting customer care, it was determined the resident needed to visit a branch location for services.</p> <p>Interview [DATE] at 4:57 P.M. with SSD #105 revealed Resident #10 needs to go to the bank in person. His brother and sister said they are not on the account. The address on his account is the address of the house he lived in with his mother. The mother is deceased and the house demolished. The brother brought original birth certificate, original Social Security card and old bank statement that was a new card activation. The resident has not seen or used his debit card in a long time. The new debit card was sent to the old address which no longer exists. The bank did transfer his address to the facility but he can not get a debit card through mobile banking because he was unable to remember the answers to his security questions and was locked out of his banking. He needs to go to the bank in person and the facility does not have a van to transport him.</p> <p>An email dated [DATE] from the Administrator revealed she made arrangements for Resident #10 to be transported to the bank on [DATE].</p> <p>4. Interview on [DATE] at 12:52 P.M. with Activities #92 revealed since [DATE] when she started in activities she has not had access to a van to take residents shopping or to community activities. In the last two years they rented a charter bus to take Veterans on an outing. They also arranged an outing to [NAME] Buffalo Park. They would love to take residents to see Christmas lights, to the store to do their own shopping, out to eat or to fun community events.</p> <p>Review of monthly activity calendars revealed the facility did not have planned activities off the property of the nursing home.</p> <p>Interview on [DATE] at 9:47 A.M. with the Administrator revealed the facility does not have a company van to use for transportation. They have not had a functioning van for about a year. She verified they did not have a van to transport residents on outings which could affect all the residents in the facility who would like to attend.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155294.</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>26706</p> <p>Based on observation and interview, the facility failed to ensure resident mail and packages was delivered unopened and on the weekends. This affected three residents (#2, #6 and #7).</p> <p>Findings include:</p> <p>1. Review of Resident #6's medical record revealed a 01/16/24 admission with diagnoses including major depressive disorder, Vitamin D deficiency, muscle weakness, alcoholic polyneuropathy, iron deficiency anemia, and anxiety disorder.</p> <p>Review of the 05/27/24 Quarterly Minimum Data Set Assessment included the resident was independent for daily decision making, and walked with supervision.</p> <p>Interview on 07/10/24 at 9:01 A.M. with Resident #6 revealed the resident has been attempting to get social security disability to get into an assisted living on a waiver. Two weeks ago Social Services Designee (SSD) #105 brought her mail from the social security office that had been opened with a clean cut like a letter opener. When she asked why it was opened she said sometimes people here try to outrun the system and open mail.</p> <p>Interview on 07/10/24 at 9:40 A.M. with Human Resources #145 revealed she lets a resident in and out the door on weekdays to get the mail from the mailbox. He places it on her desk. He does not open it. She has not seen mail come open. She puts the mail in the business office mailbox when it is sorted by personal and by what looks like checks that should go to the business office. The activity department gets the personal mail to deliver.</p> <p>Interview on 07/10/24 at 5:13 P.M. with SSD #105 revealed when she came in about two weeks ago the open mail from social security was in her mailbox. She checks her mailbox daily. She will get some magazines. She might get applications passport or home choice. The mail with the social security mail for Resident #6 was handed to her by Business Office Manager (BOM) #89. She said the mail was opened when she handed it to her. SSD #105 said she did not take the mail out of the envelope from the social security office. She delivered it to Resident #6.</p> <p>At the time of the survey, BOM #89 called off sick and was not available for interview.</p> <p>Interview on 07/10/24 at 9:40 A.M. with the Administrator verified Resident #6 received mail that had been opened. She included she questioned the staff who handled the mail and no one admitted to opening the mail. The Administrator revealed the facility does not have a mail policy.