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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	135 Reichart Avenue Wintersville, OH 43953

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm 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 open and closed medical record review, facility policy review, and interviews, the facility failed to timely identify a change in resident condition and notify the medical provider to prevent a delay in treatment/timely medical intervention. The facility also failed to ensure bowel protocols were implemented for residents on hospice services. Actual harm occurred on 03/11/26 when Resident #54, who had bilateral nephrostomy tubes and history of kidney disease, experienced a decline in functional status, decreased urine output from the nephrostomy tubes, and decreased food and fluid intake without evidence of necessary and timely medical intervention or notification to the resident's medical provider. When ordered laboratory work was obtained (five days after ordered) the resident had a critical creatinine level (blood test for monitoring kidney function with normal results between 0.6 to 1.3) of 4.9, was hypotensive (low blood pressure) and tachycardic (increased heart rate). The Nurse Practitioner ordered to transfer the resident to the emergency room where he was admitted to the intensive care unit with acute kidney injury, dehydration and sepsis related to a urinary tract infection. The resident did not return to the facility and expired at the hospital under the care of hospice services. This affected one resident (#54) of one resident reviewed for hospitalization and one resident (#13) of one reviewed for urinary tract infection. The facility census was 51. Findings Include: 1.Review of the closed medical record for Resident #54 revealed admission to the facility on [DATE] after an acute hospital stay with diagnoses including hydronephrosis (back up of water on the kidney), urinary tract infection, chronic kidney disease stage 3, bilateral nephrostomy tubes (tube placed in the kidneys to drain the urine directly from the kidneys), prostate cancer with metastases to spine and left adrenal gland, anemia and a blood clot to the left lower leg. Review of the resident's hospital medical records revealed Resident #54 was at a tertiary hospital from [DATE] through 02/01/26 (prior to admission) with diagnoses of septic shock and bilateral hydronephrosis status post bilateral nephrostomy tube placements completed in 2019. Resident #54 had weakness and a low blood pressure with lab values which indicated acute on chronic kidney failure with a creatine level (blood test for monitoring kidney function with normal results between 0.6 to 1.3) of 4.84. Resident #54 was admitted to the intensive care unit for treatment. Further review revealed Resident #54 was treated with intravenous antibiotics, intravenous medications to improve blood pressure and replacement of bilateral nephrostomy tubes. Resident #54 also had a prostate cancer diagnosis (prior to the hospitalization and the resident was receiving treatment prior) which was not addressed during the hospitalization with recommendations made to follow up with oncologist in one to two weeks as well as radiation oncology in one week post discharge. Further recommendations were made by the hospital for Resident #54 to discharge to a nursing rehabilitation facility for diagnosis of deconditioning and to receive physical and occupational therapy services to improve stamina and strength. Please note, the resident was to be admitted for short term placement of rehabilitation with a discharge goal to return home after the rehabilitative stay at the facility. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the physician orders for Resident #54 revealed an order dated 02/01/26 (admission) for irrigation of bilateral nephrostomy tubes with 10 milliliters (ml) of normal saline every day shift to maintain patency. On 02/02/26 an order was received to begin weekly weights. Further review of orders revealed an order dated 02/06/26 to monitor/record nephrostomy outputs every shift. Review of the nephrostomy care plan for Resident #54 initiated on 02/01/26 revealed nursing staff were to provide nephrostomy catheter care every shift and as needed and notify medical provider if urine was abnormal in color, consistency, or odor. Review of weight logs for Resident #54 revealed an admission weight to the facility on [DATE] of 182.6 pounds. On 02/16/26 the resident's weight was documented to be 188.6 pounds. Weight were obtained by Resident #54 standing on a scale. Review of Resident #54's Minimum Data Set (MDS) assessment completed on 02/03/26 revealed the resident was cognitively intact with no vision or hearing deficits and was able to understand others and make self-understood. The resident's life expectancy was not indicated as six months or less and the resident was not receiving hospice services. Further review of the MDS assessment revealed Resident #54 was independent in self-care, mobility, and stair climbing prior to recent exacerbation of illness. On admission to facility Resident #54 required substantial/maximum assistance from staff for toileting, bathing, dressing upper body and