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	01/21/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, observation and facility policy review, the facility failed to ensure Resident #3 was free from misappropriation. This affected one (Resident #3) of three records reviewed. Findings include:Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, malignant neoplasm of left bronchus or lung, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, depression, urinary incontinence, anxiety, dysphagia, aphasia, dementia, chronic respiratory failure with hypoxia and hypercapnia, and stage two chronic kidney disease. The resident was under hospice services.Review of Resident #3's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognition intact.Review of census revealed Resident #3 was moved from room [ROOM NUMBER]-2 to room [ROOM NUMBER]-2 on Unit 2 on 11/22/25. Review of the Grievance/Complaint log dated 11/2025, 12/2025, and 01/2026, revealed no evidence of Resident #3's concerns regarding the missing rings. Review of the missing items log dated 11/2025, 12/2025, and 01/2026 revealed no evidence of Resident #3's concerns regarding the missing rings.Review of anonymous complaint intake dated 01/12/26 revealed Resident #3's recently had a room change and several items were missing. The missing items were reported to social service office; however, none of these items have been located or replaced. The largest and most important item unaccounted for was an antique amethyst birthstone ring. The ring was real gold; the stone was [NAME] cut and beveled from years of wear. The anonymous complainant cleaned the ring for the resident, and it was irreplaceable. Resident #3 informed the anonymous complainant that the Administrator refused to replace it or come up with an amicable solution. There was another ring that was missing, this one was also real gold but with a green stone. Interview via email on 01/21/26 at 9:20 A.M., with the Ombudsman revealed the volunteer Ombudsman had visited the facility on 01/16/26 and spoken to the Unit Manger #12, due to the Director of Nursing (DON) was not there, regarding the missing rings. The Unit Manager told the volunteer Ombudsman she would relay the concern to management as soon as possible. Interview on 01/21/26 at 9:27 A.M., with the Administrator confirmed there were no grievances or concerns filed in the last three months, and he was not aware of any concerns regarding missing jewelry. Interview and observation of Resident #3 on 01/21/26 at 10:33 A.M., with the DON revealed Resident #3 was alert and oriented. The resident had a box hanging on the wall to display her rings. Resident #3 confirmed she had reported her rings missing to the Administrator the day of her room change. Both rings were gold and one had a purple stone, and one had a green stone. The rings were still missing. Interview on 01/21/26 at 11:15 A.M., with Unit Manager #12 confirmed she was notified on Friday 01/16/26 by the volunteer Ombudsman regarding Resident #3's missing rings; however, she knew the facility was aware. Interview on 01/21/26 at 11:28 A.M., with the Administrator, Social Worker #301, and Corporate Nurse #300 and follow up interview with the Administrator on 01/21/26 at 12:13 P.M., (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

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed Resident #3 had reported an allegation she had rings missing a few days after her room change. The Administrator confirmed he was aware; however, he didn't complete a concern/grievance form, nor did he submit a self-reported incident to the state agency due to the resident could not describe the rings or when she last seen them. He was not convinced the resident even had the rings because she could not provide any details about the rings. The Social Worker reported she searched the resident's room and spoke to staff, but she didn't have any documented evidence to support an investigation was completed. The Administrator and Social Worker confirmed they didn't contact Resident #3's family to confirm the resident had the rings at the facility. The Administrator reported he started a self-reported incident today with the state.Review of the undated Ohio Abuse, Neglect, and Misappropriation policy revealed misappropriation was defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. This deficiency represents non-compliance investigated under Complaint Number 2714540.