</p> <p>2. Review of Resident #2's medical record revealed a 05/07/24 admission with diagnoses including type 2 diabetes, hypertension, hyperlipidemia, chronic atrial fibrillation, stimulant abuse, gastro-esophageal reflux disease, cerebral vascular disease, and retention of urine.</p> <p>Review of the 05/14/24 Admission MDS included the resident was severely impaired for daily decision making, and had not attempted to walk.</p> <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 07/10/24 at 10:44 A.M. with Resident #2 revealed his son sent him his bills in a manila envelope a couple weeks ago. There were three pieces of opened mail in an open manila envelope. He did not mention it to anyone.</p> <p>Interview on 07/10/24 at 5:13 P.M. with SSD #105 revealed Resident #2 received a manila envelope that looked dirty and torn. She did not know when it was damaged.</p> <p>3. Review of Resident #7's medical record revealed a 10/17/23 admission with diagnoses including acute respiratory failure with hypoxia, paroxysmal atrial fibrillation, alcohol dependence, hypertension, multiple sclerosis, transient ischemic attack and cerebral infarction, chronic obstructive pulmonary disease, severe protein calorie malnutrition, nutritional anemia and insomnia.</p> <p>Review of a 05/06/24 quarterly MDS revealed the resident was independent for daily decision making.</p> <p>Interview on 07/10/24 at 10:56 A.M. with Resident #7 revealed on 07/05/24 he received an email his order from Walmart had been delivered and left by the front door. He said he did not receive the package until Monday 07/08/24 by Maintenance.</p> <p>Interview on 07/10/24 at 12:48 P.M. with Maintenance #103 revealed he saw the package in the foyer the day he took it to the resident. He did not know if anyone took the packages from the foyer and deliver them on the weekends.</p> <p>4. Interview on 07/10/24 at 12:52 P.M. with Activities #92 and Activities #130 revealed the activity department does not receive mail or deliver it on Saturday or Sunday. Activities #92 indicated if there was a piece of mail left from Friday it may be delivered on Saturday but they do not know if the mail is brought in from the mailbox on Saturday.</p> <p>Interview on 07/10/24 at 3:45 P.M. with Human Resource (HR) #145 revealed she spoke to nursing and a resident gets the mail on Saturday and gives it to nursing. Nursing puts the mail in the business office mailbox and it stays there until their next work day. HR #145 verified the facility did not deliver mail on Saturdays. HR #145 also indicated she did not know of anyone responsible for delivering packages on the weekends that are delivered for the residents.</p> <p>Interview on 07/10/24 at 9:40 A.M. with the Administrator revealed the facility did not have a mail policy.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155294.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26706</p> <p>Based on record review and interview, the facility failed to ensure new interventions were attempted to prevent recurring urinary tract infections. This affected one resident (#5) of three residents reviewed for urinary tract infections.</p> <p>Findings include:</p> <p>Review of Resident #5's medical record revealed a 09/25/23 admission with diagnoses including chronic congestive heart failure, type 2 diabetes, gastro-esophageal reflux disease, hypertension, hypothyroidism, angina pectoris, moderate protein calorie malnutrition, ischemic cardiomyopathy, transischemic attack and cerebral infarction, depression, dysphasia, obstructive and reflux uropathy, non-rheumatic mitral valve stenosis and altered mental status.</p> <p>Review of a 05/19/24 quarterly Minimum Data Set Assessment revealed the resident was independent for daily decision-making, dependent for toileting, personal hygiene and bathing. The resident had an indwelling urinary catheter at the time of the assessment and was frequently incontinent of bowel.</p> <p>The resident had an incontinence of bowels and functional bladder plan of care initiated 12/19/23. Interventions included check resident for incontinence, wash and dry perineum, changing as needed after incontinence episodes, observe for signs and symptoms of urinary track infections and report to medical provider. The resident used extra large disposable briefs. All interventions were dated 12/19/23.