putting on socks and shoes. Resident #54 was able to perform oral hygiene and grooming tasks with set-up assistance. Resident #54 required a wheelchair and staff assistance for mobility with the wheelchair. Review of a facility care conference note for Resident #54 conducted with the resident, his daughter and care team on 02/03/26 revealed discharge planning to include Resident #54 returning home after rehabilitation to get stronger. Code status was reviewed with Resident #54 and noted to continue full code status (full measures to be provided in the event of cardiac/respiratory arrest; conduct cardiopulmonary resuscitation). Review of laboratory results related to kidney function for Resident #54 obtained while in nursing facility revealed on 02/06/26 the resident's creatinine level was 1.7, on 02/19/26 creatinine level was 2.0, and on 02/25/26 creatinine level was 2.3. There were no orders to repeat labs for kidney function or electrolytes as a repeat or standing order after this date. Review of the care plan for renal disease and bilateral hydronephrosis for Resident #54 initiated on 02/12/26 revealed nursing staff were to observe for signs and symptoms of complications of renal disease i.e. decreased urine output, increased BUN/Creatinine levels, edema (swelling), dyspnea (shortness of breath), elevated blood pressure, increased heart rate, decreased peripheral pulses, fatigue, weight gain, confusion, and distended jugular veins. Staff were to notify medical provider, resident/ resident representative of abnormal findings. Further review of the care plan revealed the nursing staff were to obtain and monitor lab/ diagnostic studies, as ordered and report abnormal findings to the medical provider. Review of the output records on the treatment administration record (TAR) for February 2026 revealed 02/20/26 total daily outputs of 400 milliliters (ml), 02/21/26 320 ml, 02/22/26 210 ml, nothing recorded on 02/23/26, 02/24/26 245ml, 02/25/26 150 ml, 02/26/26 290 ml, 02/27/26 200 ml, and 02/28/26 125 ml. Review of a nurse practitioner (NP) progress note dated 03/01/26 revealed Resident #54 being seen for follow up to lab work. NP #224 noted renal function was worsened slightly and creatinine level was 2.0 referencing review of labs obtained from 02/25/26. Resident #54 had reported feeling better than he did prior. Resident #54 was noted to have loose stools and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	decreased appetite that was improving. His blood pressure (BP) was 118/60, heart rate 88, and respiratory rate was 16. His weight was 188.6 pounds. NP #224 noted diagnosis and plan on 03/01/26 included abnormal renal function-creatinine 2.0, encourage increasing water intake; dizziness, encourage him to drink at least one large pitcher of water a day, will follow up; edema to bilateral legs and arms, monitor weekly weights, increased will check next week. Review of the March of 2026 nephrostomy outputs revealed the following daily combined total outputs for Resident #54 03/01/26 through 03/11/26: On 03/01/26 230 ml, 100 ml documented for the left tube on dayshift only, no documentation on night shift on 03/02/26, on 03/03/26 300 ml total output, 03/04/26 only 100 ml from right tube only, no documentation on night shift output, on 03/05/06 80 ml total output, on 03/06/26 420 ml total output, on 03/07/26 195 ml total output, on 03/08/26 no outputs record from the bilateral nephrostomy tubes on either shift, on 03/09/26 190 ml of total output, on 03/10/26 30 ml of total output, and on 03/11/26 no outputs recorded for day shift. There was no evidence in the medical record of the medical provider being notified of any change in the recorded outputs not being obtained or the decrease in output during this time period. Review of the TAR for March 2026 revealed weekly weight monitoring for Resident #154 starting on 02/02/26 to be done every Monday. On 03/01/26 Resident #54 weighed 187.8 pounds and then a decrease on 03/09/26 down to 181.4 pounds. There was no evidence in the medical record of the 6.4 pound weight loss in one week being reported to the medical provider. Review of the bowel movement records for Resident #54 revealed bowel movements with formed stool 02/17/26 to 03/01/26. Beginning 03/02/26 Resident #54 had watery or loose stools documented twice a day and this continued through his hospitalization on 03/11/26. Review of meal intakes for Resident #54 beginning 03/03/26 through 03/11/26 revealed his meal intake decreased to an average of less than 25% or not eating at all and fluid intakes decreased to an average of 720 ml or less daily. Prior to this time period, meal and fluid intake reviewed from 02/13/26 through 03/02/26 revealed the resident ate mostly 100% of all meals and his fluid intake averaged 1,080 ml to 1,440 ml daily. On 03/09/26 Resident #54 was weighed by a mechanical lift for the first time and weighed 181.4 pounds. There was also a re-weight documented of 184 pounds on the same date. Of note, Resident #54 had a functional decline documented on 03/07/26 related to transfers and personal care.Review of a Telehealth note dated 03/06/26 at 7:07 P.M. revealed a telehealth visit occurred with Resident #54 and NP #223. Resident #54 complained of generalized