

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  03/20/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35765</p> <p>Based on closed medical record review, review of hospital records, review of an emergency medical service (EMS) report and EMS staff statements, review of facility Self Reported Incidents, review of a facility investigation, review of the facility dialysis policy and procedure, review of the facility Abuse/Neglect policy and procedure and interviews with staff, the coroner, and resident, the facility failed to prevent an incident of neglect when Resident #72 did not receive timely and necessary care to prevent major blood loss from his hemodialysis fistula site. This resulted in Immediate Jeopardy and Actual Harm with subsequent death beginning on [DATE], when Resident #72, who had intact cognition and required hemodialysis, was seen by dialysis staff, picking at his fistula site. The resident was educated not to pick at it and the resident stated he was a picker. Dialysis staff submitted a communication to the nursing home staff regarding the picking incident. The night shift nurse noted the resident asked for a band aid to cover the scabbed areas and the area was covered with a two by two (2x2) dressing with no further assessment or intervention at that time. On [DATE] at 11:25 A.M. Resident #72 was found by staff unresponsive, hemorrhaging a large amount of blood from his hemodialysis fistula in his left upper arm. The resident's call light had been activated (for an undetermined period of time) at the time he was found unresponsive. Resident #72 subsequently passed away on [DATE].</p> <p>On [DATE] at 11:20 A.M., the Administrator, Director of Nursing (DON) and Divisional Director of Risk #223 were notified Immediate Jeopardy began on [DATE] when dialysis staff notified nursing home staff Resident #72 was picking at his dialysis fistula site. Nursing home staff failed to implement adequate and effective measures and interventions after identifying the resident was picking at his fistula site to prevent complications. On [DATE] at 11:25 A.M., Resident #72 was found by Certified Nursing Assistant (CNA) #267 with his call light on (for an undetermined amount of time), hemorrhaging a large amount of blood from his hemodialysis fistula. Resident #72 was subsequently pronounced deceased on [DATE] at 12:09 P.M.</p> <p>In addition, a concern that did not rise to the level of Immediate Jeopardy was identified when the facility failed to prevent staff to resident potential abuse when a staff member was identified engaging in an inappropriate romantic relationship with Resident #71. This affected two residents (#71 and #72) of three reviewed for abuse and neglect. The facility census was 71.</p> <p>The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions:</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365629
		If continuation sheet Page 1 of 20

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:45 A.M., the DON began collecting statements from all staff who worked on Resident #72's unit in last 24 hours. All statements were collected by [DATE].</p> <p>On [DATE] at 1:00 P.M., the Director of Human Resources #260 gave the DON all cardiopulmonary resuscitation (CPR) cards of the nurses completing CPR.</p> <p>On [DATE], Licensed Practical Nurse (LPN) Unit Manager (UM) #208 completed assessments on residents who had dialysis ports or fistulas. The assessments included checking for any signs of infection, any bleeding, dry and intact dressings, and bruit and thrill for Resident #71's arteriovenous (AV) fistula and Resident #64's right upper cervical (RUC) hemodialysis (HD) port.</p> <p>On [DATE], the DON initiated education to all 24 licensed nurses which was completed by [DATE]. The education pertained to the policy titled Hemodialysis Care and Monitoring with emphasis on the assessment of ports and shunts, pre and post assessments on dialysis residents, all dialysis orders, and on dialysis monitoring orders. The education also included communication between the facility and dialysis center every dialysis day and to initiate immediate dialysis interventions. New licensed nurses would be educated by the DON or designee during new hire orientation.</p> <p>On [DATE] the DON initiated education of the facility's Abuse, Neglect, and Misappropriation Policy. The education was completed by [DATE] for all 24 licensed nurses and all 29 CNA's. New nurses and CNAs would be educated during new hire orientation.</p> <p>On [DATE], the DON initiated an audit on all dialysis residents to validate dialysis orders to monitor residents' dialysis sites. Orders were corrected for Resident #71's left upper arm fistula and added to the treatment record. A physician order to check Resident #71's dialysis graft site for bruit and thrill every shift was initiated on [DATE].</p> <p>On [DATE], the DON reviewed and revised care plans for dialysis residents to ensure accuracy and Resident #71's was updated to ensure accuracy related to the type of fistula he had.</p> <p>On [DATE], an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the Administrator, DON, Regional Director of Operations (RDO) #217, Regional Director of Clinical Operations (RDCO) #218, Divisional Director of Clinical Operations (DDCO) #219, [NAME] President (VP) of Risk #220, VP of Operations #221, and VP of Clinical Operations #222.</p> <p>On [DATE], a Root Cause Analysis was completed by the DON, Administrator, Assistant Director of Nursing (ADON) #213, Divisional Director of Risk #223, and LPN UM #208. Licensed nurses CPR licenses were verified. The analysis determined the problem to be cardiac arrest secondary to hypovolemic shock due to hemorrhage from AV fistula per hospital documentation. Care plans, orders, and code statuses were reviewed for accuracy, dialysis patients were assessed, and nurses received education on Hemodialysis Care and Monitoring and medication administration.</p> <p>On [DATE], the facility initiated audits for neglect through Angel Rounds (monitoring completed by department heads Monday through Friday on the residents) through observation and interviews of three staff and three residents, five days a week for four weeks.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Beginning on [DATE], the DON/designee would audit three dialysis residents, three times a week for four weeks then randomly thereafter to ensure dialysis orders were in place to monitor the shunt site with the schedule, pre/post dialysis forms were completed, and care plans and orders reflected dialysis recommendations, and any monitoring needed. The DON/designee will validate that the facility received communication forms from the dialysis center three days a week for four weeks then randomly thereafter.</p> <p>On [DATE], education to all staff on answering call lights in a timely fashion was completed by the DON/designee. New staff would be educated during new hire orientation.