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the Ohio Gateway system (online system for reporting abuse) and facility policy review, the facility failed timely to report allegation of misappropriation to the state agency. This affected one (Resident #3) of three residents reviewed. Findings include:Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, malignant neoplasm of left bronchus or lung, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, depression, urinary incontinence, anxiety, dysphagia, aphasia, dementia, chronic respiratory failure with hypoxia and hypercapnia, and stage two chronic kidney disease. The resident was under hospice services.Review of Resident #3's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognition intact.Review of census revealed Resident #3 was moved from room [ROOM NUMBER]-2 to room [ROOM NUMBER]-2 on Unit 2 on 11/22/25.Review of anonymous complaint intake dated 01/12/26 revealed Resident #3's recently had a room change and several items were missing. The missing items were reported to social service office; however, none of these items have been located or replaced. The largest and most important item unaccounted for was an antique amethyst birthstone ring. The ring was real gold; the stone was [NAME] cut and beveled from years of wear. The anonymous complainant cleaned the ring for the resident, and it was irreplaceable. Resident #3 informed the anonymous complainant that the Administrator refused to replace it or come up with an amicable solution. There was another ring that was missing, this one was also real gold but with a green stone. Interview via email on 01/21/26 at 9:20 A.M., with the Ombudsman revealed the volunteer Ombudsman had visited the facility on 01/16/26 and spoken to the Unit Manger #12, due to the Director of Nursing (DON) was not there, regarding the missing rings. The Unit Manager told the volunteer Ombudsman she would relay the concern to management as soon as possible. Interview on 01/21/26 at 9:27 A.M., with the Administrator confirmed there were no grievances or concerns filed in the last three months and he was not aware of any concerns regarding missing jewelry. Interview and observation of Resident #3 on 01/21/26 at 10:33 A.M., with the DON revealed Resident #3 was alert and oriented. The resident had a box hanging on the wall to display her rings. Resident #3 confirmed she had reported her rings missing to the Administrator the day of her room change. Both rings were gold and one had a purple stone, and one had a green stone. The rings were still missing. Interview on 01/21/26 at 11:15 A.M., with Unit Manager #12 confirmed she was notified on Friday 01/16/26 by the volunteer Ombudsman regarding Resident #3's missing rings; however, she knew the facility was aware. Interview on 01/21/26 at 11:28 A.M., with the Administrator, Social Worker #301, and Corporate Nurse #300 and follow up interview with the Administrator on 01/21/26 at 12:13 P.M., confirmed Resident #3 had reported an allegation she had rings missing a few days after her room change. The Administrator confirmed he was aware; however, he didn't complete a concern/grievance form, nor did he submit a self-reported incident to the state agency due to the resident could not describe the rings or when she last seen them. He was not convinced the resident even had the rings because she could not provide any details about the rings. The Social Worker reported she searched the resident's room and spoke to staff, but she didn't have any documented evidence to support an investigation was completed. The Administrator and Social Worker confirmed they didn't contact Resident #3's family to confirm the resident had the rings at the facility. The Administrator reported he started a self-reported incident today with the state.Review of the undated Ohio Abuse, Neglect, and Misappropriation policy revealed misappropriation was defined as deliberate misplacement, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with state law. Each occurrence of misappropriation would be identified and reported to the supervisor and investigated timely. The supervisor or designee would notify the DON and Executive Director (ED) of the incident or allegation immediately. Required notification of agencies, physician, and resident representatives will be completed. The ED will direct the investigation. Statements would be obtained from the resident or from the reporter of the incident, in writing whenever possible by the ED or designee. Documentation of the facts and findings would be completed in each resident medical record. A suspected misappropriation investigation report would be initiated by the Director of Nursing or designee. Statement would be obtained from staff related to the incident, including the victim and witnesses. By the fifth day, the alleged abuse investigation form is completed and reviewed for completeness and accuracy by the ED or designee and submitted to the state. Investigation files are kept in confidential file located in the ED office. This file would be accessible for follow-up and state or local police review of the investigation. Allegations of misappropriation of resident property are reported immediately, but no later than two hours after the allegation was made. The results of the facility's investigation must be reported to the survey agency, the ED/designee and other officials in accordance with state law, within five working days of the incident. This deficiency represents non-compliance investigated under Complaint Number 2714540.