weakness and did not go to his cancer appointment (scheduled this date as a follow up with his oncologist) due to feeling fatigued with no energy and no appetite. The note further revealed Resident #54 had labs done on 02/25/26 with notable Stage 3 kidney disease, an elevated creatine level of 2.3 and a blood urea nitrogen level of 5.0. An order was given to repeat a complete metabolic panel (CMP) lab test to rule out dehydration and electrolyte imbalance. Review of the physician orders for Resident #54 revealed an order on 03/06/26 by NP #223 for a CMP to be obtained that was placed in the electronic medical record. (Please note, the order did not specify when to be completed, however, the lab was ordered to rule out dehydration and electrolyte imbalance). Further review of the order audit for the CMP ordered on 03/06/026 revealed on 03/08/26 the order was acknowledged in the electronic medical record (EMR) by Registered Nurse (RN) #110. (The resident had labs (a complete blood count) scheduled on 03/09/26 but when the lab order was acknowledged on 03/08/25 by RN #110, the CMP was not scheduled to be completed with the CBC). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the treatment administration record for the month of March 2026 revealed a section titled changes noted in my resident today. Further review revealed nursing initials for each shift indicating yes or no followed by indication of change. On 03/07/26 there was a change in Resident #54 condition indicating the resident needed more help with walking, transferring, toileting more than usual. Review of the NP progress notes for Resident #54 revealed the next time Resident #54 had a medical provider visit was by NP #224 on 03/11/26 to follow up on weekly labs obtained on 03/09/26 for CBC due to leukocytosis (low white blood cells). NP #224 noted that his creatinine level on 02/25/26 was 2.0 approximately two weeks ago and now on 03/11/26 was 4.9. NP #224 further noted dark tea colored urine in nephrostomy tubes and when the NP asked Resident #54 about it he could not recall how long the urine had looked that way. Resident #54's blood pressure was noted to be low at that time 80/50 and he had an elevated heart rate of 101. NP #224's progress note revealed diagnoses for visit on 03/11/26 included acute kidney injury with creatinine 4.9 (1.7 on admission), diarrhea could contribute to dehydration and rule out sepsis. NP #224 ordered for Resident #54 to be sent to the local emergency for further evaluation after consultation with the primary physician. Review of the nursing progress note dated 03/11/26 at 2:18 P.M. revealed labs were reviewed with NP #224 and new order to send resident to the hospital due to increase in creatinine, increased weakness, and overall decline. At 2:40 P.M. Resident #54 was transported via ambulance to the hospital and he did not return to the facility. Interview on 4/07/26 at 2:17 P.M. with the Director of Nursing (DON) revealed labs were done at the facility Monday through Fridays and not obtained on weekends unless they were ordered STAT (immediately). The DON revealed orders for the CMP entered by the Telehealth NP #223 on 03/06/26 was not a STAT lab but ordered as routine. The DON reported if 03/06/26 was a Friday the lab should have been drawn on the next lab day which would have been the following Monday 03/09/26. The DON verified the CMP was not obtained on 03/09/26. Further interview on 04/07/26 at 3:04 P.M. with the DON revealed the procedure for lab orders included the medical provider or the nurse entering a verbal order would enter the lab order into the point click care electronic medical record (EMR). The nurse would then make sure the order was carried over to the treatment administration record (TAR) for the date prescribed, add to the Med Lab (the contracted lab service) list and enter order into Med Lab. Once Med Lab retrieved the blood specimen the nurse would sign off the lab as being completed on the TAR. The DON verified the CMP was never put on the TAR for completion and there was a CBC lab order on the TAR for 03/09/26. The DON verified there was no CMP completed but a basic metabolic panel (BMP) was obtained on 03/11/26 which indicated the critical lab value with the creatinine. On 04/09/26 at 10:30 A.M. interview with RN #200 verified the March 2026 MAR noted a decrease in Resident #54 being able to perform transfers and personal care on 03/07/26. The RN verified there was no communication with the resident's medical provider regarding the decline in the resident's functional status at this time. A telephone interview on 04/09/26 at 12:30 PM with NP #224 revealed she saw Resident #54 on 03/11/26 for follow up for weekly labs. NP #224 reported she was aware of the telehealth visit for Resident #54 on 03/06/26 and order for a CMP. NP #224 reported she was okay with Resident #54 having a BMP done with his weekly labs instead of the CMP originally ordered on 03/06/26. Interview on 04/13/26 at 9:30 A.M. with the DON revealed she had investigated further and looked at (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	her logs from the Monday morning care meeting on 03/09/26 and the report did show that a CMP was ordered for Resident #54 over the weekend with