</p> <p>On [DATE], the ED/designee would initiate call light audits on three call lights, three days a week and interview five residents a week on call light response times for four weeks then randomly thereafter.</p> <p>The results of audits will be forwarded to the facility QAPI committee for further review and recommendations until substantial compliance is maintained. The Medical Director will give input into any data presented and plans proposed by the Committee.</p> <p>Although the Immediate Jeopardy was removed on [DATE] the deficiency remained at a Severity Level II (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.</p> <p>Findings Included:</p> <p>1. Review of the closed medical record for Resident #72 revealed the resident was admitted to the facility on [DATE] with diagnoses including hypertensive heart, end stage renal disease with hemodialysis, diabetes, hypothyroidism, dementia, major depressive disorder, hydronephrosis, benign prostatic hyperplasia, and mood disorder. The resident was discharged to the hospital on [DATE] where he expired.</p> <p>Review of the physician order dated [DATE] revealed Resident #72 had an order for staff to check his dialysis graft site for bruit and thrill every shift.</p> <p>Review of the hemodialysis care plan dated [DATE] revealed Resident #72 was receiving hemodialysis therapy related to renal failure and he had an AV fistula to the left upper extremity. Interventions included to administer medications per medical provider's order, observe for side effects and effectiveness, on dialysis days administer medications before, during, or after dialysis according to the medical providers orders, report abnormal findings to the medical provider, nephrologist, dialysis center, resident, and resident representative, communicate with the dialysis center regarding medication, vital signs, weights, restrictions, diet orders, nutrition or fluid needs, laboratory results, and who to notify with concerns, coordinate resident care in collaboration with dialysis center, evaluate the AV fistula for bleeding and if bleeding occurred, apply continuous direct pressure to the site for at least five minutes, if unable to stop the bleeding call 911, evaluate the resident following dialysis treatment, fluid restriction per orders, do not complete blood draws/blood pressure in the same arm as AV fistula, listen for bruit and thrill, do not remove dressing applied by dialysis center, and evaluate the AV fistula for bleeding.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 had intact cognition and received dialysis. The assessment revealed the resident required (staff) set-up assistance or supervision for all activities of daily living (ADL) and mobility.</p> <p>Review of the [DATE] and February 2025 Medication Administration Records (MAR) and Treatment Administration Records (TAR) revealed no documented evidence of staff checking the dialysis graft site for bruit and thrill every shift for Resident #72 as ordered.</p> <p>Review of a Dialysis Hand Off Communication Report document dated [DATE] revealed Resident #72 had been picking at scabs on his fistula and the plan was to try to keep a band aide on the sites. The communication was signed by Dialysis Registered Nurse (RN) #225. Further review of the report revealed Facility Registered Nurse #261 signed the form indicating she checked Resident #72's bruit and thrill. She documented the resident's dialysis catheter dressing was dry and intact and the resident had no signs or symptoms of infection at that time.</p> <p>Review of a nurse's note dated [DATE] at 11:25 A.M. revealed the nursing assistant notified the nurse that Resident #72 was bleeding. Upon entering the room, Resident #72 was unresponsive with a large amount of blood noted. 911 was called immediately and a code blue (a universal emergency code indicative of a medical emergency, usually cardiac or respiratory arrest) for the staff was called. CPR was initiated at 11:26 A.M. with the arrival of other clinical staff. An intravenous (IV) access line was unable to be obtained. Resident #72's physician and family were notified. The ambulance arrived at 11:33 A.M. and the resident was transferred to the emergency room (ER).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of an Emergency Medical Service (EMS) report dated [DATE] revealed at 11:23 A.M. EMS was called for an emergency at the facility. The primary impression was Resident #72 had a cardiac arrest and the secondary (impression) was hemorrhage. The report included barriers of care that the resident was left unattended or unsupervised and he had a sharp object penetrating injury or a cut laceration at the nursing home on [DATE]. EMS was dispatched to the facility for a hemorrhage from an unknown origin and the resident was lethargic. Upon arrival, and after applying standard precautions, the staff were found at the door, holding the doors open, and reported the resident's fistula was bleeding and he was bleeding out. A large stack of four-by-four gauze along with a pressure dressing was gathered from the truck and the crew reported to the resident's bedroom. The resident was found supine in bed with active CPR being performed. The staff did not report active CPR to EMS until the crew was at the bedroom door. A crew member was sent to the truck to obtain supplies for the updated situation. Additional resources were immediately requested with one staff member reporting they did not know what happened because Resident #72 was not their resident. When asked for the patient's information and history they stated, Why don't you go get your paperwork, and another staff member provided his first and last name however, no birth date was given. Another staff member stated, talk to her (indicating to the staff member performing CPR) she would know more. This staff member reported, He was just fine a moment ago when I checked on him and then I came in and he was bleeding. Upon assessment, there was a large amount of blood loss and the (resident's) dialysis fistula, located in the anterior portion of the upper left arm, was no longer bleeding. The assumed site where the hemorrhage occurred was clotted and mostly hardened at the site. The site was closely monitored so as not to disrupt the clot. The site appeared to have been self-controlled for a considerable time as there was a large amount of dried blood to the area and no signs of active hemorrhaging. There were pools of cold blood under the resident as well as on the floor and next to the bed he was in. There was blood splatter on the headboard of the bed. There were many clots of varying size and in various stages of forming, including bright red arterial blood that was coagulating with pools of dark dried blood clots. Estimation was difficult, but total blood loss appeared to be