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	07/29/2025

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. (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
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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, review of funds list, and policy review, the facility failed to ensure residents had access to personal funds after business hours and on weekends. This affected four residents (#4, #22, #30 and #36) of four residents reviewed for personal funds managed by the facility. The facility census was 63.Findings include:Review of the facility funds list dated 07/08/25 revealed Residents #4, #22, #30, and #36 each had a personal funds account with the facility. Observation and interview on 07/08/25 at 7:26 A.M., with HR #153 confirmed she was responsible for dispensing resident funds. The surveyor requested to observe the money box for resident funds. HR #153 confirmed she did not leave a money box for staff after she left Tuesday at 5:00 P.M. The HR reported she leaves the money box on the weekends in the medical room, however, could not recall which staff member she had given to the box to the week prior. HR #153 reported most of the resident know they need to get money out before she leaves at the end of the day. Interview on 07/08/25 at 7:30 A.M., with Registered Nurse (RN) #158 reported he did not have access to personal funds, and it was the responsibility of HR #153. Interview on 07/08/25 at 7:50 A.M., with Licensed Practical Nurse (LPN) #163 confirmed there was no money left on weekends or after 5:00 P.M. on weekdays for staff to have available for residents. Interview on 07/08/25 at 8:00 A.M., with LPN #187 confirmed HR #153 was the only staff member that distributed personal funds money. LPN #187 reported the nursing staff did not have access to the money.Interview on 07/08/25 at 8:10 A.M., with Certified Nurse's Aide (CNA) #101 confirmed residents had voiced concerns regarding funds and they get frustrated because the staff doesn't have access to their funds. Interview on 07/08/25 at 10:15 A.M., with anonymous staff member #106 confirmed residents have voiced concerns that they don't have access to their money, and at times have waited days to get money due to the facility didn't have money in the personal funds box. The anonymous staff member reported in the past, a box was left in the medication room after hours to ensure residents had access to their funds after hours. Interview on 07/09/25 at 10:36 A.M., with Resident #22 confirmed the facility had ran out of money for days. The resident reported there was always an excuse why she could not get her money out. Resident #22 confirmed she cannot get her money out of her account after 5:00 P.M. during the week or on the weekends. Interview on 07/09/25 at 10:51 A.M., with Resident #4 confirmed she doesn't have access to her personal funds after 5:00 P.M. during the week and on the weekends. Resident #4 reported if you don't get your money out before 5:00 P.M. during the week, then you are just out of luck. Interview on 07/09/25 at 10:56 A.M., with Resident #30 confirmed he doesn't have access to his personal funds after 5:00 P.M. during the week or on weekends. Interview on 07/09/25 at 11:02 A.M., with Resident #36 confirmed he doesn't have access to his personal funds on the weekends or after 5:00 P.M. on weekdays. Interview on 07/10/25 at 7:07 A.M. with CNA #186 confirmed residents had voiced concerns regarding not having access to their funds. Interview on 07/10/25 at 7:16 A.M., with CNA #113 confirmed residents get flustered with her because they don't have access to their funds after management leaves. Review of the facility's policy and procedure titled Resident Trust Fund dated 06/01/16 revealed the facility would comply with all Federal and State laws and regulation regarding the handling of resident's funds and personal needs allowance accounts. This deficiency represents non-compliance investigated under Complaint Number OH00166292 (1284491).