no specified date to be obtained and the DON reported she did follow up the NP #224 to determine if Resident #54 still needed the CMP completed and when. The DON verbalized she notified the NP #224 in passing and the NP cancelled the CMP and was okay getting it with routine weekly labs. The DON confirmed there was no documentation of these communications between NP #224 and the DON regarding the labs in the medical record. The weekly labs ordered in the medical record were for a CBC which was obtained already on 03/09/26. (Please note, there was no documentation to support notification to the medical provider of the resident's missed labs, decline in functional abilities, decreased meal and fluid intakes or decreased output in conjunction with the missed labs). An additional interview on 04/13/26 at 10:53 A.M. with NP #224 revealed Resident #54 had been treating his prostate cancer for eight years. He had his most recent chemotherapy treatment in November or December of 2025 and chemotherapy was put on hold due to low blood pressure issues. The resident was very knowledgeable with his nephrostomy tubes and had them placed in 2019. NP #224 further revealed she was made aware of Resident #54 having a telehealth visit on 03/06/26 and corresponding CMP ordered on 03/06/26 verbally in passing from the DON on 03/09/26. NP #224 reported she discontinued the CMP that day and told the DON she would look over the chart and give new orders. NP #224 verified she did not enter any orders into the EMR herself on 03/09/26 and only gave a verbal order to the DON but was unaware the resident had decreased output prior to his hospitalization.Continued interview with NP #224 revealed she reviewed Residents #54's records and ordered on either Monday 03/09/26 or Tuesday 03/10/26 a BMP (telehealth had originally ordered a CMP on 03/06/26 however, that was not completed and the NP #224 ordered a BMP) to be obtained on Wednesday 03/11/26. NP #224 reported Resident #54 had a CMP completed about two weeks prior to this on 02/25/26 and she was following up with recheck of labs based on his history of labs (elevated creatinine). She also reported Resident #54 was not good at taking in oral fluids and she had discussed with him the prior week about possibility of providing intravenous fluids through his medical port (long term IV access for his chemotherapy medication). She further reported Resident #54 had been having bouts of diarrhea she was treating. The NP also verified the resident wanted full code status with no limit to his care, during his stay at the facility. Interview on 04/13/26 at 11:30 AM with the DON revealed confirmation there was no order to discontinue the CMP on 03/09/26 and no new order entered for the BMP to be obtained on 03/11/26. There was no lab order for a CMP or BMP on the TAR for the month of March 2026. A telephone interview on 04/17/26 at 11:58 A.M. with Resident #54's daughter revealed she had either visited or called her father at the nursing facility daily. Resident #54 daughter reported her dad did not mention feeling sick or different over the weekend prior to his hospital stay but stated he did not always tell her the truth about how he was feeling. Resident #54's daughter further reported Resident #54 did see his oncologist during his hospital stay and the oncologist reported the resident's cancer was throughout his body but that was not new information (he had prostate cancer for over seven years), it had been that way and was told by oncology that his cancer numbers were actually lower than they had been. Further interview with Resident #54's daughter revealed oncology discussed plans to resume chemotherapy with Resident #54 once he was stronger and in better health. Resident #54's daughter reported Resident #54 had initially went to the nursing facility to get rehabilitation with the intention of returning home and restarting chemotherapy and there was no discussion of hospice care until he was re-admitted to the hospital (on 03/11/26). The resident subsequently passed away in the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 04/21/26 at 1:37 P.M. with the DON revealed Resident #54 was weighed for the first time on 03/09/26 in the mechanical lift scale and questioned the validity of the weight loss of six pounds. The resident was re-weighed at 184 pounds. The DON reported she did not know why Resident #54 was weighed in the mechanical lift that day and not standing scale as he had been for prior weights. Further interview with the DON revealed her expectation would be that staff would have reported the progressive decrease in oral intake, decreased meal consumption, decreased urine outputs, and the return of loose watery stools from 03/02/26 to 03/11/26 to the nurse practitioner or medical provider. There was no evidence in the medical record of the staff reporting the change in condition of Resident #54 to ensure timely and/or necessary medical intervention was provided for the resident. Review of the undated facility Physician Orders policy revealed when taking orders the nurse was to make sure and discontinue any previous contradicting order. Review of the undated facility Notification of Change in Condition policy revealed changes in condition of residents could include but were not limited to accidents, incidents, transfers, changes in overall health status, significant medical changes, hospitalizations, and death. 