STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0565 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council minutes, policy review, staff interview, and resident interview the facility failed to ensure Resident Council concerns were addressed in a timely manner. This had the potential to affect all the residents in the facility. The facility census was 62. Findings Include: Review of the Resident Council minutes from 02/25 to 05/25 revealed concerns identified during the Resident Council meeting. Call light wait time concerns were mentioned during the 02/25/25, 03/20/25, and 04/17/25 Resident Council meeting. Ice water concerns were mentioned during the 04/17/25 meeting. Review of the section titled Old Business in the Resident Council minutes revealed there was no mention of any resolution related to call light wait times or ice water concerns. Review of the undated Resident Council policy indicated that any concerns that are voiced at the meeting should be documented in a concern form, distributed to the appropriate dept head, and the facility should follow the Resident Grievance Procedure for any concerns identified. Interview on 05/19/25 at 3:36 P.M. with Resident #17 revealed the resident was still concerned with call light wait times. Resident #17 revealed a call light wait time of two hours between 04/30/25 and 05/05/25 Interview on 05/19 25 at 6:07 P.M. with Director of Activities #100 revealed they preside over Resident Council meetings. Director of Activities #100 indicated they will present concerns identified during the Resident Council to administrative staff during morning meetings. Director of Activities #100 included the following: concern forms are not used, concern forms are not presented to department heads, and department heads don't have a process to communicate resolutions to presiding staff on Resident Council. Director of Activities #100 verified concern resolutions are not brought back to the Resident Council meeting to show how concerns are being addressed. Interview on 05/20/25 at 4:48 P.M. with Social Service Designee #168 revealed they maintain a concern log for concerns presented to them such as missing items. Social Services does not handle resident council concerns. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0565 Level of Harm - Potential for minimal harm Residents Affected - Many	Interview 05/20/25 at 5:42 PM with Administrator #165 verified they do not have a paper trail of complaint resolution for Resident Council. The Administrator included they were doing call light audits to fulfill part of a plan of correction for a deficient practice in which the facility was cited. Review of the call light audits revealed the last audit was 04/03/25. During the Resident Council meeting on 04/17/25 the call light wait times were still a concern of the residents. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00165450. .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, interview and policy review, the facility failed to notify a family and physician of a resident fall. This affected one resident (#64) of three residents reviewed for falls. Findings include: Review of Resident #64's medical record revealed a 09/25/23 admission with diagnoses including chronic diastolic congestive heart failure, type two diabetes, gastroesophageal reflux, disease, hypertension, hypothyroidism, moderate protein calorie malnutrition, cardiomyopathy, personal history of transient ischemic attacks without residual deficits, depression, dysphasia, neuropathy Non-rheumatic mitral valve stenosis and dementia. Review of a 05/09/25 quarterly minimum data set assessment (MDS) revealed the resident was severely impaired for daily decision-making with hallucinations, verbal behavior symptoms one to three of the look back days. She said no upper or lower body functional impairment. The resident was dependent on staff for oral hygiene, toileting, bathing, and on upper and lower body dressing and personal hygiene. She was dependent on staff for locomotion in her wheelchair. She was always incontinent of bowel and bladder. She had no falls since the last assessment. She had no unhealed ulcers or skin issues. Interview on 05/22/25 at 5:31 P.M. with Resident #64's daughter revealed she had an electronic monitoring device with a camera in her mother's room. She stated she saw her mother on the floor on camera footage and did not receive a call about a fall. She indicated she brought it to the attention of the facility and was not notiifed via text. Interview on 05/22/25 at 5:57 P.M. with the Director of Nursing (DON) verified on 03/31/25 Resident #64's daughter showed her footage of her mother in front of her wheelchair on the floor in her room on 03/28/25. Registered Nurse (RN) #126 was observed going in the room and completing an assessment. The Director of Nursing indicated the nurse told her that someone told him not to call the family. The DON said he changed his story several times including that he texted the resident's daughter. Review of the medical record revealed there was no documentation in the record of a fall on 03/28/25. The Nurse Notes included a late entry 03/31/25 at 7:19 P.M. that included the nurse was called to see the resident (#64) on arrival to the room. The resident was found to be slanted in the wheelchair with both feet on the floor. Resident #64 was put in a comfortable position. The daughter was texted to inform her of the situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility undated Notification of Change in Condition policy revealed it was the policy of the facility to provide resident centered care that meets the psychosocial, physical, and emotional needs, concerns of the residents. Changes may include but are not limited to changes in overall health status, significant medical changes and therapy services changes. The policy included the facility must inform the resident, consult with the resident's medical practitioner and/or notify the residents ' representative, authorized family member, or legal power of attorney/guardian when there was a change requiring such notification. Circumstances requiring notification included but were not limited to significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status including but not limited to life-threatening conditions or clinical complications. Interview on 05/30/25 at 7:54 P.M. with the Director of Nursing (DON) verified there was no evidence of the physician being notified of the fall. The DON further verfiied the nurse told her and the daughter he was told not to report the fall to the daughter. Later changed his story and said he texted the daughter although the daughter had not received a text. This deficiency represents findings of non-compliance investigated under Complaint Number OH00165930.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, hospice communication review, and interview, the facility failed to ensure a resident who was dependent on staff for care received showers per preference. This affected one resident (#64) of three residents reviewed for showers. Findings include: Review of Resident #64's medical record revealed a 09/25/23 admission with diagnoses including chronic diastolic congestive heart failure, type two diabetes, gastroesophageal reflux, disease, hypertension, hypothyroidism, moderate protein calorie malnutrition, cardiomyopathy, personal history of transient ischemic attacks without residual deficits, depression, dysphasia, neuropathy Non-rheumatic mitral valve stenosis and dementia. The resident had a 04/15/24 Self Care Performance plan of care related to cognition and functional deficits. The resident was totally dependent on staff for bathing. Review of a 05/09/25 quarterly minimum data set assessment (MDS) revealed the resident was severely impaired for daily decision-making with hallucinations, verbal behavior symptoms one to three of the look back days. She had no upper or lower body functional impairment. The resident was dependent on staff for oral hygiene, toileting, bathing, and on upper and lower body dressing and personal hygiene. She was dependent on staff for locomotion in her wheelchair. She was always incontinent of bowel and bladder. She had no falls since the last assessment. She had no unhealed ulcers or skin issues. Review of a 05/20/25 readmission assessment revealed the resident's representative preferred the resident receive showers daily. Review revealed the admission assessment dated [DATE] included the resident/resident representative wanted a shower daily. Review of refusals, bathing documentation and hospice documentation revealed the resident had a bed bath on 05/21/25, shower 05/22/25, bed bath 05/23/25, no bath documented on 05/24/25 and a bed bath on 05/25/25. The resident was readmitted to the hospital 05/25/25. Review of the undated Routine Resident Care policy included to provide routine daily care by a certified nursing assistant under the supervision of a licensed nurse included assist or provide personal care including bathing. Interview 05/29/25 at 1:47 P.M. with Licensed Practical Nurse (LPN) #169 revealed the facility used shower sheets for refusals of bathing. They did not have any refusal sheets for Resident #64. There was no evidence of shower refusal. LPN #169 verified the resident did not have showers daily as per preference. This deficiency represents non-compliance investigated under Complaint Number OH00165930.