around two to four liters. The resident had no easily visible veins including the jugular veins and his dialysis fistula was flattened. The resident's pupils were non-reactive, round and equal. He did not show signs of rigor mortis, dependent lividity, or an injury incompatible with life. The resident's skin displayed pallor and was dry to the touch. The resident had signs of cyanosis around the mouth and slight mottling of the skin in various areas. Resident #72 also did not have a Do Not Resuscitate (DNR) order, the decision to continue attempted resuscitation was made. The automated external defibrillator (AED) was attached by nursing home staff, when prompted for analysis it provided no shock advised, and CPR was resumed. While CPR was continuing, the resident's shirt was cut to allow for access to the chest. At the next pulse check the resident was moved to allow for the [NAME] University Cardiopulmonary Assist System (LUCAS) back plate (an automated chest compression machine) to be applied. Due to the size of the resident and the conditions of the bed, the LUCAS was not able to be attached to the back plate. The resident was moved to the cot and secured to the cot. CPR continued with the LUCAS device now applied. When the resident was moved to the cot, a large amount of additional blood and blood clots were found underneath the resident on the bed including a singular mass of coagulated/clotted blood that was several inches wide in diameter. The now revealed blood and blood clots had also varied stages of clotting and drying. This increased the suspicion of a prolonged down time due to the different dryness of blood and changes in color across the collective fluid, however the approximate downtime was not-clear due to history gathering and findings on scene. Once loaded into the ambulance, intraosseous (IO) (bone marrow) access was obtained via 25 millimeter (mm) IO needle which gave positive bone marrow return. Endotracheal intubation was successfully achieved with a 7.5 tube and stylet. Direct visualization was achieved and the endotracheal tube (ETT) was placed at 22 centimeters (cm) at the teeth line. ETT was secured with a [NAME] (a device used to secure an ETT tube). Upon arrival at the hospital the resident was transferred to the bed and care was transferred to the hospital staff with a full report given to the nurse and physician on duty. Due to the nature of the call and the circumstances that occurred, a police report was filed with the local police department and adult protective services were contacted after the call.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a hospital ER report dated [DATE] revealed Resident #72 presented to the ER in cardiac arrest and they noted a large amount of blood on the sheets. It noted that the resident came from the nursing facility after an unwitnessed cardiac arrest with concerns of a fistula rupture and an unknown downtime. The note also stated upon arrival, the resident had no active bleeding from the fistula and [the fistula] was flat with overlying scabs with no palpable pulsation or hum. Resident #72 arrived at the ER at 11:57 A.M. with a diagnosis of cardiac arrest and hypovolemic shock due to hemorrhage from AV fistula. The residents time of death was 12:09 P.M.</p> <p>Review of a handwritten Police Department Statement from Paramedic #216 dated [DATE] revealed upon arrival to the scene, Resident #72 was found lying in a pool of his own blood and the blood was beginning to clot. The resident was bleeding from his fistula. Paramedic #216 noted that once they arrived on scene staff had begun CPR. The statement revealed they were originally dispatched for a resident bleeding and lethargic. The staff stated the resident's downtime was unknown and they did not have any idea when the bleeding started. The fire department took over CPR efforts and moved the resident to the ambulance. The resident was transported to the hospital where the resident was pronounced deceased . Paramedic #216's statement included staff stated they were going to lose their jobs because of this, but the statement did not elaborate as to why the staff made the statement.</p> <p>Review of a handwritten Police Department Statement from Paramedic #215 dated [DATE] revealed when responding to an emergency call, Resident #72 was found supine in bed with an obvious injury to his dialysis fistula. The wound appeared to have been self-controlled for a significant amount of time. The wound had bleeding in various stages of clotting, there was dried blood found in significant amounts on the wound and arterial blood was found all around the resident in bed and on the headboard of the bed. There were large clots found under the resident and around various areas such as the floor and the bed sheets. Paramedic #215 noted there were no first aid supplies, such as dressings or a tourniquet found in the room, and the staff members could not provide an account of the events. No staff members could provide a name or birth date for the resident. Paramedic #215 further revealed that most of the blood found was either cool or cold and had begun to darken, and this was a cause for concern as it appeared the resident had been deceased for a substantial amount of time, and that the blood hemorrhaging had occurred as a substantial amount of time had passed prior to the nursing home calling and reporting. The resident appeared to have been bleeding to death and laid in a pool of his own blood unnoticed for an abnormally long time.</p> <p>Review of the facility investigation revealed the only documents present pertaining to an investigation into the incident related to Resident #72 from [DATE] included 31 different staff members' statements about the last time they saw Resident #72 and if he was picking at his fistula site. The statements revealed the last staff to see Resident #72 alive was RN #204 on [DATE] at 9:00 A.M. The statements revealed no facility staff observed the resident picking at his fistula site, besides Dialysis RN #225. The facility also conducted a timeline of the code blue for Resident #72 stating who was present and the sequence of events after the resident was found unresponsive.</p> <p>On [DATE] at 11:53 A.M. an interview with Dialysis RN #225 revealed on [DATE] Resident #72 had numerous small scabs on his fistula and he was picking at them. She stated there was no active bleeding when she saw him and she told him to stop, but he stated he was sorry and that he was a picker. She stated he did not have a dressing or band aid on prior to dialysis. She stated there were no concerns with his fistula and it was assessed and accessed fine for her that day. She stated she placed a pressure dressing over his fistula prior to him leaving the dialysis center.