</p> <p>Review of laboratory testing revealed positive urinalysis for infection on:</p> <p>10/06/23 Enterococcus Faecalis</p> <p>10/29/23 Klebsiella Aerogenes</p> <p>11/21/23 probably contamination</p> <p>12/06/23 Escherichia Coli</p> <p>02/14/24 Proteus Mirabilis</p> <p>03/24/24 Providencia [NAME] II</p> <p>05/16/24 was mixed flora</p> <p>06/28/24 Enterococcus Faecalis</p> <p>06/29/24 Streptococcus salivarius and Streptococcus Sanguinus</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions beside antibiotic treatment included 10/30/23 straight cath with Foley one time only for urinary retention for one day. Leave Foley in place if more than 400 milliliter of of urine drained. Refer to urologist for urinary retention, and change Foley catheter as needed per physician order. A 11/04/23 order for Foley catheter care every shift and as needed with soap and water. Secure straps if applicable, document output every shift.</p> <p>There was no evidence of the facility providing inservice education on pericare when the resident had a positive urinalysis and culture for Escherichia Coli on 12/06/23.</p> <p>The resident consulted with the urologist on 12/13/23. She had her Foley catheter removed by nursing that morning and presented to the office for a trial void. It was the first time this urologist saw the resident and said the Foley was placed at an unknown time for an unknown reason. Her residual in the office was 21 milliliters and the urologist deemed the indwelling catheter as not necessary.</p> <p>Cranberry Oral Tablet 450 milligrams (MG) (Cranberry (Vaccinium macrocarpon)) was added 04/01/24.</p> <p>The resident saw the urologist 05/14/24 due to her daughter being concerned about her recurrent urinary tract infections and the altered mental status associated. The physician indicated unknown etiology for urinary tract infections. The resident was going to have a cystoscopy at the next visit on 06/11/24. The physician was going to check her previous CT scan, urogram, continue cranberry prophylaxis, and get urinalysis records, and cultures from the facility.</p> <p>The 06/11/24 consult was canceled by the urologist and she was in the hospital with sepsis on 07/01/24 when the 06/11/24 missed visit was rescheduled.</p> <p>There was no evidence of the nursing plan of care being updated due to seven urinary tract infections in nine months. There was no evidence of the facility providing education on incontinence care, increasing the frequency of incontinence care, increasing fluid intake or other measures to provide nursing interventions to reduce the amount of urinary tract infections. There were no revisions to the plan of care since initiated 12/19/23. The resident would test positive for a urinary tract infection and be treated with antibiotics. There was no increased surveillance demonstrated in an attempt to prevent the infections from reoccurring.</p> <p>Observation on 07/10/24 at 3:15 P.M. of pericare for Resident #5 revealed the facility used periwash spray on a disposable wipe to cleanse. State tested Nurse Aide (STNA) #132 pulled the sheet and blanket up to the residents chest before changing her gloves. She was wearing the same gloves she used to clean up a bowel movement.</p> <p>Review of an email dated 07/13/24 at 4:20 P.M. from the Administrator included the resident needs to clear the urinary infection before she can go for the procedures at the urology office. The facility indicated the initial plan of care had the needed interventions on it. There was no evidence of increased nursing measures provided due to the recurrent urinary tract infections.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155294.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>26706</p> <p>Based on menu review, dislike list, interviews, and photo, the facility failed to ensure a nourishing, palatable well balanced diet was served. This affected one resident (#6) of three residents reviewed for nourishing diets.</p> <p>Findings include:</p> <p>Review of Resident #6's medical record revealed a 01/16/24 admission with diagnoses including major depressive disorder, Vitamin D deficiency, muscle weakness, alcoholic polyneuropathy, iron deficiency anemia, and anxiety disorder.</p> <p>Review of the 05/27/24 Quarterly Minimum Data Set Assessment included the resident was independent for daily decision making, and walked with supervision.</p> <p>Interview on 07/10/24 at 9:01 A.M. with Resident #6 revealed on 05/27/24 she received a roll and mashed potatoes for supper. The resident had a time stamped photo of her meal tray. On 06/25/24 the resident received plain spaghetti noodles and peaches on her supper tray.