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	365629	A. Building B. Wing	07/29/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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	365629	A. Building B. Wing	07/29/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of hospital records, review of Medscape medical reference information, policy review, and interviews, the facility failed to protect Resident #64's right to be free from neglect. This resulted in Immediate Jeopardy and Actual Harm with subsequent death beginning on [DATE] when the facility failed to provide timely and appropriate goods and services to meet Resident #64's total care and medical needs and failed to ensure the resident received timely and necessary care and treatment to prevent serious illness and death. On [DATE] Resident #64 returned from the hospital with orders for Lasix (diuretic) 20 milligrams (mg) daily and basic metabolic profile (BMP) laboratory test to be completed on [DATE]. The orders for Lasix and the BMP were not initiated or completed per the hospital discharge orders. On [DATE], Resident #64 was ordered additional laboratory testing, including thyroid stimulating hormone (TSH), Vitamins B1, B6, and B12, plasma, folate, and Vitamin D and D3 levels that were not completed. Resident #64 was hospitalized from [DATE] to [DATE] for hypoglycemia, hyperkalemia with EKG changes, hyponatremia, and encephalopathy. On [DATE], the resident was ordered Lasix 80 mg upon discharge from the hospital that was not implemented. On [DATE], the resident was ordered to have laboratory testing including a complete blood count (CBC) and BMP completed STAT (immediately) to determine if the resident's Lasix was appropriate to continue. On [DATE], a one-time order for Lasix 40 mg and Potassium 20 milliequivalents (meq) was ordered and not administered. The STAT CBC and BMP lab results ordered on [DATE] and completed on [DATE] were not reported timely to the provider, resulting in the resident being hospitalized from [DATE] to [DATE] with edema requiring a Bumex (diuretic) continuous intravenous infusion. Additionally, upon re-admission on [DATE], Resident #64 was ordered Lactulose 15 mg/milliliter (ml), 45 ml four times daily. On [DATE], Resident #64 reported to the telehealth Nurse Practitioner (NP) that she had been on Lactulose and would like to restart it again to treat her cirrhosis. The telehealth NP inadvertently ordered a duplicate dose of Lactulose 30 ml, and the resident started the dosage on [DATE]. Resident #64 received duplicate doses of Lactulose, 45 ml and 30 ml doses, from [DATE] until [DATE] (with the exception of [DATE] and [DATE] when the medication was not administered). On [DATE], the resident's progress notes referenced the resident had left calf pain and was ordered an unspecified scan, which was not completed. Resident #64 continued to decline, could not stand, and requested to go the emergency room (ER) on [DATE]. However, Resident #64 was not transferred to the ER, nor was the nurse practitioner (NP) notified. On [DATE], Resident #64 again requested to go to the ER because she could not stand, which was abnormal for her. In the ER, the resident was diagnosed with hyperkalemia (elevated potassium level), acute kidney injury, and encephalopathy (a condition that affects brain function or structure and can lead to changes in mental state, behavior, or cognitive abilities). The resident subsequently went into acute respiratory arrest (in the ER) and expired in the hospital on [DATE]. This affected one resident (#64) of three residents reviewed for abuse and neglect. The facility census was 63. On [DATE] at 2:07 P.M., the Administrator, Interim Director of Nursing (IDON) #600, Assistant Director of Nursing/Registered Nurse (ADON/RN) #179, and Regional Nurse #601 were notified Immediate Jeopardy began on [DATE] when the facility failed to provide timely and appropriate goods and services to meet Resident #64's total care and medical needs and failed to ensure the resident received timely and necessary care and treatment to prevent serious illness and death. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 3:00 P.M., Regional Director of Clinical Services #601 educated the Interim Director of Nursing #600 and Director of Nursing #179, LPN #135 and LPN #107 on the facility Abuse Neglect and Misappropriation, Residents Rights, Laboratory and Radiologic Services Reporting, Medication Administration, and Notification of Change in Condition policies, with emphasis on residents receiving the care and treatment needed to prevent serious illness and/or death, including medications needed to treat serious medical issues, providing ordered lab work and diagnostic tests that could identify medical issues, identifying serious changes and decline in a resident's condition. On [DATE] all new admissions (Resident #18, #28, #33, #43, #59 and #66) from [DATE] to current were audited and reviewed from 3:00 P.M. to 6:00 P.M., by Licensed Practical Nurse (LPN) #135 and LPN #107 to ensure all new admission orders were identified and implemented at time of admission. On [DATE], all 63 residents from [DATE] to current, were audited and reviewed from 3:00 P.M. to 8:00 P.M., by LPN #135 and LPN #107, to ensure all lab work was completed as ordered. Eight residents (Resident #4, #27, #28, #43, #50