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:15 P.M. an interview with Visitor #226 revealed she had been visiting her family member on [DATE] and stated the call light for Resident #72 had been on for a long period of time that morning when she was in the facility.</p> <p>On [DATE] at 1:00 P.M. an interview with the Director of Nursing confirmed Resident #72 had an order for his dialysis fistula bruit and thrill to be checked every shift. However, there was no documentation this was completed.</p> <p>On [DATE] at 2:31 P.M. an interview with the DON confirmed an aide did leave at 8:00 A.M. on [DATE], leaving three aides and one restorative aide for four halls. No additional information was provided related to the activation of Resident #72's call light or the length of time it had been on before the resident had been found unresponsive.</p> <p>On [DATE] at 2:32 P.M. an interview with the Administrator revealed she did not know what they facility could have done differently regarding the circumstances of in the incident with Resident #72 on [DATE].</p> <p>On [DATE] at 9:20 A.M. an interview with CNA #241 revealed she was in the dining room when the code blue was called for Resident #72. She revealed the staff had been working short on the units on [DATE] because they had an aide go home sick.</p> <p>On [DATE] at 9:46 A.M. an interview with CNA #286 revealed she had been working the day Resident #72 coded (indicating when the code blue was called), but stated she was not working his hall. She stated they had an aide go home sick, so they had three aides for four units. She stated CNA #241 did not help on the floor or help answer call lights, she only completed her restorative programs. She stated she did not know how long Resident #72 had his call light on, but confirmed the resident's call light was on when she went into the room to help with the code.</p> <p>On [DATE] at 9:55 A.M. an interview with CNA #244 revealed she was not working on Resident #72's unit on [DATE], however when they called the code she ran into the resident's room. She stated she did not notice the call light on when she went into the room, but it was on when she came out of the room. She stated she saw Resident #72 at breakfast when she took his tray to him at around 7:30 A.M., but you could not see his fistula because it was higher up on his arm and his gown covered it but she stated she did not see any blood on his gown at that time. She stated she also heard him talking to Director of Public Relations #249 when she (Director of Public Relations #249) picked up his breakfast tray (at approximately 8:10 A.M.), but she (CNA #244) did not see him at that time.</p> <p>On [DATE] at 12:16 P.M. an interview with CNA #267 revealed he was the only aide working on Resident #72's unit. He stated he was in the shower room giving a shower to a different resident. After the shower, he took that resident back to her room to get her dressed and then took her down to the dining room. When he came back to the unit, the lunch cart was sitting in the hallway outside Resident #72's room. He stated he got Resident #72's tray off the meal cart, went to take it in the room, saw all of the blood, immediately put the tray down, and went to get help. He stated Resident #72's call light was on when he went into the room. He stated he had not been in Resident #72's room for a little while and he indicated no other staff were on the unit when he was in the shower room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 7:25 A.M. an interview with RN #261 revealed on [DATE] Resident #72 had a couple scabbed areas to his fistula site and she applied a dressing to it. However, the RN revealed she did not document this or write any new orders because the dialysis sheet (from the treatment on this date) already indicated they placed a band aide on it earlier. She stated she did not see any concerns with his fistula site at that time and she did not personally see the resident picking at his fistula site, but stated he had been picking at his forehead. There was no evidence any new interventions were implemented at that time to prevent the resident from picking or to prevent complications with the resident's dialysis fistula site.</p> <p>On [DATE] at 12:10 P.M. an interview with Coroner #214 revealed she knew about Resident #72. She stated she did not handle the resident's body and she did not know what the resident's official cause of death was on the death certificate, but she remembered the nurses in the ER calling her to tell her about Resident #72. The nurses told her the resident had been bleeding profusely from his left upper arm fistula as it had ruptured. She stated the nurses explained the resident had passed away from cardiac arrest, but Coroner #214 stated that would have been considered cardiac arrest secondary to hypovolemic shock secondary to a ruptured fistula based on the circumstances. She further revealed the nurses told her there was so much blood that they had to clean the resident up completely before they allowed the family in to see him.</p> <p>Review of the undated facility policy titled, Ohio Abuse, Neglect and Misappropriation, revealed neglect occurred when the facility was aware of, or should have been aware of, goods or services a resident required but the facility failed to provide them to the resident resulting in, or which may result in, physical harm, pain, mental anguish, or emotional distress.</p> <p>Review of the undated facility policy titled, Hemodialysis Care and Monitoring, revealed it was the policy of the facility to provide resident centered care that met the psychosocial, physical, and emotional needs and concerns of the residents and that safety was the primary concern for the residents, staff and visitors. It noted that resident may require hemodialysis in the event of critically low kidney function, usually ,d+[DATE] percent to less, that allowed the buildup of lethal toxins in the blood. Hemodialysis may be required due to renal damage attributable to long term uncontrolled diabetes and/or hypertension or for acute episodes due to physical or chemical injury to the kidney. Residents would be individually evaluated by a nephrologist or physician for hemodialysis and would have a vascular access device placed specific to their needs. It was important that the nurse understand the type of venous access device each resident had, signs and symptoms to monitor, was pruritus or itchy skin present and if lotion could relieve, aneurysm which may rupture, bleeding, lack of bruit and thrill palpated at the site. General care was to monitored for infection, thrill and bruit.</p> <p>2. Review of the medical record for Resident #71 revealed the resident was admitted to the facility on [DATE] with diagnoses including end stage renal disease, diabetes, neuropathy, hepatitis C, hypertension, anxiety disorder, major depressive disorder, complete traumatic amputation between the elbow and wrist of the left arm and phantom limb syndrome. Resident #71 was his own responsible party.