</p> <p>Interview on 07/10/24 at 12:11 P.M. with Culinary Director #115 revealed it is possible to get only a few food choices or no entree on a meal tray. Culinary Director #115 indicated the computer program they use will eliminate all dislikes from a tray ticket. If a resident has both entrees on the dislike list they will not get one on their tray. The [NAME] should know to put something on in from the substitute list but not everyone does because they may get a complaint they did not want what was sent. Culinary Director #115 revealed they did not have a policy about how to handle a resident having a lot of dislikes.</p> <p>Review of the menu for 05/27/24 revealed the first entree country fried steak and second entree pork chops, both were on Resident #6's dislike list. She also doesn't get the vegetables served so she would have had mashed potatoes and a roll. She also gets a salad with lunch and supper. On 06/25/24 she would have received spaghetti noodles and the peaches because she had the first entree shrimp on her dislike list and the pizza is on her dislike list. She would not have received the zucchini but would have received a tossed salad.</p> <p>Interview 07/11/24 at 10:57 A.M, with Dietician #185 revealed he has been contracted by the facility for two years. The facility uses Mealtracker to enter dislikes and allergies. Mealtracker then produces the diet slips for each day and meal for the residents based their preference. Dietician #185 did not know did trays were coming out without an entree. He said he will work on having a plan in place if both entrees for the day are dislikes. He said it would be common sense not to send a tray out with just a roll and potatoes.</p> <p>Review of the facility, Dining and Food Preference policy (revised 09/2017) included the registered dietitian/nutritionist or other clinically qualified nutrition professional will review and after consultation with the resident, adjust the individuals meal plan to ensure adequate fluid volume and appropriate nutritional content for residents that do not consume certain foods or food groups.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>26706</p> <p>Based on observation, interview, and test tray, the facility failed to serve palatable chicken. This had the potential to affect all the residents in the facility except two residents (#36, #69) who do not receive nourishment from the kitchen. The facility census was 77 residents.</p> <p>Findings include:</p> <p>Observation of meal service on 07/10/24 at 11:28 A.M. revealed the chicken breast served to Resident #6 appeared dry. Resident #7 revealed he was ordering out because his chicken was dry. Resident #2 said he did not like the meal and was ordering a substitute.</p> <p>Observation of the kitchen on 07/10/24 at 11:42 A.M. revealed the tray line was finishing. The facility ran out of asparagus and provided green beans instead. There were less than a dozen chicken breast remaining. There was no juice in the pan with the chicken and the outside appeared dry.</p> <p>Interview on 07/10/24 at 11:44 A.M. interview with [NAME] #155 revealed he baked the chicken about 30 minutes.</p> <p>On 07/10/24 at 11:46 A.M. a chicken breast was tasted for palatability. The temperature of the chicken breast was 153.4 degrees. The chicken was tough to cut, The ends were dry and crispy. The chicken was tough to chew. The muscle fibers were hard to chew and swallow. The dry chicken was difficult to swallow.</p> <p>Interview on 07/10/24 at 11:55 A.M. with Culinary Director #115 verified the chicken did not have any juice running out of it and looked dry and fibrous when cut. Culinary Director #115 indicated he would instruct the [NAME] not to cook it as long.</p> <p>Interview on 07/10/24 at 4:43 P.M. with the Director of Nursing revealed she told the Administrator several residents complained to her about the chicken served at lunch. She asked for substitutes for them.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155294.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365629	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2024
NAME OF PROVIDER OR SUPPLIER  Dixon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  135 Reichart Avenue Wintersville, OH 43953	