2. Record review revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes, anemia, and cellulitis. On 03/05/26 the resident was admitted to hospice services. Review of Resident #13's at risk for constipation plan of care related to side effects of medication and poor mobility dated 02/23/26 revealed to administer medication per medical providers orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/resident representative. Monitor bowel movements and side effects of medication for constipation. Keep medical provider, resident/resident representative informed of any problems. Observe for signs and symptoms of complication of constipation (vomiting and abdomen guarding, tenderness, rigidity of the abdomen, and fecal compaction). Review of Resident #13's hospice certification dated 03/05/26 revealed for the bowel protocol was one to two sennoside (stool softener) 8.6 milligrams (mg) at bedtime as needed. Bisacodyl (laxative) 10 mg rectally one daily as needed for constipation, enema of sodium phosphate rectally as needed for constipation, and loperamide 2 mg tablet by mouth as directed and as needed for diarrhea. Review of Resident #13's orders and medication records dated 03/2026 revealed on 03/02/26 the resident's scheduled Miralax and Naloxegol (used for opioid induced constipation) was discontinued on 03/02/26. On 03/06/26 the resident was ordered Oxycodone 5 mg every four hours as needed for pain or discomfort and to monitor for adverse side effects of pain medication: constipation. Staff had signed off twice a day they were monitoring for adverse effects of pain medication including constipation, and the resident had received eleven doses of Oxycodone from 03/06/26 to 03/30/26. On 03/13/26 the resident was ordered Senna 8.6 mg two tablets twice daily for constipation. Further review of Resident #13's orders and medication record review revealed no evidence of the hospice bowel protocol (1-2 sennoside 8.6 milligrams (mg) at bedtime as needed. Bisacodyl 10 mg rectally one daily as needed for constipation, enema of sodium phosphate rectally as needed for constipation, and loperamide 2 mg tablet by mouth as directed and as needed for loose stools) entered in the medical record as an active order for Resident #13. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #13's significant change Minimum Data Set (MDS) dated [DATE] revealed the resident had an indwelling urinary catheter (discontinued on 03/06/26), was occasionally incontinent of urine and frequency incontinent of bowel. Review of Resident #13's bowel records dated 03/25/26 to 03/29/26 revealed the resident did not have a bowel movement on 03/25/26, 03/26/25, 03/27/25, 03/28/25 and 03/29/26. Review of Resident #13's hospice note dated 03/27/26 revealed the resident's last bowel movement was three days ago. Review of Resident #13's progress notes dated 03/23/26 to 03/30/25 revealed no evidence the provider was notified of no bowel movements. Review of Resident #13's encounter note dated 04/03/26 revealed Resident #13 was seen for abdominal pain and no bowel movement. The resident reported she started having right side pain and she was still nauseated and vomiting. The resident reported she had one emesis this morning. The resident had as needed Zofran and Phenergan for nausea. The resident had not had a documented bowel movement for five days. She was on Movantik for opioid induced constipation but was discontinued by hospice. She is on senna two tablets twice a day. The resident denied diarrhea and was passing gas. The resident was ordered a urinalysis to rule out urinary tract infection as cause of the symptoms. Interview on 04/08/26 at 8:37 A.M. and 12:06 P.M., with the Director of Nursing (DON) confirmed the resident had gone five days without a bowel movement. The DON reported the facility didn't have a bowel policy; however the protocol was if the resident didn't have a bowel movement within three days, staff were to alert the provider. The DON confirmed the electronic medical record had a program on the dash board that would alert staff if the resident didn't have a bowel movement, however not all nurses reviewed each dash board daily for each resident. The DON confirmed hospice had a bowel protocol, however the facility never entered the orders.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on open and closed medical record review, review of notice of Medicare Non-Coverage (NOMNC) and//or Advance Beneficiary Notice of Non-Coverage (ABN), review of beneficiary protection notification review form, and interview the facility failed to ensure NOMNC's included Quality Improvement Organization (independent reviewer authorized by Medicare to review the decision to end these services) name and contract information, NOMNC and ABN was provided and or provided timely. This affected four residents (Resident's #7, #39 #60, and #61) of four residents reviewed for beneficiary protection notification review. The facility census was 51.1. Closed medical record review revealed Resident #60's was admitted to the facility on [DATE] with diagnoses of left femur fracture, heart failure, diabetes, convulsions, head injury, and hypothyroidism. Review of the beneficiary protection notification review form completed by the facility on 04/14/26 revealed the resident last covered day of Part A service was 12/09/25 and the resident was discharged home. The form indicated the resident was not issued a NOMNC and should have been issued one. Interview on 04/14/26 at 12:35 P.M., with Social Service Director (SSD) #149 and Administrator confirmed Resident #60 was discharged home and did not receive the NOMNC and should have received a NOMNC. 