</p> <p>Review of the plan of care dated [DATE] revealed no documentation of inappropriate sexual behaviors being exhibited by the resident.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #71 had intact cognition and had no behaviors.</p> <p>(continued on next page)</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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the signed handwritten statement from Certified Nursing Assistant (CNA) #287 dated [DATE] revealed she had called the Director of Human Resources #260 on [DATE] to let her know about an incident that occurred on Tuesday ([DATE]) morning in the parking lot, directly after working. Resident #71 walked to her (CNA #287's) car with CNA #227. CNA #227 got into the car and Resident #71 leaned down and thanked her (CNA #287) for giving CNA #227 a ride home, they both giggled then Resident #71 leaned in and kissed CNA #227. CNA #287 stated she turned her head away because she did not want to see it. Resident #71 then walked away.</p> <p>Review of the signed, typed statement for Director of Human Resources #260 revealed she had received a call from CNA #241 stating she spoke to a coworker and the coworker reported to her that CNA #227 and Resident #71 kissed in the parking lot after CNA #227's shift on the morning of [DATE]. CNA #241 stated to her that she received a call from CNA #287 stating she was taking CNA #227 home the morning after her scheduled shift on [DATE]. She stated Resident #71 walked to her [CNA #287's] car with a crutch and kissed CNA #227 in the car in the parking lot.</p> <p>Review of the facility Self Reported Incident (SRI) investigation dated [DATE] revealed a State surveyor called the facility Administrator and asked if she was aware of an allegation of sexual activity between a resident and staff. The investigation noted that the facility had been working on an investigation regarding a staff member and resident and possible romantic involvement that did not include allegations of sexual activity. Both the resident and staff member had previously denied the allegations of romantic involvement. The investigation further revealed CNA #227 was previously suspended upon arrival to work [DATE], pending the investigation of a suspected kiss with Resident #71. CNA #287 reported to the Director of Human Resources #260 on [DATE] that in the evening, she had driven CNA #227 home and Resident #71 walked them to the car and kissed CNA #227. CNA #227 denied that the resident kissed her. CNA #287's interview and statement indicated that CNA #227 was in the car, Resident #71 leaned in the window, and CNA #287 assumed the resident was going to kiss CNA #227, and CNA #287 looked away. Resident #71 was interviewed and stated he did not kiss CNA #227 but only walked her to the car. CNA #227 was interviewed via phone on [DATE] and she denied any sexual interactions with Resident #71. Resident #71 was interviewed on [DATE] and he denied any sexual interactions with CNA #227. The investigation noted Resident #71's psychosocial care plan was updated with new interventions and he would continue to see the facility psychiatric nurse practitioner and the facility counselor.</p> <p>Review of the facility investigation revealed the following text message exchange between CNA #227 and CNA #287 on [DATE]:</p> <p>CNA #287 stated, Did you find a ride home?</p> <p>CNA #227 replied, Nope</p> <p>CNA #227 then stated, Mister man says he loves you But not the way he loves me</p> <p>CNA #287 replied, Lol I hope not</p> <p>CNA #227 stated, Girl . maybe I should just find a different job</p> <p>CNA #287 replied, Oh [expletive] what happened now?</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>CNA #227 stated, I miss my boyfriend</p> <p>CNA #287 replied, Lol just be careful.</p> <p>CNA #227 stated, I'm just meaning this drama [expletive] won't be for me lol</p> <p>CNA #287 replied, Ya I know all this crap is [expletive] and [Resident #28] is the root.</p> <p>The text messages jump to another unknown date revealing following text message exchange between CNA #227 and CNA #287:</p> <p>CNA #227 stated, Hey.</p> <p>CNA #287 replied, What's up.</p> <p>CNA #227 stated, I got suspended. (she was suspended on [DATE])</p> <p>CNA #287 replied, For?</p> <p>CNA #227 stated, You work tonight?</p> <p>CNA #287 replied, Yes What for?</p> <p>CNA #227 stated, They think we was making out in the parking lot Tues morning. I told her he [Resident #71] walked me out to the car, and thanked you for having my back and getting me home</p> <p>CNA #287 replied, Oh someone saw you guys kiss? . girl that's why I told you to stay away from him .</p> <p>CNA #227 stated, [NAME] all I know is it's not true Is it?</p> <p>CNA #287 replied, What? Yes you did . girl don't bring me into this . and now bc I was in that car I'll probably get in trouble too bc I didn't report it. [Expletive].</p> <p>CNA #227 stated, I'm not wantin [TRUNCATED]</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35765</p> <p>Based on review of the medical record, review of facility Self Reported Incidents, review of facility investigation, interview with staff, interview with residents, and review of facility policy and procedure, the facility failed to report an allegation of staff to resident sexual abuse to the State agency. This affected one resident (Resident #71) out of five residents reviewed for abuse and neglect.</p> <p>Finding included:</p> <p>Review of the medical record for Resident #71 revealed the resident was admitted to the facility on [DATE] with diagnoses including end stage renal disease, diabetes, neuropathy, hepatitis C, hypertension, anxiety disorder, major depressive disorder, complete traumatic amputation between the elbow and wrist of the left arm and phantom limb syndrome. Resident #71 was his own responsible party.</p> <p>Review of the plan of care dated 06/14/24 revealed no documentation of inappropriate sexual behaviors being exhibited by the resident.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #71 had intact cognition and had no behaviors.</p> <p>Review of the signed handwritten statement from Certified Nursing Assistant (CNA) #287 dated 02/27/25 revealed she had called the Director of Human Resources #260 on 02/26/25 to let her know about an incident that occurred on Tuesday (02/25/25) morning in the parking lot, directly after working. Resident #71 walked to her (CNA #287's) car with CNA #227. CNA #227 got into the car and Resident #71 leaned down and thanked her (CNA #287) for giving CNA #227 a ride home, they both giggled then Resident #71 leaned in and kissed CNA #227. CNA #287 stated she turned her head away because she did not want to see it. Resident #71 then walked away.