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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 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 record review, interview, observation and facility policy review the facility failed to investigate allegation of misappropriation. This affected one (Resident #3) of three residents reviewed.Findings include: Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, malignant neoplasm of left bronchus or lung, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, depression, urinary incontinence, anxiety, dysphagia, aphasia, dementia, chronic respiratory failure with hypoxia and hypercapnia, and stage two chronic kidney disease. The resident was under hospice services.Review of Resident #3's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognition intact.Review of census revealed the resident was moved from room [ROOM NUMBER]-2 to room [ROOM NUMBER]-2 on Unit 2 on 11/22/25. Review of anonymous complaint intake dated 01/12/26 revealed Resident #3's recently had a room change and several items are missing. The missing items were reported to social service office, however none of these items have been located or replaced. The largest and most important item unaccounted for is an antique amethyst birthstone ring. The ring was real gold; the stone was [NAME] cut and beveled from years of wear. The anonymous complainant cleaned the ring for the resident, and it was irreplaceable. Resident #3 informed the anonymous complainant that the Administrator refused to replace it or come up with an amicable solution. There was another ring that was missing, this one was also real gold but with a green stone. Interview via email on 01/21/26 at 9:20 A.M., with the Ombudsman revealed the volunteer Ombudsman had visited the facility on 01/16/26 and spoken to the Unit Manger #12, due to the Director of Nursing (DON) was not there, regarding the missing rings. The Unit Manager told the volunteer Ombudsman she would relay the concern to management as soon as possible. Interview on 01/21/26 at 9:27 A.M., with the Administrator confirmed he was not aware of any concerns regarding missing jewelry. Interview and observation of Resident #3 on 01/21/26 at 10:33 A.M., with the DON revealed Resident #3 was alert and oriented. The resident had a box hanging on the wall to display her rings. Resident #3 confirmed she had reported her rings missing to the Administrator the day of her room change. Both rings were gold and one had a purple stone, and one had a green stone. The rings were still missing. Interview on 01/21/26 at 11:15 A.M., with Unit Manager #12 confirmed she was notified on Friday 01/16/26 by the volunteer Ombudsman regarding Resident #3's missing rings; however, she knew the facility was aware. Interview on 01/21/26 at 11:28 A.M., with the Administrator, Social Worker #301, and Corporate Nurse #300 and follow up interview with the Administrator on 01/21/26 at 12:13 P.M., confirmed Resident #3 had reported an allegation she had rings missing a few days after her room change. The Administrator confirmed he was aware; however, he didn't complete a concern/grievance form. He was not convinced the resident even had the rings because she could not provide any details about the rings. The Social Worker reported she searched the resident's room and spoke to staff, but she didn't have any documented evidence to support an investigation was completed. The Administrator and Social Worker confirmed they didn't contact Resident #3's family to confirm the resident had the rings at the facility. Review of the undated Ohio Abuse, Neglect, and Misappropriation policy revealed misappropriation was defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Each occurrence of misappropriation would be identified and reported to the supervisor and investigated timely. The supervisor or designee would notify the DON and Executive Director (ED) of the incident or allegation immediately. Required notification of agencies, physician, and resident representatives will be completed. The (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ED will direct the investigation. Statements would be obtained from the resident or from the reporter of the incident, in writing whenever possible by the ED or designee. Documentation of the facts and findings would be completed in each resident medical record. A suspected misappropriation investigation report would be initiated by the Director of Nursing or designee. Statements would be obtained from staff related to the incident, including the victim and witnesses. By the fifth day, the alleged abuse investigation form is completed and reviewed for completeness and accuracy by the ED or designee and submitted to the state. Investigation files are kept in confidential file located in the ED office. This file would be accessible for follow-up and state or local police review of the investigation. This deficiency represents non-compliance investigated under Complaint Number 2714540.