2. Closed record review revealed Resident #61 was admitted to the facility on [DATE] with a diagnoses of left knee effusion, diabetes, anemia, heart failure, and dementia. Review of Resident #61's beneficiary protection notification review completed by the facility on 04/14/26 revealed the resident's last covered day of Part A services was 10/23/25 due to the facility/provider initiated the discharge from Medicare part A services when benefit days were not exhausted. The resident remained in the facility and received ABN and NOMNC. Review of Resident #61's the NOMNC dated 10/22/25 revealed the resident was discharged from therapy services on 10/23/25. There was no evidence of the QIO name or contact information to appeal or ask questions was provided on the form. Further review revealed a handwritten note authored by SSD #149 that indicated she had called the resident's representative at 12:40 P.M. on 10/22/25 to review the NOMNC. The resident's representative reported verbal agreement of the discharged services and doesn't want to appeal. There was no documented evidence that the resident representative signed or received a copy of the NOMNC or was given a two-day notice prior to discharge of services on 10/23/25. Review of Resident #61's ABN dated 10/22/25 revealed the resident was discharged from therapy services on 10/23/25 due to meeting maximum potential. Staff had checked a box that indicated the resident did not want care listed above and understood that they would not be responsible for paying and couldn't appeal to see if Medicare would pay. There was an additional handwritten note dated 10/22/25 at 12:40 P.M., authored by SSD #149 that indicated the resident's representative was agreeable to determination of services and verbally understood. There was no documented evidence that the resident representative received a two-day notice of discharged services or received and signed a copy of the ABN. Interview on 04/14/26 at 12:35 P.M., with SSD #149 and Administrator confirmed Resident #61's representative was not provided with a two-day notice that Resident #61 was being discharged from therapy services nor was there documented evidence that a copy of the NOMNC or ABN was sent to the resident's representative for signatures. The SSD #149 confirmed the NOMNC did not contain the QIO name or contact information for the representative to appeal or ask questions. 3. Medical record review revealed Resident #39 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, malignant neoplasm of thorax, and peripheral vascular disease. Review of Resident #39's beneficiary protection notification review form completed by the facility on 04/14/26 revealed the residents last covered Part A services was 02/25/26 and the resident remained in the facility and received the NOMNC and ABN. Review of Resident #39's NOMNC dated 02/23/26 revealed the resident last covered day for physical therapy service was 02/25/26. There was no documented evidence of the QIO name or contact information to appeal or ask questions (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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	135 Reichart Avenue Wintersville, OH 43953

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was on the form. Interview on 04/14/26 at 12:35 P.M., with SSD #149 and Administrator confirmed the QIO name and contact information was not provided on the form signed by the resident. 4. Review of Resident #7's beneficiary protection notification review form completed on 04/14/26 by the facility revealed Resident #7's last covered day of Part A services was 01/26/26 and the resident remained in the facility. The resident received an ABN and NOMNC. Review of Resident #7's NOMNC dated 01/23/26 revealed the resident last covered day for therapy service was 01/26/26. There was no documented evidence of the QIO name or contact information to appeal or ask questions was on the form. Interview on 04/14/26 at 12:57 P.M., with SSD #149 confirmed Resident #7's NOMNC did not contain the QIO name or contact information to ensure the resident could appeal or ask questions. The SSD reported a few weeks ago (end of March) corporate office had provided training throughout the company on NOMNC and ABNs to staff, however she had not had to issue any ABN's or NOMNC since 03/16/26. The education included providing resident or resident representatives with QIO name and contact information, two day notice, and obtaining representative signature in person or mailing certified copy to representative to complete.