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, facility policy and procedure review, and interview, the facility failed to provide timely, necessary and adequate care and services following an acute change in condition involving Resident #63. The facility failed to ensure changes in the residents' medical condition were comprehensively assessed, the resident change in condition, including abnormal vital signs, was communicated to the medical health provider, and individualized interventions were implemented for Resident #63 when the resident was identified by therapy staff to have a decline in health including tachycardia, hypoxemia, and excessive daytime sleepiness and lethargy. This resulted in Immediate Jeopardy and Actual Harm with subsequent death beginning on [DATE] at approximately 12:30 P.M. when Resident #63 had hypoxemia, increased sleepiness, lethargy, and tachycardia while sitting at rest in therapy without adequate intervention. On [DATE] following an inability to complete therapy, Resident #63 returned to his room with no evidence the resident was comprehensively assessed by nursing staff (including Assistant Director of Nursing (ADON) #164 who had been notified by therapy staff) or the on-site nurse practitioner related to the identified decline and change in condition. On [DATE] at 8:10 P.M. Resident #63 was found absent of vital signs. Staff initiated cardiopulmonary resuscitation (CPR) and called first responders from the local fire and rescue; however, the resident was subsequently pronounced deceased by first responder staff. On [DATE] at 12:01 P.M. the Administrator, Regional Director of Clinical Operations Registered Nurse (RN) #171, and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] at approximately 12:30 P.M. when the therapy staff identified Resident #63 exhibited a decline and a change in condition which included hypoxemia, increased sleepiness/somnolence, lethargy, tachycardia with an inability to continue therapy without evidence of timely or adequate interventions/medical treatment being provided. Resident #63 remained in his room with increased somnolence, sleepiness, lethargy, and loud snoring that was not comprehensively addressed and without necessary and individualized interventions provided to the resident. On [DATE] at approximately 8:10 P.M. Resident #63 was found absent of vital signs when Licensed Practical Nurse (LPN) #86 entered the room to administer medication. Cardiopulmonary Resuscitation was initiated, 911 was called with local fire and rescue responding, and the resident was pronounced deceased at 8:40 P.M. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following actions: • On [DATE], audits were completed by Licensed Practical Nurse (LPN) #75 and LPN #169 for all 62 current residents from [DATE] to current to ensure timely identification and adequate and necessary medical care and intervention was provided following an acute change in condition. • On [DATE] LPN #65 reviewed the nursing notes and care plans for all 62 residents from [DATE] to current for change of condition. • (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	From [DATE] to [DATE] all residents with a Brief Interview for Mental Status (BIMS) score of 12 or higher were interviewed during daily ambassador rounds, to see if they had any concerns that needed to be addressed health or otherwise. This was completed by all department heads and would be an ongoing process. • From [DATE] to [DATE] all residents who were not able to be interviewed had a skin assessment completed by the DON/Designee. • On [DATE] the DON, Unit manager LPN #169 and MDS LPN #75 reviewed the last two weeks of residents who had been transferred to the hospital and/or who had expired in the facility to ensure adequate medical interventions were provided. • On [DATE] at 10:00 A.M., Regional Director of Clinical Services RN #171 re-educated the Director of Nursing on the policies Clinical Documentation Standards and Notification of Change in Condition to include ensuring timely identification of a resident acute change in condition and adequate and necessary medical care and intervention were provided following an acute change in condition. • On [DATE] from 10:00 A.M. to 4:00 P.M. the Director of Nursing re-educated all nurses either in person or via phone (including 10 RNs and 12 LPNs) on the Policies Clinical Documentation Standards and Notification of Change in Condition which included: Verbal communication with attending nurses. Ensuring timely identification and adequate and necessary medical care and intervention following an acute change in condition. If at any time staff felt a resident needed a higher level of care, call 911. • On [DATE] the Director of Rehabilitation (DOR) #173 educated 16 therapists either in person or via phone on the Notification of Change policy which included: Verbal or written communication to the nursing department. Communication with the nurse responsible for the resident. • Beginning on [DATE], upon hire any new nurse practitioner (NP) would receive education on the facility Clinical Documentation Standards and Notification of Change in Condition policies by the DON/Designee. • (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:00 P.M., the Administrator presented the facility Quality Assessment and Performance Improvement (QAPI) Team with investigation and all findings for discussion and review. Discussion included an abatement plan from incident regarding Resident #63, to ensure timely identification and adequate and necessary medical care and intervention is provided following an acute change in condition. Staff in attendance included the Administrator, DON, Infection Control Preventionist LPN #169, Medical Records Director #107, SSD #168, MDS # 75, HR Director #74 and Regional Director of Clinical Operations #171 and (RDCO) #172. Via phone included the Medical Director, Regional Director of Operations #174 (RDO), Diversional Director of Clinical Operations #175 (DDCO), and [NAME] President (VP) of Risk #176. • Beginning on [DATE], the facility implemented a plan for the Administrator and/or designee/DON to conduct an audit on three to five residents/week for four weeks, and randomly thereafter to ensure timely identification and adequate and necessary medical care and intervention was provided following an acute change in condition. All findings of concern would be immediately addressed and reported to the QAPI committee for further review and prompt response and resolution. In addition, nurse's notes would be reviewed daily in the clinical A.M. meeting Monday through Friday ongoing. Any concerns noted would be directed to the medical providers. Although the Immediate Jeopardy was removed on [DATE] the deficiency remains at a Severity Level 2 (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. Findings include: Review of the closed medical record for Resident #63 revealed an admission date of [DATE] with diagnoses of cellulitis, morbid severe obesity (410 pounds (lbs.) on [DATE]), cor pulmonale (right sided heart failure), congestive heart failure, sleep apnea, hypertension, respiratory failure, acute and chronic renal failure, adult failure to thrive, psychoactive substance abuse, Stage 3 chronic kidney disease, chronic venous insufficiency, iron deficiency anemia, and lymphedema. Review of the facility physician's order dated [DATE] revealed Resident #63 was admitted to the facility for skilled level of care with therapy and/or nursing services (including antibiotic use for cellulitis to right posterior lower leg). Review of Resident #63's medical record revealed the resident was a full code (advance directive status) indicating the resident wished to receive all possible life-saving measures in the event of a cardiac or respiratory arrest. Review of Resident #63's physician's orders dated [DATE] revealed an order for physical and occupational therapy to evaluate and treat. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the physician orders dated [DATE] revealed the resident would receive occupational therapy services five times a week for 30 days with treatment including therapeutic exercises, therapeutic activities, neurologic reeducation, activity of daily living (ADL) training, and group therapy. Additionally, there was an order for the resident to receive physical therapy five times a week for 30 days for therapy exercise, therapy activities, neurological re-education, gait training and group therapy. A plan of care dated [DATE] revealed the resident had Bilevel Positive Air-way Pressure (BiPAP) Therapy for Obstructive Sleep Apnea. (A breathing device that delivers pressurized air through a mask, helping to open the airways an assist with breathing; often used to sleep apnea, chronic obstructive pulmonary disease (COPD) or other respiratory problems). The goal was for the resident to adhere to BiPAP regimen. Interventions included to educate resident/representative on the importance of BiPAP Therapy and encourage resident's use of BiPAP. There was not a general respiratory or oxygen plan of care for Resident #63. Review of the admission Minimum Data Set Assessment (MDS) assessment dated [DATE] revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score that reflected he was cognitively intact and independent for daily decision making. The resident exhibited no behaviors, and the assessment included the resident rejected care one to three days in the look back period. Review of a Functional assessment dated [DATE] revealed Resident #63 had no upper or lower body functional impairment. The resident used a walker and wheelchair, was (staff) dependent for toileting, shower, upper and lower body partial moderate assistance with dressing, and personal hygiene. The resident was receiving physical and occupational therapy. The assessment revealed the resident required partial/moderate (staff) assistance to move from sitting position to lying position, required substantial/maximal (staff) assistance to move from lying position to sitting on the side of the bed, and required substantial/maximal (staff) assistance to transfer from a bed to a wheelchair. On [DATE] a physician order included oxygen at three liters per minute via nasal cannula as needed for shortness of breath or sign and symptoms of hypoxia/respiratory failure. Review of Nurse Practitioner (NP) #163's note dated [DATE] at 1:00 A.M. revealed the resident denied any chest pain or shortness of breath and had no other complaints. Review of Nurse Practitioner (NP) #163's note dated [DATE] revealed Resident #63 had been seen in the emergency department (ED) for a wound infection on [DATE] but had not been admitted . Upon assessment, the resident was sleeping in his bed with his legs dependent off of the bed. The resident was not wearing his BiPAP and noted to have loud snoring respirations. The NP note revealed she was able to wake the resident easily and upon asking why he wasn't wearing his BiPAP the resident reported he wore it when he could. Staff had frequently reported the resident refused the BiPAP. While in the ED venous blood gas testing showed a PCO2 of 87 which compared to one year prior was 84 and noted to be associated with hypoventilation due to obesity. The NP note revealed the resident had a diagnosis of sleep apnea and was supposed to be wearing a BiPAP, however he had been noted to be sleeping often without the BiPAP. The resident's vital signs included pulse of 76 beats per minute (BPM), blood pressure 130/64 mm/Hg, and oxygen saturation 98 percent on room air. The note included recommend using BiPAP all night and even throughout the day. Recommend follow up with pulmonology. Monitor respiratory status and vitals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed there was no evidence of an appointment made with a pulmonologist as recommended by NP #163. Review of a nurse's note dated [DATE] at 3:00 A.M. and completed by LPN #77 revealed Resident #63 was pleasant. The resident took all evening medications as ordered without difficulty and had been medicated for generalized pain. The note included the resident refused to use BiPAP and had refused dressing changes to bilateral lower legs for this nurse, stating he was too tired. Review of the nurse's note dated [DATE] at 11:25 A.M. and completed by LPN #78 revealed the resident was alert and oriented to person, place and time. Receiving Occupational Therapy, receiving Physical Therapy and psychiatric consults. The note included the resident makes poor decisions; cues/supervision required. Review of Resident #63's occupational therapy note completed by Occupational Therapist (OT) #83 dated [DATE] and signed 12:58 P.M. revealed Resident #63's oxygen saturation at resting fluctuated between 75 and 89 percent (%) with an inability to recover with purse lip breathing (PLB). The resident came to the therapy room on three liters of oxygen. Increasing oxygen to four liters per minute via nasal cannula resulted in the resident's oxygen saturation fluctuating 82% to 95% PLB with inability to maintain greater than 90% consistently. The resident's resting heart rate was fluctuating between 86 and 116 beats per minute. The note revealed consult with nursing regarding this resident inappropriate for therapy at this time. Review of Resident #63's physical therapy note by Physical Therapy Assistant (PTA) #147 dated [DATE] at 1:24 P.M. included the resident was seen supine in bed with wound nurse removing intravenous therapy. The note included the nurse stated she had put the resident's oxygen on him while he was sleeping. The resident woke up and sat on the edge of bed (with) minimum assist times one. The resident remained on the edge of bed for 10 minutes to dress sitting unsupported. Resident edge of bed transfer to wheelchair with moderate assist times one, with cueing for sequencing and safety. Unable to reposition in wheelchair without momentum and required therapy behind wheelchair or it would tip. The resident wheeled halfway down to therapy and then requested be pushed the rest of the way. Resident's oxygen saturation checked upon arrival to therapy room and was 77%. Resident cued to breathe properly to increase oxygen saturations. Resident's oxygen was unable to stabilize at three liters increased to four liters, nursing aware. The resident was not appropriate for treatment on this date and returned to his room. Encouraged to keep oxygen on. The resident was also encouraged to sleep with a C-PAP (Note: this documentation identified the resident was using a C-Pap but Resident #63 was ordered and was using a BiPAP machine) machine on to increase patients' alertness during the day. The note included the resident still continues to spontaneously fall asleep no matter what he is doing. Review of Resident #63's medical record revealed no evidence a comprehensive nursing assessment or individualized interventions were initiated following this identified decline and change in condition per therapy notes on [DATE] at 12:58 P.M. and 1:24 P.M. respectively. Record review revealed documentation on Resident #63's treatment administration record that the resident refused to have vital signs taken by LPN #78 on [DATE] at 4:50 P.M. On [DATE] at 5:08 P.M. LPN #78 documented completion of a wound treatment to the resident's bilateral lower extremities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the local Fire and Rescue Patient Care Record revealed a call came in to dispatch on [DATE] at 8:11 P.M. for a resident (#63) in cardiac arrest. Emergency responders were dispatched to the facility, arriving onsite at 8:15 P.M. and to the resident at 8:16 P.M. Upon arrival, the resident was found lying supine on the floor with cardiopulmonary resuscitation (CPR) in progress by facility staff. Staff reported to responders the resident had been lying in bed at 7:00 P.M., sleeping and snoring. Making rounds at 8:10 P. M., they found Resident #63 pulseless and apneic. The resident was in asystole (the complete absence of electrical and mechanical activity in the heart). Resuscitation efforts continued for over 20 minutes with the resident's skin becoming colder, and his color becoming more pale and cyanotic with lividity noted to his back. The resident's pupils were non-reactive. The resident was pronounced deceased on [DATE] at 8:40 P. M. Review of a nurse's note dated [DATE] at 9:10 P.M. revealed Resident #63 was found at 8:10 P.M. by Licensed Practical Nurse #86 (LPN) with no pulse or respirations. The note included the resident was last talked to at 7:15 P.M. by Certified Nurse Aide (CNA) #105. Staff quickly got help from a Curriculum Practicum Training (CPT) Intern (a nurse licensed in another country waiting to take the Ohio State Nursing Boards) RN #140 and CPT Intern RN #138 to call 911. LPN #86 grabbed the crash cart, and Automatic External Defibrillator (AED). The resident was lowered to the floor being especially careful not to hit his head. After which chest compressions started. An oxygen bag was obtained. The AED was put on scanned and no shock was advised. After about two to three minutes of chest compression, the resident started foaming out of the mouth and had blood come out of his nose. Staff went to get a suction kit. CNA's #116 and #162 were in the room assisting. Ambulance staff arrived at 8:16 P.M. and after a quick briefing of the situation they took over chest compressions, hooked the resident to a monitor, put in an oral air way and pushed epinephrine. At 8:40 P.M. emergency medical staff pronounced the resident deceased after contacting their physician. Review of Resident #63's Certificate of Death revealed the immediate cause of death was acute hypoxic respiratory failure and hypercapnic respiratory failure leading to the immediate cause. Interview on [DATE] at 3:03 P.M. with Occupational Therapist (OT) #83 revealed she called Assistant Director of Nursing (ADON) #164 into the therapy room on [DATE] when Resident #63 was in therapy. PTA #147 was also in the therapy room. OT #83 revealed she was unable to increase Resident #63's oxygen saturations. She had ADON #164 come into the therapy room to see him. The ADON was told they were