</p> <p>Review of the signed, typed statement for Director of Human Resources #260 revealed she had received a call from CNA #241 stating she spoke to a coworker and the coworker reported to her that CNA #227 and Resident #71 kissed in the parking lot after CNA #227's shift on the morning of 02/25/25. CNA #241 stated to her that she received a call from CNA #287 stating she was taking CNA #227 home the morning after her scheduled shift on 02/24/25. She stated Resident #71 walked to her [CNA #287's] car with a crutch and kissed CNA #227 in the car in the parking lot.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility Self Reported Incident (SRI) investigation dated 03/06/25 revealed a State surveyor called the facility Administrator and asked if she was aware of an allegation of sexual activity between a resident and staff. The investigation noted that the facility had been working on an investigation regarding a staff member and resident and possible romantic involvement that did not include allegations of sexual activity. Both the resident and staff member had previously denied the allegations of romantic involvement. The investigation further revealed CNA #227 was previously suspended upon arrival to work 02/27/25, pending the investigation of a suspected kiss with Resident #71. CNA #287 reported to the Director of Human Resources #260 on 02/26/25 that in the evening, she had driven CNA #227 home and Resident #71 walked them to the car and kissed CNA #227. CNA #227 denied that the resident kissed her. CNA #287's interview and statement indicated that CNA #227 was in the car, Resident #71 leaned in the window, and CNA #287 assumed the resident was going to kiss CNA #227, and CNA #287 looked away. Resident #71 was interviewed and stated he did not kiss CNA #227 but only walked her to the car. CNA #227 was interviewed via phone on 03/07/25 and she denied any sexual interactions with Resident #71. Resident #71 was interviewed on 03/07/25 and he denied any sexual interactions with CNA #227. The investigation noted Resident #71's psychosocial care plan was updated with new interventions and he would continue to see the facility psychiatric nurse practitioner and the facility counselor.</p> <p>Review of the facility investigation revealed the following text message exchange between CNA #227 and CNA #287 on 02/24/25:</p> <p>CNA #287 stated, Did you find a ride home?</p> <p>CNA #227 replied, Nope</p> <p>CNA #227 then stated, Mister man says he loves you But not the way he loves me</p> <p>CNA #287 replied, Lol I hope not</p> <p>CNA #227 stated, Girl . maybe I should just find a different job</p> <p>CNA #287 replied, Oh [expletive] what happened now?</p> <p>CNA #227 stated, I miss my boyfriend</p> <p>CNA #287 replied, Lol just be careful.</p> <p>CNA #227 stated, I'm just meaning this drama [expletive] won't be for me lol</p> <p>CNA #287 replied, Ya I know all this crap is [expletive] and [Resident #28] is the root.</p> <p>The text messages jump to another unknown date revealing following text message exchange between CNA #227 and CNA #287:</p> <p>CNA #227 stated, Hey.</p> <p>CNA #287 replied, What's up.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #227 stated, I got suspended. (she was suspended on 02/27/25)</p> <p>CNA #287 replied, For?</p> <p>CNA #227 stated, You work tonight?</p> <p>CNA #287 replied, Yes What for?</p> <p>CNA #227 stated, They think we was making out in the parking lot Tues morning. I told her he [Resident #71] walked me out to the car, and thanked you for having my back and getting me home</p> <p>CNA #287 replied, Oh someone saw you guys kiss? . girl that's why I told you to stay away from him .</p> <p>CNA #227 stated, [NAME] all I know is it's not true Is it?</p> <p>CNA #287 replied, What? Yes you did . girl don't bring me into this . and now bc I was in that car I'll probably get in trouble too bc I didn't report it. [Expletive].</p> <p>CNA #227 stated, I'm not wanting to bring you into it Wherever it came from I don't know But already guaranteed they are going to ask you.</p> <p>CNA #287 replied, See this is why I was upset that day, I need this job and you both didn't care that it would put me in the middle by doing that</p> <p>CNA #227 stated, Just call me.</p> <p>CNA #287 replied, No I'm upset and now worried I'm going to lose my job. Someone saw you obviously so denying it isn't going to help. I'm [expletive] and I wasn't even the one who did it .</p> <p>CNA #227 stated, You aren't [expletive] I did deny it, and I'm firm I'm assuming you being asked would mean you will tell her I did Just wondering if I shouldn't start looking for a job now</p> <p>CNA #287 replied, If I lie when there's a witness I can lose my job and licenses over this [expletive]. So, what the [expletive]?? I do not know what to do. I need this job and you know that. I love being an aide. So, I don't know [CNA #227] I need to think about this seriously. Bc you guys didn't care about putting me in this position, but you're wanting me to lie to save you and risk me? How is that right? A real friend wouldn't have done that to me. So yes I'm stressed the [expletive] out and [explicit] off bad. Did the thought even cross your mind to tell the truth to keep me from getting in trouble? No, you just want me to lie and take a risk .</p> <p>CNA #227 stated, I am not asking you to do anything .truly 100 % I don't know what to do other than deny it I love doing what I do too I have for YEARS This has never happened I did not mean for it to happen And you're right I wasn't thinking and I apologize a million times Guarantee it ain't gonna happen again regardless of the outcome I'm just trying to be calm I [expletive] up bad and not exactly sure how to get out of it</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a termination event form revealed CNA #227 was terminated for violating company policy. Her last day of work was 02/26/25 and her termination date was 03/07/25.</p> <p>Review of the updated psychosocial plan of care for Resident #71 dated 03/06/25 revealed he had a decline related to his medical condition. Interventions included to encourage him to express any feelings/concerns regarding another staff members behavior, encourage him to come out of his room often with other residents and staff, observe the resident for signs of new onset of psychosocial issues and initiate resident specific interventions, offer and encourage attendance and involvement in facility activities, and offer emotional support as needed.</p> <p>Review of Resident #71's late entry progress note dated 03/06/25 at 5:06 A.M. revealed the facility nurse practitioner was notified of an allegation of inappropriate behavior from a staff member.</p> <p>On 03/06/25 at 2:31 P.M. an interview with the Administrator revealed she had been aware of rumors of inappropriate behavior between CNA #227 and Resident #71, however they both denied it when interviewed.