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	07/29/2025

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Dixon Healthcare Center	135 Reichart Avenue Wintersville, OH 43953

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of self-reported incidents (SRI), interviews, and policy review, the facility failed to prevent misappropriation of Resident #48's narcotic pain patches. This affected one resident (#48) of three residents reviewed for controlled medications. The facility census was 63. Findings include: Medical record review revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including hospice services, chronic obstructive pulmonary disease, type two diabetes, absence of eye and above right knee, anxiety, peripheral vascular disease, aphasia, bursitis of right elbow, and heart disease. Review of Resident #48's orders dated 03/31/25 to present revealed Fentanyl (an opioid analgesic) 50 microgram (mcg) patch. Instructions stated to apply one patch topically to the resident's upper torso every 72 hours routinely for pain. Review of Resident #48's admission assessment completed 03/31/25 revealed the resident was not capable of verbalizing pain. The resident was noted to have displayed non-verbal indicators of pain. The resident was receiving scheduled pain medication. Review of Resident #48's aphasia plan of care dated 03/31/25 and revised 06/17/25 revealed the resident had a communication problem. Listed interventions included to observe and document for physical and non-verbal indicators of discomfort or distress and to follow-up as needed. Review of Resident #48's chronic pain plan of care dated 04/01/25 revealed to observe the resident for pain every shift and follow physician orders for complaints of pain. Review of Resident #48's Minimum Data Set (MDS) admission assessment dated [DATE] revealed the resident's was rarely/never understood. The resident had non-verbal sounds and facial expressions as indicators of pain or possible pain. The resident was noted to have indicators of pain or possible pain daily. Review of Resident #48's controlled drug record dated 04/2025 revealed on 03/31/25, five Fentanyl 50 mcg patches were delivered. The first patch was recorded as administered on 04/01/25 and the second patch on 04/04/25 as scheduled. There was a missed dose on 04/07/25, and the third dose was administered on 04/10/25. The fourth dose was administered on 04/13/25, and the fifth dose did not have a date or time it was administered. Two additional Fentanyl 50 mcg patches were sent by the pharmacy on 04/11/25. The first patch was administered 04/16/25, there was missed dose on 04/19/25, and the second patch was administered on 04/22/25.Review of Resident #48's medication administration records dated 04/2025 revealed a Fentanyl 50 mcg patch was to be applied to the resident's upper torso every 72 hours routinely for pain. The patch was signed out on the controlled drug record on 04/13/25 and 04/16/25. There was no documented evidence that an additional patch was administered between 04/13/25 to 04/16/25 to account for the fifth patch that was sent on 03/31/25.Review of Resident #48's pain assessment dated [DATE] revealed the resident received scheduled pain medication and was unable to express acceptable pain level and/or tolerance. Interview on 07/08/25 at 12:22 P.M. with Registered Nurse (RN) #158 revealed there had been several instances where Resident #48's Fentanyl patch was not in-place. He could not recall dates, but the first time he didn't think anything about it. The second time he started to wonder. The third time another nurse reported to him Resident #48's Fentanyl patch was missing, and he knew it was in-place because he was the one that administered the patch. The fourth time he spoke to the previous Director of Nursing (DON) regarding his concerns that someone was removing patches from Resident #48, however she had theories of what could have happened, but did not do anything. Then, on 06/03/25, RN #158 reported he started his own investigation and tried to rule out the hospice aide. On 06/03/25, he noticed there was not a patch in place where it was documented it was placed, however there was an old patch on her lower back that was outdated (not three days prior but could not recall exact date). RN #158 reported he waited until the hospice aide gave the resident a shower and left. The outdated patch was still on the resident's lower back. He asked another nurse to witness him applying the new patch and when he went back two hours later to give the