

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 10/31/2024
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701</p> <p>Based on medical record review, hospice provider self-reported incident review, review of a facility self-reported incident investigation, and staff interview, the facility failed to thoroughly investigate an allegation of missing narcotic medications. This affected one (Resident #8) of three residents reviewed for narcotic medication use. The facility census was 73</p> <p>Findings include:</p> <p>Review of Resident #8's medical record revealed an admitted [DATE] with diagnoses that included rheumatoid arthritis, adult failure to thrive and hypertension. Further review of the medical record revealed on 04/19/24 Resident #8 was prescribed the use of morphine sulfate (Roxanol, opioid analgesic medication) 20 milligram (mg) per one milliliter (ml) 0.25 ml every two hours as needed for pain. Review of the Medication Administration Record (MAR) revealed a total of 31 doses of medication administered between 04/21/224 and 07/19/24. Thirty-one 0.25 ml doses from a 30 ml bottle would equal 22.25 ml remaining in the 30 ml bottle.</p> <p>Review of the controlled drug administration record for Resident #8's Roxanol revealed a 30 ml bottle was provided to the facility on [DATE] and 29 doses were documented as administered for a total of 22.25 ml remaining in the bottle. However, 29 doses (0.25 ml per dose) from a 30 ml bottle would equal 22.75 ml remaining in the 30 ml bottle.</p> <p>Review of the Hospice provider's self-reported incident (SRI) revealed on 10/17/24 a discrepancy was noted on the facility controlled drug administration record for Resident #8. The SRI revealed that the controlled drug administration records indicated a total of 22.5 milliliters (ml) of morphine sulfate was to be remaining in the medication bottle. The hospice employee observed only 16 ml of medication remaining in the medication bottle, which indicated a total of 6.5 ml unaccounted for.</p> <p>Review of the facility SRI Tracking Number 253102 with a created date of 10/18/24 indicated an allegation of missing Roxanol. Review of the facility investigation revealed eight doses of medication were not signed out by staff on the controlled drug administration record and three doses were not signed out on the Medication Administration Record (MAR). Further review of the facility investigation identified a total of eight doses were not documented on the controlled drug administration record. Eight 0.25 ml doses would equal two ml, which would not make up the difference in the actual 16 ml in the medication bottle and 22.5 ml on the controlled drug administration record.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of a picture of a Roxanol medication bottle, taken by the Director of Nursing, revealed approximately 16 ml of medication was remaining in the bottle.</p> <p>Interview with the Director of Nursing on 10/31/24 at 10:40 A.M. verified documentation concerns of staff not documenting medication administrated on the controlled drug administration record and the MAR.</p> <p>Interview with the Administrator on 10/31/24 at 10:55 A.M. verified the facility did not complete a throughout investigation as the SRI investigation did not identify or address several missing doses of medication, approximately four ml.</p> <p>Review of the untitled facility policy titled Chain of Custody for Controlled Substances revealed that nurse will sign both the MAR and the Drug Count sheet when administering a controlled substance to a resident.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159154</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, hospice provider self-reported incident, facility self-reported incident investigation, and staff interview, the facility failed to accurately document medication administration in the medical record and controlled drug administration records. This affected one (Resident #8) of three residents reviewed for narcotic medication use. The facility census was 73</p> <p>Findings include:</p> <p>Review of Resident #8's medical record revealed an admitted [DATE] with diagnoses that included rheumatoid arthritis, adult failure to thrive and hypertension. Further review of the medical record revealed on 04/19/24 Resident #8 was prescribed the use of morphine sulfate (Roxanol, opioid analgesic medication) 20 milligram (mg) per one milliliter (ml) 0.25 ml every two hours as needed for pain. Review of the MAR revealed a total of 31 doses of medication were administered between 04/21/24 and 07/19/24. Thirty-one 0.25 ml doses from a 30 ml bottle would equal 22.25 ml remaining.</p> <p>Review of the controlled drug administration record for Resident #8's Roxanol revealed a 30 ml bottle provided to the facility on [DATE] and revealed 29 doses documented as administered and a total of 22.25 ml remaining. Twenty-nine 0.25 ml doses from a 30 ml bottle would equal 22.75 ml remaining.</p> <p>Review of the Hospice provider self-reported incident (SRI) revealed on 10/17/24 a discrepancy was noted to the facility controlled drug administration record for Resident #8. The SRI indicated that the controlled drug administration records indicated a total of 22.5 milliliters (ml) of morphine sulfate was to be remaining in the medication bottle. The hospice employee observed only 16 ml of medication remaining in the medication bottle, which indicated a total of 6.5 ml unaccounted for.</p> <p>Review of the facility SRI #253102 with a created date of 10/18/24 indicated an allegation of missing Roxanol. Review of the facility investigation revealed eight doses of medication not signed out by staff on the controlled drug administration record and three doses not signed out on the Medication Administration Record (MAR). Further review of the facility investigation identified a total of eight doses not documented on the controlled drug administration record. Eight 0.25 ml doses would equal 2 ml, which would not make up the difference in the actual 16 ml in the medication bottle and 22.5 ml on the controlled drug administration record.</p> <p>Observation of picture of Roxanol medication bottle taken by the Director of Nursing revealed approximately 16 ml of medication remaining in the bottle.</p> <p>Interview with the Director of Nursing on 10/31/24 at 10:40 A.M. verified the staff were not documenting medication administered on the controlled drug administration record and the MAR resulting in discrepancies between the two administration sources.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The deficiency was corrected on 10/28/24 after the facility implemented the following corrective actions:</p> <p>Root Cause Analysis was completed on 10/18/24 by the Administrator, Director of Nursing, Assistant Director of Nursing and Unit Manager. The root cause was determined to be related to staff not documenting the medication delivery on the MAR and narcotic sheet.</p> <p>Staff Education on Chain of Custody for Controlled Substances provided to 22 total nurses, seven Registered Nurses and 15 Licensed Practical Nurses. Sixteen were provided in person and six by phone. Completed on 10/23/24.</p> <p>Review of Resident #8's narcotic medication orders and count sheets by the Director of Nursing. Completed on 10/18/24.</p> <p>Review of all other residents utilizing narcotic medications by the Director of Nursing, Assistant Director of Nursing and Unit Manager was completed on 10/22/24.</p> <p>Audits of narcotic medication count sheets beginning on 10/28/24.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159154.</p>		