unable to get the resident's vital signs to stabilize and could not continue therapy. The resident would fall asleep and wake up. They had to constantly get his attention. The resident would keep the oxygen on for therapy, per nasal cannula. Nurse Practitioner (NP) #163 was in the hall outside the therapy. The ADON went out to inform the nurse practitioner of the Resident #63's condition. However, the nurse practitioner did not come into the therapy room to assess the resident. OT #83 revealed therapy staff were shocked nothing happened. She believed she recalled the resident wheeling himself out of the therapy room when they could not continue therapy due to his oxygen saturations being low and pulse elevated. OT #83 revealed she signed her documentation of the therapy session at 12:58 P.M. She indicated that it would have been close to the time she would have seen him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview [DATE] at 3:44 P.M. with Nurse Practitioner (NP) #163 revealed on [DATE] she was talking to Licensed Practical Nurse #169 at her door which was across the hall from the therapy room. ADON #164 walked down the hall and in general passing told her Resident #63 keeps falling asleep in therapy. She asked if he had a follow up scheduled with an infectious disease doctor and was informed it was the following day. NP #163 stated she told ADON #164 to have the resident go to his appointment and do a telehealth visit if he changed and if it was needed that day. NP #163 indicated she saw the back of the resident's head while he was in therapy on [DATE]; but denied actually assessing the resident on this date. The NP revealed she felt like the resident had been falling asleep easily and refusing his BiPAP since admission and did not think this was any type of change for the resident over the past week. Interview on [DATE] 4:43 P.M. with PTA #147 revealed she went to Resident #63's room on [DATE]. The wound nurse was in there and told her she put oxygen on him when he was sleeping because of his loud snoring. PTA #147 revealed on [DATE] she was monitoring his vital signs; his pulse was erratic, and his oxygen saturation would go low and high. ADON #164 was walking past the room, and she asked ADON #164 to come in. The ADON stood and watched Resident #63 in therapy; his pulse and oxygen were erratic all over the place. OT #83 and PTA #147 then saw ADON #164 talk to NP #163 thinking the NP would then come in and assess the resident, but she did not. PTA #147 left the therapy room and upon her return, the resident was not in the therapy room. She stated she did not know how he got back to his room and denied taking him to his room. PTA #147 revealed this was the first date the resident had been unable to participate in therapy and was deemed not appropriate for therapy. PTA #147 revealed Director of Rehabilitation #173 told therapy staff she had reported in morning meeting the day after the resident passed away that he had not been appropriate for therapy the morning prior. Interview on [DATE] at 5:14 P.M. with Director of Rehabilitation (DOR) #173 revealed she was not working on [DATE]. However, on [DATE] her staff mentioned to her Resident #63 passed away. They informed her his oxygen saturations were all over (up and down), his heart rate was high, and he was inappropriate for therapy the previous day. DOR #173 revealed her staff told her they notified nursing. She mentioned in morning meeting the therapy staff said the resident's oxygen saturations were up and down the day prior. They increased his oxygen a liter, his pulse was high, and he was not appropriate for therapy. Interview on [DATE] at 5:36 P.M. with ADON #164 revealed on [DATE] one of the therapy staff called her into the therapy room and said Resident #63 did not look well. ADON #164 stated she saw the resident was in the therapy room, and verified he did not look well. She stated she went to get the NP (#163) and the NP said the resident had an infectious disease appointment the next day and to keep it and to do a telehealth visit if needed. The ADON verified she did not complete a head-to-toe comprehensive assessment on the resident. She thought the resident wheeled himself to his bedroom. The ADON denied recalling anyone else reporting anything new the rest of that day related to Resident #63. The ADON said she did not remember if she told the floor nurse on his hall that day ([DATE]) what happened in therapy. She said she probably should have documented therapy calling her in to see Resident #63 and what she saw that day in therapy, but she did not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A subsequent interview on [DATE] at 9:11 A.M. with ADON #164 occurred when the ADON called with additional information. She said (on [DATE]) Resident #63 was tired in the therapy. She stated she did speak to LPN #78, the nurse on his hall, and LPN #78 said this was the resident's normal. The ADON revealed she did not recall what exactly she reported to LPN #78 regarding the resident and therapy on this date. ADON #164 revealed Resident #63 was not doing well on [DATE]; he was not chatty like a normal day. An additional interview on [DATE] at 2:10 P.M. with ADON #164 included Resident #63 was falling asleep in therapy and did not look well. His head was falling down, and he was supporting it by holding it up with hand. ADON #164 included the resident was nodding off but easily arousable. When he was sleeping, he looked sick like he didn't feel well. She included she went to NP #163 to decide if they should transfer the resident to the emergency room. ADON #164 indicated she asked the NP if she (the NP) could look at the resident. However, the NP told her the was going to see the infectious disease physician the next day and to have staff do a telehealth visit if needed. Interview on [DATE] at 9:47 A.M, with LPN #86 revealed he was the night nurse who came in at 7:00 P.M. on [DATE]. He stated Resident #63's call light was on during report, and he thought CNA #105 answered the call light but said the resident did not want anything that he had just bumped it. LPN #86 revealed during shift change report he was not told of any episode in therapy related to Resident #63. He was told the resident was extremely tired throughout the day. LPN #86 revealed the first time he saw the resident was when he took in his medications at 8:10 P.M. at which time he found the resident's skin cool to touch, and he was not breathing. The resident's oxygen was up by his head and not in his nose. LPN #86 stated he ran out of the room and grabbed the crash cart and had a nurse call 911. A nurse supported the resident's head, they lowered him to the floor, and they began cardiopulmonary resuscitation. Interview on [DATE] at 9:27 A.M. with CNA #110 revealed on [DATE] she was assigned to Resident #63's hall. The resident had been very lethargic, and his lips were cyanotic, but he did go to therapy. CNA #110 revealed she had not assisted the resident back to bed after therapy and was unsure who had helped him get into bed. The CNA revealed she was not real familiar with Resident #63 but indicated the resident had not eaten any breakfast, or just a bite or two, indicating he was not hungry. However, she did have another staff enter he had eaten 26-50 percent of breakfast (she did not have access to enter the documentation). The CNA denied collect the resident's lunch tray, so she stated she did not write down a percentage eaten down, but revealed it was entered that he had eaten 76-100 percent (the accuracy of this could not be verified). The resident did not eat any dinner; however, the TASK kiosk included the resident consumed 51-75 percent of the dinner meal. CNA #110 revealed she told the aide coming in during shift report the resident had been lethargic, had not eaten. The resident's lips looked bluish, and he was taking gasps of air laying on the bed. The CNA stated it looked like he was going septic. She said she told the nurse (LPN #78) what she was seeing. She said the nurse reporting checking the resident's vital signs after lunch and they were fine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 10:07 A.M. with LPN #78 revealed on [DATE] the resident was asleep every time she went in his room, but she was able to wake him up. She stated she did not recall Resident #63 eating breakfast on this date. At lunch she tried to wake him up to eat lunch and he said OK. The LPN didn't recall if the resident ate supper on this date. The LPN revealed residents were not required to have vital signs taken every day and denied obtaining vital signs for the resident on this date. The LPN denied recall of ADON #164 saying anything to her or therapy saying anything to her about Resident #63's condition on [DATE]. LPN #78 revealed if she knew the resident's oxygen saturations were low and pulse fast, she would have obtained a set of vital signs every 20 minutes, turned on his oxygen and made sure he wore it. LPN #78 stated she thought Resident #63's face was flushed that day ([DATE]). The LPN then indicated Resident #63 refused his vitals to be taken at 4:50 P.M. as part of his daily orders. Interview on [DATE] at 10:39 A.M. with RN #149 