resident oral medication, the patch was missing. He asked the nurse to come back to verify the patch was missing. The facility searched for the room and resident and the patch could not be found. They told the unit manger which told the Administrator. RN#158 reported he never thought it would come up missing in two hours and he even put a transparent patch over the pain patch to ensure it was secure. Interview on 07/08/25 at 4:00 P.M., with Regional Nurse #203 confirmed the fourth patch was signed out on the 04/13/25 and the next patch would have due on 04/16/25. Regional Nurse #203 confirmed there was documented evidence on the narcotic control sheet the date and time the fifth patch was administered, however an additional two patches were sent on 04/11/25 and staff had signed out one patch on 04/16/25 leaving patch five on the previous

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	07/29/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and facility policy review, the facility failed to timely investigate an injury of unknown origin. This affected one resident (#31) of three residents reviewed for abuse. The facility census was 63. Findings include:Medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia with other behavioral disturbance, conversion disorder with seizures or convulsions, anxiety, depression, paranoid schizophrenia, and nontraumatic intracerebral hemorrhage. Review of Resident #31's skin assessment dated [DATE] revealed the resident had skin tear on the left elbow measuring 2.0 centimeter (cm) in length by one cm in width by 0. 1 cm depth. The diagnoses was fragile skin. Review of Resident #31's order dated 07/02/25 revealed to cleanse the left elbow with normal saline, pat dry, apply xeroform (a non-adherent gauze dressing) and cover with silicone boarder foam dressing. Instructions included to change the dressing daily and as needed, every day shift, for impaired skin integrity.Further review of Resident #31's record revealed no evidence how the resident sustained the skin tear or documentation regarding the bruise to the left lower arm. Observation on 07/08/25 at 10:50 A.M. of Resident #31 revealed the resident was sitting in common area in a wheelchair. The resident had a dressing intact, and a bruise noted to his left lower arm.Interview and observation of Resident #31 on 07/09/25 at 2:38 PM with Regional Nurse #202 and Administrator revealed the resident had a dark purple bruise on his left lower arm, scratches on the upper arm, scabs noted above the dressing on the left lower arm, and slight edema to the left arm. Regional Nurse #202 confirmed the facility did not conduct an investigation to determine how the resident sustained the skin tear, nor was there documentation regarding the bruise on the left lower arm. The Administrator reported the facility had started an self-reported incident (SRI) that day (07/09/25).Review of the facility's policy titled Abuse Neglect, and Misappropriation undated revealed an injury should be classified as an injury of unknown origin when both of the following conditions are met: the source of the injury was not observed by any person and the source of injury could not be explained by the resident and the injury was suspicious. The accurate and timely identification of any event which would place a resident at risk is a primary concern of the facility. The following procedure will assist the staff in the identification of incident and direct them to appropriate steps and interventions. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source, or report of alleged abuse, neglect, or misappropriation of funds would be identified and reported to the supervisor and investigated timely. This deficiency represents non-compliance investigated under Complaint Number OH00166698 (1284492).

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	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	365629	A. Building B. Wing	07/29/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interviews, the facility failed to ensure that adequate care and treatment was provided for a resident with left arm edema and failed to ensure bruising was assessed and documented. This affected one resident (#31) of three residents reviewed for change in condition. The facility census was 63. Findings include:Medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia with other behavioral disturbance, conversion disorder with seizures or convulsions, anxiety, depression, paranoid schizophrenia, and nontraumatic intracerebral hemorrhage. Review of Resident #31's progress notes dated 07/04/25 to 07/06/25 revealed no evidence the resident had left arm edema. Review of Resident #31 progress note dated 07/07/25 at 12:35 P.M., revealed the resident had a telehealth visit completed for concern of a swollen left arm. Nurse Practitioner (NP) #200 ordered a doppler (a non-invasive ultrasound used to assess the health of blood vessels) of the left