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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>26706</p> <p>Based on interview, observation, and invoice review, the facility failed to ensure the facility was administered in a manner to enable it to use its resources effectively to maintain the highest practicable well being of each resident when the facility transport van has not been available for resident use for over one year. This had the potential to affect all the residents in the facility. The resident census was 77.</p> <p>Findings include:</p> <p>During the course of the investigation, the surveyor observed and determined the facility did not have transportation available to transport a resident to a doctor appointment. It was discovered the facility did not have a van for transportation or activities.</p> <p>Interview on 07/10/24 at 9:47 A.M. with the Administrator revealed the facility does not have a company van to use for transportation. They have not had a functioning van for about a year.</p> <p>Review of facility provided documentation and invoice revealed the lift in the facility van broke in June 2022. The van was out of service until 04/20/23 when it was repaired.</p> <p>Review of an email dated 07/11/24 at 11:42 A.M. from the Administrator verified the van was not in use from June 2022 until 04/20/23. The van went back into service after the 04/20/23 repair until August 2023.</p> <p>In August 2023 the van door was rusted, would not close and would not engage in drive. A mechanic came to the facility 08/31/23 and reported he could not order parts. There was no further evidence of action until 02/21/24 when a used car place was contacted. They assessed the van on 02/24/24 and informed the facility they would attempt to order parts. The Administrator contacted the used car dealership who reported they expect the parts to be in this month. He thinks they are the correct parts. The van is currently out of service. The van was in service for four of the last 25 months.</p> <p>There was no evidence of the facility attempting to purchase another vehicle. There was no evidence of the facility attempting to share a sister facility van except for two isolated times they borrowed the van from a sister facility to transport a resident.</p> <p>Interview on 07/10/24 at 6:50 P.M. with the Administrator revealed it takes a long time to get parts. The Administrator said there could be a year or two wait to get another van. She verified measures had not been put in place to routinely share a van with the closest sister facility so the residents could go on outings or appointments.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155294.</p>		

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NAME OF PROVIDER OR SUPPLIER  Dixon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  135 Reichart Avenue Wintersville, OH 43953	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>26706</p> <p>Based on observation, policy review, and interview, the facility failed to ensure sanitary pericare technique and availability of soap in the kitchen at the handwashing sink. This affected one resident (#5) who received personal care from staff and had the potential to affect all the residents in the facility except for two residents (#36, #69) who do not receive nourishment from the kitchen. The facility census was 77.</p> <p>Findings include:</p> <p>1. Observation on 07/10/24 at 3:15 P.M. of pericare for Resident #5 took place with State tested Nurse Aides (STNA) #132 and #108. After both STNA's gowned and gloved STNA #132 revealed the facility used periwash spray on a disposable wipe to cleanse the resident wiping from front to back, changing areas on the cloth and then dried with a towel. STNA #108 rolled the resident onto her left side. STNA #132 cleaned the bowel movement with a disposable wipe wet with periwash. After cleaning the bowel movement State tested Nurse Aide (STNA) #132 pulled the sheet and blanket up to the residents' chest before changing her gloves. She was wearing the same gloves she used to clean up the bowel movement.</p> <p>Review of the facility's Perineal Care Male and Female policy (dated 2018) included on page four under Final Step Procedures to remove gloves and discard into designated container. Perform hand hygiene, put on gloves, then reposition the bedcovers and make the resident comfortable and place the call light within reach.</p> <p>Interview on 07/10/24 at 3:35 P.M. with STNA #132 verified she touched the resident bedsheets and blanket, pulled them back up to cover her before she removed the gloves she had on when she cleaned the bowel movement.</p> <p>2. Observation of the kitchen on 07/10/24 at 11:42 A.M. revealed there was one handwashing sink. The sink did not have soap available for use.</p> <p>Interview on 07/10/24 at the 11:42 A.M. observation with [NAME] #155 verified there was not hand soap at the handwashing sink for the kitchen staff to wash hands. Not washing hands with soap could affect all the meals provided to residents.</p> <p>Interview on 07/10/24 at 11:44 A.M. with Dietary Aide #116 revealed they leave it up to housekeeping to change the soap. She indicated she washes her hands in the bathroom.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155294.</p>		