revealed on [DATE] Resident #63 was difficult to arouse; however, the RN did not believe this was uncommon for the resident. The RN indicated she had discontinued the resident's intravenous antibiotic this morning and did not feel there was anything off about him at that time. Interview on [DATE] at 11:39 A.M. with the Director of Nursing revealed on [DATE] she documented Resident #63's supper meal percentage as 51-75 percent. She included someone would have had to tell her that percentage for her to write it. Interview on [DATE] at 11:53 A.M. with CNA# 162 revealed when she came in for night shift on [DATE] Resident #63 was asleep on walking rounds. She went out to her car and when she came in, they (staff) had started a code (for Resident #63). Interview on [DATE] at 10:28 A.M. with NP #163 revealed she was not provided any vital signs by ADON #164 to review from [DATE] for Resident #63. The NP stated if she knew the resident's oxygen saturation was 76 percent, pulse 118 and he was unable to complete therapy, she would have had the nurses keep the resident's BiPAP on him and would have transferred him to the emergency room if he continued with the elevated pulse and lower oxygen saturation. She stated she would have assessed him if she would have been aware of the change in condition. Interview on [DATE] at 5:04 P.M. with CNA #105 revealed on [DATE] Resident #63's call light was on at 6:53 P.M. when she arrived to work on this date. She stated she clocked in and put her stuff behind the nurse's station and then started answering lights (there were five resident call lights on). Resident #63's call light was the second light she answered. The resident way laying sideways in bed with his feet hanging down off the side of the bed and his head touching the mattress and propped up just a little bit. The CNA stated she asked the resident if he was alright or needed anything. The CNA stated the resident sort of sat up partially and his eyes were opened but he did not say anything. The CNA stated she took this as him not needing anything and left the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility undated Notification of Change in Condition policy revealed it was the policy of the facility to provide resident centered care that meets the psychosocial, physical, and emotional needs, concerns of the residents. Changes may include but are not limited to changes in overall health status, significant medical changes and therapy services changes. The policy included the facility must inform the resident, consult with the resident's medical practitioner and/or notify the residents' representative, authorized family member, or legal power of attorney/guardian when there was a change requiring such notification. Circumstances requiring notification included but were not limited to significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status including but not limited to life-threatening conditions or clinical complications. Review of the facility's Oxygen-Medical Gas Use policy (dated 2014) included a licensed nurse, or respiratory personnel would provide respiratory assessments as indicated. This deficiency represents non-compliance investigated under Complaint Number OH00165450.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Sheriff report review, interview, and policy review, the facility failed to ensure resident needs were met related to a fall and supervision was provided related to resident safety. This affected two residents(#42 and #64) of seven residents reviewed. Findings include: 1. Review of Resident #64's medical record revealed a 09/25/23 admission with diagnoses including chronic diastolic congestive heart failure, type two diabetes, gastroesophageal reflux, disease, hypertension, hypothyroidism, moderate protein calorie malnutrition, cardiomyopathy, personal history of transient ischemic attacks without residual deficits, depression, dysphasia, neuropathy, non-rheumatic mitral valve stenosis and dementia. Review of a 05/09/25 quarterly minimum data set assessment (MDS) revealed the resident was severely impaired for daily decision-making with hallucinations, verbal behavior symptoms one to three of the look back days. She had no upper or lower body functional impairment. The resident was dependent on staff for oral hygiene, toileting, bathing, and on upper and lower body dressing and personal hygiene. She was dependent on staff for locomotion in her wheelchair. She was always incontinent of bowel and bladder. She had no falls since the last assessment. She had no unhealed ulcers or skin issues. Interview on 05/22/25 at 5:31 P.M. with Resident #64's daughter revealed the resident had an electronic monitoring device with a camera in her room. The resident's daughter stated she saw her mother on the floor on camera footage and did not receive a call about a fall. She showed the footage to the Director of Nursing who said she did not know about the fall. Interview on 05/22/25 at 5:57 P.M. with the Director of Nursing (DON) verified on 03/31/25 Resident #64's daughter showed her footage of her mother in front of her wheelchair on the floor in her room on 03/28/25. Registered Nurse (RN) #126 was observed going in the room and completing an assessment. Review of Resident #64's medical record revealed there was no documentation in the record of a fall on 03/28/25. There was not an intervention put in place. The Nurse Notes included a late entry dated 03/31/25 at 7:19 P.M. included the nurse was called to see the resident on arrival to the room. The resident was found to be slanted in the wheelchair with both feet on the floor. The resident was put in a comfortable position. On examination, the resident was oriented to person but neither time or place. Vital signs were checked and recorded as temperature 98.2 degrees Fahrenheit, blood pressure 121/72, pulse 78 beats per minute, respirations 18 breaths per minute and oxygen saturation 96 percent oxygen saturation on room air. Review of the plan of care at risk/actual for falls related to impaired mobility, medication side effects, and impaired safety awareness included the resident had an intervention dated 03/28/25 for staff supervision when up in wheelchair for safety as resident allows. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated Fall Prevention and Management policy included attempt to put an intervention in place that could prevent further falls. Complete the Post Fall Assessment, complete the Fall Follow Up at least twice each day times three days unless the residents condition is such that it should be continued longer. A report should be initiated in Risk Watch and update the care plan with new interventions. Interview on 05/30/25 at 7:54 P.M. with the Director of Nursing (DON) revealed the intervention was added 03/31/25 after she was made aware of the fall. The DON included the electronic record allowed the writer to back date an intervention and she entered the date of the fall. The DON verified the nurse did not document the fall, fill out an incident report or put an immediate intervention in place. The DON verified the Fall Prevention and Management policy identified to Complete the Post Fall Assessment, the Fall Follow Up at least twice each day times three days, report initiated in Risk Watch and update the care plan with new interventions and these were not done by the nurse for Resident #64. 2. Review of Resident #42's medical record revealed a 05/31/24 admission with diagnoses including pulmonary embolism, pleural effusion, chronic pain, and abnormalities of breathing. Review of the 04/08/25 Quarterly MDS included the resident was independent for daily decision making. He did not feel depressed or socially isolated. The resident had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) one to three days of the look back period and rejection of care four to six days. There was no functional impairment. He utilized a wheelchair manual, required staff supervision sit to stand or transfer, and could wheel himself 150 feet. He was always continent of bowel and bladder. He received as needed pain medication, anticoagulants and opiods. Review of an anonymous complaint called into the state on 05/30/25 included a resident left the facility, was in the middle of the street in a wheelchair, the police responded and it was reported in the local newspaper. Interview on 05/30/25 at 2:05 P.M. with the DON verified on 05/24/25 Resident #42 was in his wheel chair in the street and they called 911 to get him to return to the building. The DON indicated they did not consider it an elopement due to the resident being independent for decision making. She revealed when she received the call from staff the resident was in the road, she was told he was on Route 22 (a busier road) so she told the caller to call 911. The DON phoned the Administrator and they both went to the facility. The Administrator and Sheriff convinced the resident to return to the facility. Review of documentation revealed the resident signed himself out on 05/24/25 at 4:05 P.M. for a leave of absence. Record review included a Nurse Note dated 05/24/25 at 6:20 P.M. Resident #42 wanted to go to the store to get a beer. Staff tried to