arm. Further review of Resident #31's record revealed no documented evidence an assessment of the left arm edema was completed. Review of Resident #31's record revealed no evidence of the telehealth visit that was completed on 07/07/25 by NP #200.Review of Resident #31's orders dated 07/07/25 revealed no evidence a doppler of the left arm had been ordered. Review of Resident #31's telehealth visit completed by NP #201 dated 07/08/25 (actual time of visit was not noted) revealed the nurse reported the resident's left arm was swollen. The nurse stated it was not like that when she last cared for the resident a few days prior. The note stated Resident #31 did not seem to be in pain when at rest and when the arm was not being disturbed. Resident refused to straighten the left arm, even with the nurse trying on video. The resident was swatting her away. The resident had scrapes on the left arm that the nurse stated were from hitting his arms on things like the wheelchair. The note referenced there had been no recent significant trauma or falls. Resident #31's left upper arm did appear slightly swollen with mild pitting edema. A full evaluation could not be done due to the resident not being cooperative at the time of the exam. The note stated the left arm had no erythema (redness) observed on areas that could be observed via video in the current position. The plan was to apply ice and cold compress to the left upper arm for 30 minutes at a time, every three hours as tolerated by Resident #31 and to elevate the left upper extremity on pillows or rolled towels while in bed. The note stated to continue with orders by the previous provider (doppler examination). The note stated to report any results received to the provider for review upon receipt. The note concluded by instructing staff to monitor Resident #31 and report any acute changes in condition or declines noted to the providers promptly. Review of Resident #31's July 2025 physician orders revealed no evidence of any orders for ice and/or cold compresses for 30 minutes at a time every three hours as tolerated. Additionally, there was no evidence of an order to elevate Resident #31's left upper extremities on pillows or rolled towels while in bed as referenced in NP #201's note. Further review of Resident #31's physician orders revealed two orders were entered on 07/08/25 at 12:21 A.M. and 3:55 P.M. for a doppler of the left arm to rule out deep vein thrombosis (DVT) for new onset edema of left upper extremity for two days. Observation on 07/08/25 at 10:50 A.M., of Resident #31 revealed the resident was sitting in common area in a wheelchair. The resident had a dressing intact to his left lower arm and a dark purple bruise was noted on left lower arm measuring 5 centimeters (cm) by 4 cm. Review of Resident #31's progress notes dated 07/08/25 at 4:07 P.M. revealed the resident's left arm was still swollen. The resident had no complaints of pain or discomfort. A venous doppler was ordered to rule out DVT and labs were ordered for the following morning. Review of Resident #31's plan of care revealed no evidence a plan of care, or any interventions such as ice or elevation, had been implemented to address Resident #31'sleft upper extremity edema. Review of Resident #31's medical record on 07/09/25 revealed no evidence the doppler had been performed. Additionally, there was no evidence the dark purple bruise on the resident's left lower arm had been assessed. Interview and observation of Resident #31 on 07/09/25 at 2:38 PM with Regional Nurse #202 and the Administrator revealed the resident had a dark purple bruise on left lower arm, scratches on the upper arm and scabs noted above the dressing on the left lower arm, and slight edema noted to the left arm. The resident was lying in bed, and the resident's arm was not elevated. There was no evidence any ice or cold compress had been recently applied. Interview on 07/10/25 at 8:56 AM with Regional Nurse #202 confirmed the doppler should have been done within 24 hours of the original order on 07/07/25 at 12:35 P.M. The Regional Nurse confirmed the progress note indicated NP #200 had ordered the doppler on 07/07/25 at

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	07/29/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and policy review the facility failed to ensure residents received effective pain management. This affected three residents (#48, #61, and #65) of three residents reviewed that received pain patches. Findings include:1. Medical record review revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including hospice services, chronic obstructive pulmonary disease, type two diabetes, absence of eye and above right knee, anxiety, peripheral vascular disease, aphasia, bursitis of right elbow, and heart disease. Review of Resident #48's admission assessment completed [DATE] revealed the resident was not capable of verbalizing pain. The resident was displaying non-verbal