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the infection control log, policy review, interviews, and observation the facility failed to ensure the infection control log was comprehensive and failed to ensure enhanced barrier precautions were maintained during incontinence care. This affected three (Resident #7, #9, and #13) of four residents reviewed for infections and one (Resident #1) of one residents observed for incontinence care. The facility census was 51. Findings include: 1.Record review revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes, anemia, and cellulitis. Review of Resident #13's urinalysis dated 04/02/26 revealed on 04/02/26 the urine was collected and abnormal findings were reported on 04/03/26. The abnormal findings included: the urine was light orange in color, extra turbid, plus one ketones, plus three blood, protein plus one, positive nitrite, plus four positive, 21-50 red blood cells, greater than 50 white blood cells, few bacteria and epithial cells, and presence of mucous and white blood cells present in the urine. There was no evidence the culture was obtained. Review of Resident #13's order dated 04/05/26 revealed to administer one gram of Rocephin intramuscular times one then Vantin oral 100 milligrams (mg) twice daily for urinary tract infections (UTI) for five days. Review of Resident #13's medical administration record (MAR) dated 04/2026 revealed the resident received the one-time dose of Rocephin intramuscular on 04/04/26 and started Vantin 100 mg twice a day for UTI for five days on 04/05/26. Review of Resident #13's infection surveillance criteria report dated 04/05/26 revealed the resident had a urinary tract infection (UTI) acute dysuria (pain or discomfort) or acute pain, swelling, tenderness of the testes, epididymis or prostate. Greater than 100,000 colony forming units (cfu) per milliliter (ml) of no more than two species of organisms in a voided urine sample (there was no evidence in the medical record a urine culture was performed at that time). The report indicated the resident met criteria for treatment. The Infection Preventionist (P) #120 signed the report. Review of the infection control log dated 04/2026 revealed Resident #13 had a bacterial infection, the site was urinary tract infection (UTI), the resident had flank pain, the organism was UTI, the resident was treated with Vantin (antibiotic), and the infection met McGeer's criteria for treatment. Interview on 04/13/26 at 1:04 P.M., with IP #120 and the Director of Nursing (DON) confirmed Resident #13's infection surveillance criteria report and the infection control log were inaccurate due to the urine culture and sensitivity was not completed until 04/09/26 and the report and log on 04/07/26 indicated the resident's urine culture showed greater than 100,000 CFU/ML of no more than two species of organisms in a voided urine sample when the culture was not completed at that time. The IP and DON confirmed the infection control log was not comprehensive to include the organism and, at the time the log and criteria report were completed, there was no documented evidence the resident met McGeer's criteria due to the culture was not completed at that time. The infection control log didn't include the one dose of Rocephin that was administered as ordered. 2. Medical record review revealed Resident #7 was as admitted to the facility on [DATE] with diagnoses including dementia, depression, left femur fracture, hypertension, and age-related (continued on next page)

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	365629	A. Building B. Wing	04/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	osteoporosis. Review of Resident #7's urinalysis results dated 03/18/26 revealed the resident's urine culture showed greater than 100,000 CFU/ml of enterococcus faecalis (bacteria) and was sensitive to ampicillin (antibiotic), cirpofloxin (antibiotic), nitrofurantoin (antibiotic), penicillin (antibiotic), and vancomycin (antibiotic). Review of Resident #7's progress note dated 03/18/26 revealed laboratory results were reviewed and no new orders. Review of the infection control log and trending map dated 03/2026 revealed no documented evidence of Resident #7 enterococcus faecalis infection or urinalysis. Interview on 04/13/26 at 1:04 P.M., with IP #120 and the Director of Nursing (DON) confirmed Resident #7's urinalysis indicated the Resident #7 had an enterococcus faecalis infection and it was not included on the infection control log or trending map. The DON confirmed all infections should be included on the infection control log and the facility map for trending even if the infection was not treated with an antibiotic. 