redirect the resident and told him that was not a good idea. He signed himself out in the book and was waiting on a cab. Will continue to monitor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 05/24/25 [NAME] County Sheriff's Office Call Record Report included the dispatch was called at 7:28 P.M. and the clearance time was 7:40 P.M. The sheriff's department arrived at 7:37 P.M. An employee of the facility requested a deputy to assist with a patient who walked away from the facility and who was refusing to return. Several other employees were currently with the patient near [NAME] Avenue however the patient has been combative and refusing staff's direction. Upon arrival the lieutenant spoke with Resident #42 who was in his wheelchair in the middle of [NAME] Avenue stating he hated the facility and he was not going back. Resident #42 stated he was going to the smoke shop to get some weed marijuana and a Twisted Tea and then he would go back. Resident #42 stated he's a grown man and just wants to live his life. The facility Administrator, stated the resident was allowed to sign himself out for the day if he wants, but he cannot be rolling down the road in a wheelchair. The officer advised the resident he would go get him a pop if he wanted and he said he only wanted a Twisted Tea. The officer explained to him he could not buy him alcohol in uniform and asked him if he was on a medication. Resident #42 admitted he was on oxycodone so the officer explained they would have to speak with the doctor before they gave him marijuana and alcohol while taking a narcotic. After a brief discussion Resident #42 agreed to go back to the facility and let the administrator talk to the doctor and nurse supervisor to see if they could work something out with him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/02/25 at 10:18 A.M. with Licensed Practical Nurse (LPN) #104 revealed she was the nurse on duty 05/24/25. It started about 3:00 P.M. with Resident #42 wanting a beer. The resident said he wanted a beer. She told him it was not a drinking facility. They have to have an order from the doctor. He said he would drink it there at the little store at the end of the road then turn left. It is a 76 gas station with a store. The store on the hill. He had money in his wallet. He had been here a year and to her knowledge never asked for alcohol in the past. We tried to redirect him. He said he was signing himself out for a leave of absence and calling a taxi. There was not a taxi in Wintersville or Steubenville that she knows of and she guesses he called Weirton [NAME] Virginia. He went and sat out front of the facility in his wheelchair at 4:05 P.M It was a little after 5:00 P.M. and he came back in and said he had to pee. LPN #104 said to the resident , you're back already? He said no he never left he was still waiting on a cab. He came back in to pee and then went back out. He did not eat supper. She did not see him again. She did not see him out front and he did not come back in. The next time she saw him was when the next shift was coming in before 7:00 P.M. An aide came in and said asked me if I knew Resident #42 was up the hill. She stopped and asked him what he was doing and he did not answer. He was at the top of the road that leads from the facility. He was talking to someone who was sitting on their porch from the apartment building at the top of the road. You can look up the hill from the nurse station. She did not see him and thought the cab must have come. A friend who use to work at the facility had stopped off to visit. She called LPN #104 when she left and said Resident #42 was sitting at the top of the hill in the middle of the street on [NAME]. They were in shift report. She told the night shift nurse who texted the DON who said call 911 if he won't move. After report she drove up the hill and parked the car in the street to shield him. A night shift aide was there in front of the wheelchair to stop it from going further because it was a hill to get to the main road. The resident would not get out of the middle of the road. He said it was his holiday weekend too, he has rights too. At that point he said he wanted pot also and wanted to go to Smokey's in Steubenville. He had never mentioned pot for the year he was there that she knows of. He would not leave the middle of the road. The police and the Administrator came so the employees left. The resident never seemed confused. When she saw him the next day he said he did everything right. She told him sitting in the middle of the road isn't exactly right and he told her sometimes shit happens. LPN #104 verified the resident had never signed out for a leave in the past. He said he was calling a taxi although she knew there was probably no taxi service in the area. She verified he sat outside from approximately 4:05 P.M. until 7:40 P.M. when he was returned to the facility by the Administrator. There was no knowledge of anyone going out to check on the resident. LPN #104 did not call the physician to get the resident a beer order. Interview on 06/02/25 at 10:48 A.M. with the DON revealed when she arrived to the facility (on 05/24/25) the Administrator was wheeling Resident #64 back to the building and the police were following. The resident had never mentioned a beer to her before. She had never known him to call a taxi. She told him if he wanted to go out he needed to wait till the taxi got here then sign out. He never mentioned friends or goes out with people. The facility van has been broken down for years so residents do not get to go on outings or shopping. They were borrowing a van from a sister facility on a routine day. They were cited last July (2024 during the annual recertification survey) for not having a van and not taking residents on appointments and outings. They were supposed to get a van from a sister facility on routine days but she doesn't know what happened to that because they stopped using the van. She verified if the facility could take Resident #64 to stores so he could shop himself especially because he was a greeter at Walmart for 10 years, he may not be saying he was leaving to go get a beer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/02/25 at 11:20 A.M. with Social Services #168 revealed she applied for Home Choice for Resident #42 last fall. The facility recommended assisted living. He did not agree with that. He wanted independent living. So Home Choice left. He now wants to go to an assisted living a friend went to and she contacted Home Choice to start the process again. They do not have a van. It comes up quite frequently from residents and families who want to go shopping. Last August (2024) they wanted to go to a festival in Steubenville having to do with the fort there and they couldn't go. She would tell the old Administrator who did not have an answer. She spoke to the new Administrator after getting a call from a company asking if we had a van, for him to follow up with the company. She does not know if he did anything with it. Interview on 06/02/25 at 12:16 P.M. with Activity Aide #79 revealed they were borrowing a van. The last outing was 08/26/24. The person who drove the van left so they quit going on trips. She said the residents are fed up. Resident #42 is young. He wanted to go get donuts but we could not take him because we don't have a van. He wants to be in the vehicle and see things. He wants to go out and is trapped inside. Review of the facility's undated Elopement Prevention of Management Overview policy included a leave of absence is defined as when a cognitively intact resident who is capable of independent decision or resident representative notifies the facility of intent to go on a leave of absence prior to leaving the facility. The interdisciplinary team plans the least restrictive interventions to promote mobility and safety to meet the individuals needs and goals of the resident/patient. Components of the elopement prevention and management program include but are not limited to environmental modifications to promote safe mobility with monitoring for effectiveness, regular rounds and structured group activities. This deficiency represents non-compliance investigated under Master Complaint Number OH00166127 and Complaint Number OH00165930.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to provide evidence the physician conducted in-person examination of all residents. This affected one resident (#51) of three residents reviewed for physician documentation. The facility census was 62. Findings include: Record review of Resident #51 revealed an admission date of 10/04/24. Diagnoses include Type 2 Diabetes Mellitus with diabetic neuropathy (nerve pain), Asthma, Morbid Obesity, Bipolar Disorder, Atrial Fibrillation (an abnormal hearth rhythm), Acute Respiratory Failure, Hypertension (high blood pressure), and Hyperlipidemia (high levels of fat in the blood). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was admitted to the facility from a short-term general hospital. Review of the progress notes since admission revealed no notes in the electronic medical record written by the Medical Director #1 who was the attending physician for Resident #51. Interview with the director of nurse (DON) #1 on 05/22/25 at 3:55 P.M. revealed Medical Director #1 would co-sign Physician Assistant or Nurse Practitioner notes but did not have physician notes within Resident #51's medical record. Interview with DON #1 on 05/22/25 at 3:55 P.M. verified the facility was unable to provide physician notes from Medical Director #1 for Resident #51. Review of the undated policy titled General Physician Services revealed the physician was responsible for reviewing the resident's plan of care during visits and a progress note is to be written and signed. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00165450.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, the facility failed to maintain accurate resident medical records. This affected two residents (#42 and #64) of seven residents reviewed. Findings include: 1. Review of Resident #64's medical record revealed a 09/25/23 admission with diagnoses including chronic diastolic congestive heart failure, type two diabetes, gastroesophageal reflux, disease, hypertension, hypothyroidism, moderate protein calorie malnutrition, cardiomyopathy, personal history of transient ischemic attacks without residual deficits, depression, dysphasia, neuropathy Non-rheumatic mitral valve stenosis and dementia. Interview on 05/22/25 at 5:31 P.M. with Resident #64's daughter revealed she had an electronic monitoring device with a camera in her mother's room. She stated she saw her mother on the floor on camera footage and did not receive a call about a fall. She showed the footage to the Director of Nursing who said she did not know about the fall. Interview on 05/22/25 at 5:57 P.M. with the Director of Nursing (DON) verified on 03/31/25 the Resident #64's daughter showed her footage of her mother in front of her wheelchair on the floor in her room on 03/28/25. Registered Nurse (RN) #126 was observed going in the room and completing an assessment. Review of the medical record revealed there was no documentation in the record of a fall on 03/28/25 until three days later when the resident's daughter showed the DON the camera footage. Review of the facility undated Clinical Documentation Standards policy, included it is the policy of this facility to provide resident center care that meets the psychosocial, physical and emotional needs and concerns of the residents. Nurses will follow the basic standard practice for documentation, including, but not limited to providing a timely and accurate account of resident information in the medical record documenting legibly in English using only acceptable medical abbreviations. The primary purpose of the medical record is to provide continuity of care. Other reasons include clinical evidence of care, treatment records as evidence of care and regulatory statues that require maintaining and recording care. The nurse is expected to document accurately and truthfully to the best of his or her knowledge what is heard or seen during assessments or encounters that concern the resident. Document information specific to that resident in the record and not include another residents' information. Document entry during the work shift to complete all entries before leaving the facility for that shift. Document the status of the resident, including changes. The medical record will reflect the current status of the resident. Chart in real time when an event is occurring or shortly thereafter, as is practical. Avoid late entries. Late entries may be confusing and contradictory, and use only sparingly. Interview on 05/30/25 at 7:54 P.M. with the Director of Nursing (DON) verified the nurse did not document the fall, fill out an incident report or put an immediate intervention in place for Resident #64 and the resident's medical record was not complete and accurate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #42's medical record revealed a 05/31/24 admission with diagnoses including pulmonary embolism, pleural effusion, chronic pain, and abnormalities of breathing. Review of an anonymous complaint called into the state 05/30/25 included a resident left the facility, was in the middle of the street in a wheelchair, the police responded and it was reported in the local newspaper. Interview 05/30/25 at 2:05 P.M. with the DON verified Resident #42 was in his wheel chair in the street and they called 911 to get him to return to the building. The DON indicated they did not consider it an elopement due to the resident being independent for decision making. She revealed when she received the call he was in the road, she was told he was on Route 22 a busier road so she told the caller to call 911. She phoned the Administrator and they both went to the facility. The Administrator and Sheriff convinced the resident to return to the facility. Record review included a Nurse Note dated 05/24/25 at 6:20 P.M. Resident #42 wanted to go to the store to get a beer. We tried to redirect and told him that was not a good idea. He signed himself out in the book and was waiting on a cab. Will continue to monitor. Review of a 05/24/25 [NAME] County Sheriff's Office Call Record Report included the dispatch was called at 7:28 P.M. and the clearance time was 7:40 P.M. The sheriff's department arrived at 7:37 P.M. An employee of the facility requested a deputy to assist with a patient who walked away from the facility and who was refusing to return. Several other employees were currently with the patient near [NAME] Avenue however the patient has been combative and refusing staff's direction. Upon arrival the lieutenant spoke with Resident #42 who was in his wheelchair in the middle of [NAME] Avenue stating he hated the facility and he was not going back. Resident #42 stated he was going to the smoke shop to get some weed marijuana and a Twisted Tea and then he would go back. Resident #42 stated he's a grown man and just wants to live his life. The facility Administrator, stated the resident was allowed to sign himself out for the day if he wants, but he cannot be rolling down the road in a wheelchair. The officer advised the resident he would go get him a pop if he wanted and he said he only wanted a Twisted Tea. The officer explained to him he could not buy him alcohol in uniform and asked him if he was on a medication. Resident #42 admitted he was on oxycodone so the officer explained they would have to speak with the doctor before they gave him marijuana and alcohol while taking a narcotic. After a brief discussion Resident #42 agreed to go back to the facility and let the administrator talk to the doctor and nurse supervisor to see if they could work something out with him. The medical record did not contain an entry of the resident being in the middle of the street, police being called and the Administrator and Director of Nursing coming to the facility to assist with the resident. Interview on 06/02/25 at 10:48 A.M. with the DON verified the medical record did not contain the events of the day on 05/24/25 for Resident #64. The DON verified it did not include the difficulty the staff had getting the resident out of the road and back into the facility. This deficiency represents non-compliance investigated under Complaint Number OH00165930.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, the facility failed to ensure contact isolation precautions were implemented for a resident with a multi drug resistant organism with drainage that was not contained. This affected one resident (#63) of seven residents reviewed for infection control practices. Findings include: Review of the closed medical record for Resident #63 revealed an admission date of 03/28/25 with diagnoses of cellulitis, morbid severe obesity (410 pounds (lbs) on 04/21/25), cor pulmonale, congestive heart failure, hypertension, respiratory failure, acute and chronic renal failure, adult failure to thrive, psychoactive substance abuse, Stage 3 chronic kidney disease, chronic venous insufficiency, iron deficiency anemia, and lymphedema. Review of a Medical Director order dated 03/29/25 revealed Resident #63 was admitted to the facility for skilled level of care with therapy and/or nursing services. He was receiving oral and intravenous antibiotics for cellulitis to right posterior lower leg measuring 0.2-centimeter (cm) x 9 cm width x 10 cm length. Review of Resident #63's orders by the Medical Director included a 03/29/25 order for vital signs every shift for 72 hours then daily, a wound care consult and wound care to lower right leg posterior wound cleanse with soap and water, rinse with normal saline solution, pat dry, apply Silvadene cream to wound bed. cover with ABD , secure with Kling, and ace bandages from toes to below knees bilateral lower extremities, and a 03/31/25 order to evaluate and treat for physical and occupational therapy. Review of the Medical Directors orders dated 03/31/25 revealed the resident had enhanced barrier precautions implemented. Review of the admission Minimum Data Set Assessment (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) that indicated Resident #63 was cognitively intact and independent for daily decision making. The resident exhibited no behaviors and rejected care one to three days in the look