indicators of pain. The resident was receiving scheduled pain medication. Review of Resident #48's aphasia plan of care dated [DATE] and revised [DATE] revealed the resident had a communication problem. Interventions included observing/document for physical/nonverbal indicators of discomfort or distress and follow-up as needed. Review of Resident #48's chronic pain plan of care dated [DATE] revealed to observe pain every shift and follow physician orders for complaints of pain. Review of Resident #48's admission minimum data set (MDS) dated [DATE] revealed the resident's cognition was rarely/never understood. The resident had non-verbal sounds and facial expression as indicators of pain or possible pain. The resident had indicators of pain or possible pain daily. Review of Resident #48's pain assessment dated [DATE] revealed the resident received scheduled pain medication and was unable to express acceptable pain level and or tolerance. Review of Resident #48's orders dated [DATE] to present revealed Fentanyl (narcotic medication) 50 microgram (mcg) patch. Apply one patch topically to upper torso every 72 hours for pain. Review of Resident #48's Fentanyl 50 mcg control drug record dated [DATE] to [DATE] revealed no evidence a pain patch was administered on [DATE] and [DATE]. Interview on [DATE] at 4:00 P.M., with Regional Nurse #203 confirmed Resident #48's Fentanyl patch was not administered on [DATE] and [DATE] per physician orders and therefore would not have provided effective pain control for the resident.Interview on [DATE] at 9:43 A.M., with Registered Nurse (RN) #108 revealed Resident #48 had communication impairment and if she likes you she will nod when questioned. The resident had general chronic pain all over. The resident was receiving hospice services and the resident's hospice provider ordered the resident's pain medication on a schedule to ensure adequate pain control. 2. Record review revealed Resident #61 was admitted to the facility on [DATE] with diagnoses including dorsalgia, chronic pain, epilepsy, peripheral autonomic neuropathy, and hyperlipidemia. Review of Resident #61's chronic pain plan of care dated [DATE] revealed to provide medications per orders.Review of Resident #61's current orders revealed Buprenorphine (pain medication that works to block pain signals between the brain and the rest of the body) 10 mcg patch, one patch transdermal every seven days for pain (order written by pain center medical provider).Review of Resident #61's MAR dated [DATE] revealed the resident was not administered Buprenorphine pain patch on [DATE] or [DATE] due to medication was not available. The last dose was administered on [DATE] and resumed on [DATE]. Review of Resident #61's progress note dated [DATE] revealed resident requested as needed pain medication around 10:00 A.M. The nurse explained to the resident that it was an hour too early. The resident became irritated and started yelling that it was bullshit because it was only helping for four hours and they only let him have them every six hours and he had not slept for seven days because he was in pain. He states that they don't want to do anything about it and that they gave him a patch and nobody even changes it, that it has been over ten days since it was changed. The nurse reported she would look into it. The resident continued to curse at the nurse. The resident reported he would believe it all when he saw it because he had heard this all before. The nurse asked the resident to stop cursing and he reported he had enough and was tired of being the one in pain and no one doing anything about it. After checking into the residents' orders, this nurse tried to explain to the resident that the patch was due to be changed on [DATE] but it was not available. The nurse reported the facility called the pain clinic and was waiting on them to call back. Review of Resident #61's progress notes dated [DATE] to [DATE] revealed the facility did not attempt to notify the pain clinic the resident was out of Buprenorphine until [DATE]. The office was closed on [DATE]. The next attempt to contact the pain clinic was [DATE]. The office was closed. A third attempt was made on [DATE] and facility staff left a voice message. Review of Resident #61's Buprenorphine 10 mcg patch control drug record sheet revealed no evidence the resident received a pain patch on [DATE] or [DATE]. Further review revealed pharmacy had sent four additional patches on [DATE], however staff never administered the medication until [DATE]

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	365629	A. Building B. Wing	07/29/2025