</p> <p>On 03/10/25 at 9:20 A.M. an interview with CNA #241 revealed she was unaware of the date, but stated she received a telephone call from CNA #287 indicating Resident #71 and CNA #227 were outside the facility in her car kissing. She stated Resident #71 went outside on midnights a lot to talk to the girls. She stated she reported it to the Director of Public Relations #249 right away.</p> <p>On 03/10/25 at 9:34 A.M. an interview with Director of Public Relations #249 revealed she received a phone call from CNA #241 that an employee had called her stating a resident kissed an employee. She stated she told CNA #241 to have that employee call her immediately. She stated CNA #287 called her and stated as her [CNA #287] and CNA #227 were leaving to go home on 02/24/25, Resident #71 was outside, and he went up to CNA #227 and kissed her good-bye. Director of Public Relations #249 stated she looked at her telephone and stated she was informed on 02/26/25 at 8:53 P.M. and she immediately called the Administrator to inform her. She stated CNA #227 was immediately fired.</p> <p>On 03/10/25 at 11:04 A.M. an interview with CNA #227 revealed the morning of 02/25/25 she did not have a ride home from work so CNA #287 gave her a ride home. She stated CNA #287 was actually off that night and came to pick her up. She stated Resident #71 was walking out with her to the car because she had been having issues with an ex-boyfriend and had very high anxiety walking outside at night. She stated she got into the car and Resident #71 stood up and had his head in the window. She stated Resident #71 told CNA #287 thanks for picking her [CNA #227] up that morning and taking her home. She stated he never kissed her and she never kissed him. She stated he knew about her ex-boyfriend from hearing them talk about it at night.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/11/25 at 7:00 A.M. an interview with CNA #287 revealed she was picking CNA #227 up from work on 02/25/25 and Resident #71 was walking her to the car. She stated CNA #227 got into the car, Resident #71 leaned down in the car and told her thank you for picking CNA #227 up and then he bent over to kiss CNA #227. She stated she was surprised and turned her head so she did not see them kiss, but you could hear them kissing. She stated they had left, and she asked CNA #227 what the hell she was doing and it was not right because he was a resident. She stated she told CNA #227 that she put her [CNA #287] in a terrible position. She stated later that day CNA #227 texted her stating she was not thinking, it was not going to happen again, she knew she [explicit] up bad, and did not know what to do now. CNA #287 stated she did not call and report it until she went back to work on 02/26/25 and Director of Public Relations #249 asked her to fill out a statement. She stated she filled out a statement on 02/27/25 and gave them all of the text messages.</p> <p>On 03/10/25 at 3:15 P.M. an interview with Resident #28 revealed one night when CNA #227 was her aide, her roommate had her call light on for over 30 minutes so she got out of bed and went down to the nurse's station to find CNA #227. She stated she asked the nurse working where CNA #227 was and she stated she was out in the dining room talking to Resident #71. She stated she was mad because her roommates call light had been on for a while so she went back to the dining room and they were not back there, but they were in the back room that they call the bird cage, but it was really the employee breakroom. She stated she went back out and told the nurse to go get her because her roommate had to go to the bathroom. She stated a little while later, she turned her call light on for CNA #227 because she felt light-headed. She stated she had her call light on for about 20 minutes and so she just went looking for her. She stated the nurse was at the nurse's station again and told her CNA #227 was down in Resident #71 room. She stated she went down to his room and CNA #227 was sitting on Resident #71's bed talking with him. She stated she did not see them doing anything sexual, but after that she watched them and they would flirt a lot. She stated she even asked CNA #227 what the hell she was doing because Resident #71 was a resident and she [CNA #227] could not have a relationship with him. She stated CNA #227 actually said to her, why not? Resident #28 stated she could not believe she said that.</p> <p>On 03/11/25 at 9:00 A.M. an interview with the Administrator confirmed she had not reported the incident between Resident #71 and CNA #227 to the State agency because she believed it was not sexual abuse and they both denied the incident ever happening.</p> <p>On 03/11/25 at 2:30 P.M. an interview with Resident #71 revealed he denied having a sexual relationship with CNA #227. He stated the Administrator asked him if he was having sex with CNA #227 and he told her his [explicit] penis did not work anymore and stated he never leaned into the car and kissed her.</p> <p>On 03/19/25 at 9:20 A.M. an interview with Regional Director of Clinical Operations #218 revealed CNA #227 was no longer with the facility and she did not know why the termination letter stated the aide violated company policy, but from what she was told, even though CNA #227 and Resident #71 both denied anything happened between them, they decided to be overly cautious and terminate CNA #227.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated facility policy titled, Ohio Abuse, Neglect and Misappropriation, revealed sexual abuse was non-consensual sexual contact of any type with a resident. It was the policy of the facility to provide resident centered care that met the psychosocial, physical and emotional needs and concerns of the residents. It was the intent to the facility to prevent abuse, mistreatment or neglect of residents or misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct care staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property. The facility would provide staff education and training upon hire, annually and as needed for re-training to include but not limited to, the definition of abuse, neglect, and misappropriation, prohibiting such acts in the facility, and methods of protecting residents from verbal, mental, sexual and physical abuse, and misappropriation.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163468.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35765</p> <p>Based on review of the medical record, interview with staff, and review of facility policy and procedure, the facility failed to follow physician's orders to monitor the dialysis fistula bruit and thrill for Resident #72. This affected one resident (Resident #72) of three reviewed for dialysis.