back period. Review of the Functional assessment dated [DATE] revealed no upper or lower body functional impairment. The resident used a walker and wheelchair, was dependent on staff for toileting, shower, upper and lower body partial moderate assistance with dressing, and personal hygiene. The resident was administered routine antipsychotics, antianxiety, antidepressant, diuretics, antibiotics, opioids, and hypoglycemic medications. The resident was receiving physical and occupational therapy. He required partial/moderate assistance to move from sitting position to lying position, required substantial/maximal assistance to move from lying position to sitting on the side of the bed, and required substantial/maximal assistance to transfer from a bed to a wheelchair. A wound culture was ordered 04/10/25 due to odor from the right leg wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a wound consult by Nurse Practitioner (NP) #177 dated 04/15/25 revealed the right lower leg vascular ulcer measured 15.00 centimeters (cm) x 10 cm x 0.3 cm with 100% granulation and improving without complications. Review of the medical record revealed the right leg wound culture was finalized 04/16/25 with heavy growth of Acinetobacter Baumannii (CRAB). This specimen was carbapenem resistant and positive for carbapenemase production. Review of Nurse Practitioner #163's note dated 04/17/25 at 1:00 A.M. revealed resident did have wound cultures that were reviewed today, and they are growing Acinetobacter Baumannii Carbapenem Resistant. I discussed with the patient that he may need to receive intravenous antibiotics for this. I did discuss the possible need for hospitalization. He did not want to go to the hospital at this time. He tells me the pain in his legs is getting better. Staff have reported refusal of dressing changes; however, the patient tells me he did not refuse dressing changes. He was noted to have an odor to the wound. No fever reported. I discussed with the patient that I am going to obtain blood cultures and labs here at the facility and plan to start intravenous gentamicin, an antibiotic, as long as his blood cultures are negative. He denies any chest pain or shortness of breath. He has no other complaints. Review of a Nurses Note by Licensed Practical Nurse (LPN) #78 dated 04/17/25 at 10:08 A.M. included Resident got some critical labs from lower legs. Nurse Practitioner (NP) notified, order to send to the emergency room for antibiotic intravenous therapy. Review of the right lower leg wound culture included the results were finalized 04/16/25. The wound culture grew heavy growth of Acinetobacter Baumannii Carbapenem Resistant bacteria. The culture included to notify local health department. There was no evidence of the health department being notified. Review of a Nurses Note written by LPN #77 dated 04/17/25 at 11:52 P.M. included at 7:52 P.M. the resident returned to the facility from the emergency department. There were no new orders. Vitals within normal limits for resident. Physician orders dated 04/18/25 written by Assistant Director of Nursing (ADON) #169 included to discontinue enhanced barrier precautions. There was no evidence of contact precautions ordered or initiated for Resident #63. Review of Nurse Practitioner #163's note dated 04/21/25 revealed Resident #63 was sent to the Emergency Department due to a wound infection on 4/17/25. He was evaluated in the emergency department and had full sepsis work up. He was given one dose of intravenous antibiotics then sent back to the facility. I reviewed his labs at the emergency department. Blood cultures were obtained and pending. His white blood cell count was negative. Procalcitonin was 0.041 and lactic acid was 1.4. The Chemistry panel showed a creatinine of 1. 42 which was his baseline. He was noted to have a foul odor from his wounds. He received one dose of Ceftazidime then was sent back on no further antibiotics. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a finalized blood culture report dated 04/22/25 from Resident #63's emergency room visit of 04/17/25 returned no growth. A Peripherally Inserted Central Catheter (PICC) and Gentamycin Sulfate Solution 800 milligrams (mg) intravenously every 24 hours for infection for seven days in 0.9% normal saline solution (NSS) 100 milliliters was ordered intravenous and the first dose was administered 04/23/25 at 10:18 A.M. Interview on 05/2725 at 2:49 P.M. with Registered Nurse (RN) #179 from the [NAME] County Health Department revealed the facility did not call the health department to let them know they had a resident infected with Acinetobacter Baumannii Carbapenem Resistant bacteria. She reviewed the Ohio Department of Health (ODH) website. The local hospital will upload drug resistant bacteria cases to the ODH website. On the website she can see [NAME] County cases. RN #178 said she called the facility on 05/08/25 and asked them for a disease case report which she sent to them to fill out and return. She called the facility back on 05/22/25 and spoke with the Director of Nursing and told her she still did not have the information. On 05/27/25 she still had not received the information from the facility. Interview on 05/27/25 at 3:04 P.M. with Physical Therapy Assistant (PTA) #147 included Resident #63 had bilateral ace wraps to his lower legs. He would leave wet footprints on their floor when he was in the therapy department for treatment. His lower legs were edematous and they would seep down his legs and get his slipper socks wet. The slipper socks would leave wet footprints. He would leave wet foot prints with dripping from the edematous leg. We used gloves and at times gowns when we stood or transferred the resident. We put his feet on towels when he was in therapy to catch the drainage because they noticed he was getting their floor wet. PTA #147 included the resident would propel himself through the halls in a wheelchair with his feet and leave wet areas. Interview on 05/27/25 at 3:20 P.M. with RN #149 revealed Resident #63 was on enhanced barrier precautions not contact precautions. Resident #63 did not have dedicated equipment and staff did not gown and glove to enter the resident's room. Interview on 05/27/25 at 3:30 P.M. with the Director of Nursing verified there was no evidence Resident #63 was on contact precautions. The DON figured the ADON was canceling enhanced barrier precautions on 04/18/25 to change to contact precautions and did not write an order for contact precautions. Review of the Questionnaire for Reportable Condition form sent by the health department revealed for the question was the patient on contact precautions question #6 it was marked yes from 03/28/25-04/23/25. Question #11 ask if yes to above, was the patient on contact precautions was answered yes start date of 03/31/25 till 04/18/25. Questions #16, #17 and #21 were not answered. Interview 05/27/25 at 3:44 P.M. with LPN #169 revealed she took over infection control last week for the facility. The Director of Nursing was overseeing infection control in the interim after the ADON left until she received her certification. She received her certificate 05/16/25. She verified she marked the Resident #63 was on contact precautions when the resident was on enhanced barrier precautions. She indicated she took the isolation bin to Resident #63's room but did not know what isolation sign was up. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility undated Enhanced Barrier Precautions policy included the policy is applicable as an infection control intervention designed to reduce transmission of multi drug resistant organisms. Required personal protective equipment (PPE) included gowns and gloves. Communication to staff and visitors included to post a sign on the door, indicating enhanced precaution is required. Employees hand hygiene, gown, and glove use during high contact resident care activities that include dressing, bathing, showering, transferring providing hygiene, changing linens, changing or assisting with toileting, device care, use of central line, urinary catheter, feeding tube, tracheostomy, ventilator, wound care and any skin opening requiring addressing. In general gowns and gloves would not be recommended when performing transfers in common area, such as dining or activity rooms when contact is anticipated to be a shorter duration. Outside the resident room enhanced precaution should be followed when performing transfers or assisting during bathing in a shared shower room, and when working with resident in the therapy gym specifically with physical contact with transfer mobility. Residents are not restricted to the rooms or limited from participation in group activities. Enhanced precautions is intended to be in place for the duration of the resident stay in the facility until resolution of the wound or discontinuation of the indwelling medical device. Implementing contact versus enhanced barrier precautions applies to infected or colonized with any Multi drug Resistant organism (MDRO) and has secretions or exclusions that are unable to be covered or contained contact precautions are to be initiated. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00165450.