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.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and policy review the facility failed to ensure narcotic medication (pain patches) were properly disposed of. This affected two residents (#48 and #65) of three residents reviewed that received narcotic pain patches. The facility census was 63.Findings include:1. Medical record review revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, type two diabetes, absence of eye and above right knee, anxiety, peripheral vascular disease, aphasia, bursitis of right elbow, and heart disease. Review of Resident #48's orders dated [DATE] to [DATE] revealed Fentanyl (narcotic medication) 50 microgram (mcg) patch. Apply one patch topically to upper torso every 72 hours for pain. Review of Resident #48's Fentanyl 50 mcg control drug record dated [DATE] to [DATE] revealed on [DATE], [DATE], [DATE], unknown date (no date documented), [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] (times two), [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] there was no documented evidence the used Fentanyl patches was destroyed by two nurses. Interview on [DATE] at 4:00 P.M., with Regional Nurse #203 confirmed Resident #48's Fentanyl patch destruction was not witnessed by two staff nurses on [DATE], [DATE], [DATE], unknown date (no date documented), [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] (times two), [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Interview on [DATE] at 9:48 A.M., with Licensed Practical Nurse (LPN) #189 confirmed she had removed Resident #48's Fentanyl patch and did not have a second nurse witness the destruction of the patch. The LPN reported she had placed the old patches in the sharp's container. 2. Closed medical record review revealed Resident #65 was admitted to the facility on [DATE] and expired on [DATE] and had received hospice services. The resident's diagnoses included rheumatoid arthritis and diabetes. Review of Resident #65's orders dated 03/2025 to 06/2025 revealed the resident was ordered Fentanyl 75 mcg patch apply two patches topically to upper torso every 72 hours for pain.Review of Resident #65's control drug record dated [DATE] to [DATE] revealed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] there was no documented evidence the used Fentanyl patch was destroyed by two nurses. Further review of the control drug records revealed no evidence of a control sheet for the Fentanyl patch that was administered or destroyed on [DATE], [DATE], [DATE], [DATE], and [DATE]. Interview on [DATE] at 3:14 P.M., with Administrator, Interim Director of Nursing (IDON) #600, and Corporate Nurse #601 confirmed there was no documented evidence the Fentanyl patch was destroyed by two nurses on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] per the facility's policy. Corporate Nurse #601 confirmed the facility was not able to find a control sheet for the Fentanyl patches that were administered on [DATE], [DATE], [DATE], [DATE], and [DATE]. The Administrator confirmed he had submitted a self-reported incident (SRI) on [DATE] for Resident #48 pain patch that missing and the facility had reviewed Resident #48 and #65's medical records, however the discrepancies identified by the surveyor with the Fentanyl patches were not discovered during the facility's investigation completed on [DATE]. Resident #65 was Resident #48's roommate, and they were the only residents receiving Fentanyl patch medication during the investigation. Review of the facility's policy and procedure titled Fentanyl Transdermal Patch (undated) revealed the regulation required the facility have a system to account for controlled medications' receipt and disposition in sufficient detail to enable an accurate reconciliation. Fentanyl transdermal patches present a unique situation given the multiple boxed warnings, and the substantial amount of Fentanyl remaining in the patch after removal, creating a potential for abuse, misuse, diversion, or accidental exposure. Remove the previous patch and dispose of immediately prior to adding the next patch. If no patch is located, provide a complete body scan and search clothing, bed linens and surrounding area if the patch has fallen off. Validate there is no patch on skin prior to applying the next patch. Document that no patch was located to be removed and verify with a second nurse. Notify the DON and/or Nursing management for follow-up. Re-check security of the patch and see that it actually sticks. The nurse will dispose of the patch in the presence of a second nurse. The nurse will stick the sticky sides of the patch together and place them in the drug disposal system. Both nurses will sign on the controlled substances proof of use sheet or the current use narcotic sign out sheet stating destruction, date, time, and method of destruction. Review of the facility's policy and procedure titled Medication Controlled Drugs and