</p> <p>Findings included:</p> <p>Review of the medical record revealed Resident #72 was admitted to the facility on [DATE]. Diagnoses included hypertensive heart, end stage renal disease with dialysis, diabetes, hypothyroidism, dementia, major depressive disorder, hydronephrosis, benign prostatic hyperplasia, and mood disorder. He was discharged to the hospital on [DATE] where he later expired.</p> <p>Review of the physician order dated [DATE] revealed Resident #72 had an order to check his dialysis graft site for bruit and thrill every shift.</p> <p>Review of the hemodialysis care plan dated [DATE] revealed Resident #72 was receiving hemodialysis therapy related to renal failure and he had an AV fistula to the left upper extremity. Interventions included to administer medications per medical provider's order, observe for side effects and effectiveness, on dialysis days administer medications before, during, or after dialysis according to the medical providers orders, report abnormal findings to the medical provider, nephrologist, dialysis center, resident, and resident representative, communicate with the dialysis center regarding medication, vital signs, weights, restrictions, diet orders, nutrition or fluid needs, laboratory results, and who to notify with concerns, coordinate resident care in collaboration with dialysis center, evaluate the AV fistula for bleeding and if bleeding occurred, apply continuous direct pressure to the site for at least five minutes, if unable to stop the bleeding call 911, evaluate the resident following dialysis treatment, fluid restriction per orders, do not complete blood draws/blood pressure in the same arm as AV fistula, listen for bruit and thrill, do not remove dressing applied by dialysis center, and evaluate the AV fistula for bleeding.</p> <p>Review of the Annual Minimum Data Set assessment dated [DATE] revealed Resident #72 intact cognition and received dialysis. He required set up assistance or supervisor for all Activities of daily living and mobility.</p> <p>Review of the [DATE] to February 2025 Medication Administration Records (MAR) and Treatment Administration Records (TAR) revealed no documentation of staff checking the dialysis graft site for bruit and thrill every shift for Resident #72.</p> <p>On [DATE] at 1:00 P.M. an interview with Director of Nursing confirmed Resident #72 had an order to check his dialysis bruit and thrill every shift. However, the nurse had not been doing it because it was never transcribed onto the MAR or TAR.</p> <p>(continued on next page)</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  03/20/2025
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated facility policy titled, Hemodialysis Care and Monitoring, revealed it was the policy of the facility to provide resident centered care that met the psychosocial, physical, and emotional needs and concerns of the residents and that safety was the primary concern for the residents, staff and visitors. It noted that resident may require hemodialysis in the event of critically low kidney function, usually .d+[DATE] percent to less, that allowed the buildup of lethal toxins in the blood. Hemodialysis may be required due to renal damage attributable to long term uncontrolled diabetes and/or hypertension or for acute episodes due to physical or chemical injury to the kidney. Residents would be individually evaluated by a nephrologist or physician for hemodialysis and would have a vascular access device placed specific to their needs. It was important that the nurse understand the type of venous access device each resident had, signs and symptoms to monitor, was pruritus or itchy skin present and if lotion could relieve, aneurysm which may rupture, bleeding, lack of bruit and thrill palpated at the site. General care was to monitored for infection, thrill and bruit.</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  03/20/2025
NAME OF PROVIDER OR SUPPLIER  Dixon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  135 Reichart Avenue Wintersville, OH 43953	

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35765</p> <p>Based on observations, review of the medical record, interview with staff, and review of manufacture guidelines, the facility failed to maintain a medication error rate below five percent (%). There were two medication errors out of 29 opportunities for error, equaling a medication error rate of 6.9 %. This affected two residents (#59 and #66) of five residents (Resident #6, #48, #52, #59 and #66) observed for medication administration.</p> <p>Findings included:</p> <p>1. Review of the medical record revealed Resident #66 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), dyspnea, and schizophrenia.</p> <p>Review of the March 2025 physician's orders revealed Resident #66 had an order dated 09/21/23 for Fluticasone propionate and salmeterol inhalation powder 250/50 micrograms (mcg) with instructions to administer one puff twice daily for COPD, and swish and spit after usage.</p> <p>Observation of medication administration on 03/11/25 at 7:30 A.M. revealed Medication Technician #200 administered one inhalation of Fluticasone propionate and salmeterol inhalation 250/50 mcg to Resident #66, however she did not have the resident rinse her mouth out and spit after use.</p> <p>On 03/11/25 at 7:35 A.M. an interview with Medication Technician #200 confirmed she had not had Resident #66 rinse and spit after the administration of Fluticasone propionate and salmeterol inhalation.</p> <p>Review of the manufactures instruction for Fluticasone propionate and salmeterol inhalation powder revealed the user was to rinse their mouth with water after breathing in the medication then spit it out and not to swallow it.</p> <p>2. Review of the medical record revealed Resident #59 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), acute respiratory failure, asthma, cerebral ischemia, dependence on supplemental oxygen, and emphysema.</p> <p>Review of the March 2025 physician's orders revealed Resident #59 had an order dated 01/24/25 for Fluticasone propionate and salmeterol inhalation powder 250/50 micrograms (mcg) with instructions to administer one puff twice daily for asthma.</p> <p>Observation of medication administration on 03/11/25 at 8:19 A.M. revealed Intern Registered Nurse #201 administered one inhalation of Fluticasone propionate and salmeterol inhalation 250/50 mcg to Resident #59, however he did not have the resident rinse her mouth out and spit after use.</p> <p>On 03/11/25 at 8:25 A.M. an interview with Intern Registered Nurse #201 confirmed he had not had Resident #59 rinse and spit after the administration of Fluticasone propionate and salmeterol inhalation.</p> <p>(continued on next page)</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the manufactures instruction for Fluticasone propionate and salmeterol inhalation powder revealed the user was to rinse their mouth with water after breathing in the medication then spit it out and not to swallow it.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163468.</p>		