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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 medical record review, review of work order, interview, observation and facility policy review, the facility failed to ensure bilateral enabler bars were in-place per orders to prevent Resident #3 from falling out of bed twice. This affected one (Resident #3) of three records reviewed for accidents. Findings include:Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, malignant neoplasm of left bronchus or lung, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, depression, urinary incontinence, anxiety, dysphagia, aphasia, dementia, chronic respiratory failure with hypoxia and hypercapnia, and stage two chronic kidney disease. The resident was under hospice services.Review of Resident #3's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognition intact. The resident didn't have any falls during the look back period. The resident was occasionally incontinent of urine and always incontinent of bowel. The resident had no restraints or alarms. The resident had no functional limitation with range of motion and used a wheelchair. The resident required supervision or touching assistance when sitting to stand and chair/bed to chair transfer.Review of census revealed Resident #3 was moved from room [ROOM NUMBER]-2 to room [ROOM NUMBER]-2 on Unit 2 on 11/22/25.Review of Resident #3 activity daily living (ADL) dated 08/26/25 and 11/24/25 revealed bilateral enabler to assist with turning and repositioning.Review of Resident #3's orders dated 01/2026 revealed the resident was ordered bilateral enabler bars to assist with turning and repositioning since 08/27/25. Review of Resident #3's progress notes dated 12/11/25 revealed the nurse was called to see the resident lying on the floor near her bed around 7:26 A.M. (witnessed) with her hands supporting her on the floor and leg lying flat. I was trying to get up from bed when I fell with my left hip. Resident denies pain and discomfort, pain zero out of ten. Resident #3 could move all extremities, pupils react to light, grips strongly, and vital signs obtained. Telehealth was called and notified with new orders for neurological checks, and call if there were any changes. The resident's family was informed of the current status of the resident. On 12/12/25, clarification, the fall was unwitnessed. Review of Resident #3's progress note dated 01/16/25 revealed at 5:30 A.M. the resident was observed lying on right side on floor next to bed, resident denied attempting to get out of bed and stated I slid oxygen was applied due to the resident removes per self. Oxygen saturation was 91%. Denies hitting head, range of motion adequate, two by two bruise noted to left lower extremity, blue in color. Assisted to wheelchair via two certified nursing assistants (CNAs) while linen was changed to bed. Neuro checks within normal limit. Provider called and new orders to apply foam dressing to left lower extremity bruise for protection for three days. The resident's representative was notified. Review of Resident #3's medication and treatment administration records dated 12/2025 and 01/2026 revealed staff had been signing off the resident had bilateral enabler bars to assist with turning and repositioning in-place even though there were no bars. Review of anonymous complaint intake dated 01/12/26 revealed the resident had fallen out of bed because she doesn't have assist bars on bed. The resident has had a stroke that affected one side of her body. The resident had asked four times since 12/18/25 for assist bars to be added to her bed. Review of work order dated 01/16/26 revealed the Unit Manger #12 put a work order in for room [ROOM NUMBER]-2 (Resident #3) for bed rail to right side of bed for transfer assistance. Interview on 01/21/26 at 9:20 A.M., via email with the Ombudsman revealed on 01/16/26 the volunteer Ombudsman had spoken to the Unit Manger #12 regarding Resident #3 was requesting assist bars to her bed to aid in getting in and out of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed independently. Observation and interview on 01/21/26 at 10:33 A.M., of Resident #3 confirmed she didn't have enabler bars on bed since moving into her new room until yesterday (01/20/26) the staff installed the half rail. The resident reported she would prefer the enabler bar. The resident's right side of bed was against the wall, and the resident had a half rail on the left side. Interview on 01/21/26 at 11:15 A.M., with Unit Manger #12 confirmed the volunteer Ombudsman had voiced concerns that Resident #3 did not have enabler bars on her bed on 01/16/26, and she put in a work order to have them added. Interview on 01/21/26 at 12:34 P.M., with the Maintenance Director (MD) confirmed he had received a work order to add a side rail to Resident #3's bed, but he could not find an enabler bar to fit the bed. Yesterday 01/20/26 he had found a 1/2 rail and placed it on her bed but was just told by the Director of Nursing (DON) she needed an enabler bar. The MD confirmed the resident's bed did not have any side rails until he put one on yesterday. Interview on 01/21/26 at 10:33 A.M. and 3:17 P.M., with the DON revealed she believes when Resident #3's room was changed on 11/22/25, the resident did not take the bed. On 12/17/25 hospice brought the resident a new bed; however, hospice did not bring the enabler bars. The DON confirmed the resident was ordered bilateral enabler bars since 08/27/25, and the enabler bars were not in place per orders and per the resident plan of care. The DON confirmed the resident had sustained two falls out of bed on 12/11/25 and 01/16/26. The DON confirmed the facility received an order today for the half bedrail until the enabler bar arrived due to it had to be ordered from hospice. The DON confirmed staff were signing off the enabler bars were in-place twice a day in 12/2025 and 01/2026 when the bilateral enabler bars were not in-place. Review of the undated facility policy titled Fall Prevention and Management revealed fall prevention and management was the process of identifying risk factors that can minimize the potential for falls and also a process to manage a resident's care if a fall occurs.This deficiency represents non-compliance investigated under Complaint Number 2714540.