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on review of pest invoices, review of concerns submitted to the state survey agency complaint intake unit, interviews, observation, and review of facility policy revealed the facility failed to ensure an effective pest control program was maintained. This had the potential to affect all 63 residents residing in the facility. Findings include:1 a. Review of concerns submitted to the state survey agency complaint intake unit dated 06/13/25 and 07/10/25 revealed a concern with cockroaches in the kitchen. Review of the pest control invoice dated 06/10/25 revealed the building was inspected for services including all interior areas for possible pest entry ways and activity. All glue boards were replaced as needed. Open area of concern was noted in the kitchen. The wall covering was loose/peeling. Wall tile was cracked and there were gaps between baseboards and wall. These areas need repaired or replaced to help prevent pest entry and harbor sites. The kitchen door seal was not rodent proof. The seal needed repaired. There were German Cockroaches noted to be found on the devices. Concerns were discussed with Licensed Practical Nurse (LPN) #108. Review of the pest invoice dated 06/23/25 revealed there were still open concerns with the wall covering and door seal in the kitchen. Findings were discussed with the previous Maintenance Director (MD) #204.Observation on 07/08/25 at 7:34 A.M. of the kitchen with Dietary Manger (DM) #300 revealed there was several sticky bug traps with numerous bugs observed in the boxes. There were additional closed red boxes that contained pests but could not be observed. Dietary Manager (DM) #300 reported the facility had a few oriental roaches which come up through the drains, but they were mostly German roaches that come from the wooded area behind the building. The DM #300 and staff reported they had not seen any live roaches, but there had been some found in the traps. The DM #300 confirmed the back door seal was missing from the bottom door and the light from outside was coming through the bottom of the door. The DM #300 confirmed the observed findings and reported the pest control company had voiced concerns that the pests were coming from the back door. There were several broken floor tiles noted in front of the door. The DM #300 confirmed the seal had been missing for some time. The DM #300 reported the facility did not have a Maintenance Director (MD) at this time. Observation on 07/08/25 at 10:52 A.M. of the kitchen with the Administrator and DM #300 confirmed the areas of concern listed on the pest control invoices on 06/10/25 and 06/23/25 had not been repaired. The Administrator and DM #300 confirmed the tiles in the dishwasher area were pulled away from the wall, the back door seal on the bottom was missing, and the tile on the floor and wall near the back door were broken and tile was pulling away from the wall. Interview on 07/09/25 at 11:45 A.M., with the previous Director of Nursing (DON) confirmed staff had voiced concerns regarding roaches in the last monthly meeting, however she had never seen any live roaches. b. Interview on 07/08/25 at 1:22 P.M., with an Ombudsman representative via phone revealed she had received a call from a medical provider that was visiting Resident #20 and had noticed gnats in Resident #20's room. The resident had voiced concerns, and the medical provider was concerned due to the resident had a colostomy bag and was not able to get out of bed on his own. Observation on 07/09/25 at 8:19 A.M., of Resident #20's room revealed there were 12 gnats observed in the resident room. The gnats were observed on the resident pillow, bedside table, and wall by bed. The resident reported that the gnats had been a problem for the last two weeks and he was happy to see the surveyor so hopefully the surveyor could do something about it. Observation and interview on 07/09/25 at 8:21 A.M., with Housekeeper Manager (HM) #413 confirmed there was 12 gnats in Resident #20's room. The HM #413 reported she would have staff clean the room immediately. Interview on 07/10/25 at 7:07 A.M., with Certified Nurse Aide (CNA) #186 confirmed there were issues with gnats and roaches. CNA #186 reported Resident #20's room was really bad with gnats and the roaches were mostly in the kitchen area. Interview on 07/10/25 at 7:16 A.M., with CNA #113 confirmed there was issues with gnats and roaches in the building currently. The roaches were worse in the kitchen area. Interview and observation on 07/10/25 at 7:28 AM with Resident #20 revealed there were still gnats in his room, but he reported it was better than yesterday. There was one gnat observed flying near the resident's face. Review of the facility's policy and procedure titled Pest Control dated 09/15/21 revealed the pest control company would establish a regimented time each month for spraying and to eliminate pests in the center. If a problem should develop, the Environmental Service Director will contact the pest control company for an additional visit. The pest control company would report any problems or changes to the Environmental Service Director. This deficiency represents non-compliance investigated under Complaint Number OH00166698 (1284492) and OH00166292 (1284491)