3. Medical record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including pressure ulcer on sacral region, diabetes, chronic pain, chronic viral hepatitis C, gout, and colostomy. a. Review of March 2026 infection control log dated 03/2026 revealed on 03/10/26 the resident had other as the type of infection and site, the symptoms were altered mental status and elevated white blood cells, the diagnostic testing was urinalysis, the organism was marked not applicable, the treatment was Rocephin, and the infection met McGeer's criteria. Review of Resident #9's encounter note dated 03/11/26 revealed the Nurse Practitioner was following up on the resident's altered mental status and right lower extremity pain and edema. His urinalysis was negative. Rocephin continued for cellulitis and blood cultures were still pending. Review of Resident #9's infection surveillance criteria report dated 03/12/26 revealed the report was completed for a UTI. The criteria included the resident must have greater than 100,000 cfu/ml of no more than two species of organisms in a voided urine sample. The report did not indicate if the resident met criteria or not. There was no evidence that an infection surveillance criteria report was completed for cellulitis. Review of Resident #9's urinalysis dated 03/13/26 revealed the resident had less than 10,000 CFU/ml of gram-positive cocci and no sensitivity would be done. b. Review of Resident #9's blood culture results dated 03/18/26 revealed the final result was Methicillin-resistant Staphylococcus epidermidis (MRSE). Review of the March 2026 infection control log dated 03/2026 revealed on 03/23/26 the resident had a bacterial infection, the site was bacteremia, symptoms were elevated white blood cells, the organism was marked not applicable, the treatment was vancomycin, and the log indicated the resident met McGeer's criteria for treatment. There was no evidence of the organism MRSE. (continued on next page)

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	365629	A. Building B. Wing	04/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of infectious disease progress note dated 03/19/26 revealed the skilled nursing facility obtained four blood cultures and three of the four indicated Methicillin-resistant Staphylococcus epidermidis (MRSE), which was a common skin contaminant and the blood cultures were negative. There were concerns there may be occult bacteremia from his wounds that may be causing his pain. Recommend orthopedic consult for evaluation and aspiration to be sent for cell count, gram stain, and cultures and crystal analysis to rule out septic arthritis and gout. Continue on Vancomycin intravenously for 4-5 weeks and with laboratory monitoring. Recommend orthopedic consult for evaluation and aspiration to be sent for cell count, gram stain, and cultures and crystal analysis to rule out septic arthritis and gout. Review of Resident #9's infection surveillance criteria report dated 03/25/26 revealed the resident had bacteremia. There was no evidence if the resident met criteria or not. Review of the facility trending map dated 03/2026 revealed the resident had two skin infections and one blood infection. There was no documented evidence what the type of infection just the location of the infection. Interview on 04/13/26 at 1:04 P.M., with IP #120 and the Director of Nursing (DON) confirmed on 03/10/26 the resident was treated with antibiotics for cellulitis not a urinary tract infection per the infection surveillance criteria report and infection control log. The DON confirmed there was not a surveillance criteria report completed for the cellulites. The IP nurse confirmed there was no place on the surveillance criteria report to indicate if the resident meets or does not meet criteria. The DON confirmed the infection control log didn't include MRSE as the organism or trending map per the blood culture results. 4. Review of the facility's infection trending dated 01/2026 to 04/2026 revealed the facility utilized a facility map to trend infections. The map for January, February, and March only included the site (eye, oral, skin, blood, respiratory, UTI, osteo, fungal) of the infection and April's 2026 trending map was not started and the infection control log indicated there were three infections (one dental, one UTI without the organism, and one staphylococcus epidermis. Interview on 04/13/26 at 1:04 P.M., with IP #120 and the Director of Nursing (DON) confirmed the facility used a facility map of the rooms to trend infections. The IP and DON confirmed the log indicated the location/site of the infection but there was no way to indicate if there was an outbreak of infections such as Methicillin-resistant Staphylococcus Aurus (MRSA) or Escherichia coli which could be in different location/sites. Review of the facility's policy and procedure titled Infection Prevention Infection Control undated revealed the facility's infection prevention program was comprehensive in that it addresses detection, prevention, and control of infections among residents and employees. A systematic and organized data-driven method is in place to prevent infections, track existing infections, track and trend for in-house infections, surveillance for outbreaks effective and timely implementation of appropriate interventions and monitor infection control practices for compliance. 5. Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia, tracheostomy, quadriplegia, history of traumatic brain injury, and congestive heart failure. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/03/26, revealed a Brief (continued on next page)

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	365629	A. Building B. Wing	04/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview for Mental Status (BIMS) interview could not be conducted. The MDS further revealed Resident #1 required staff assistance with activities of daily living (ADLs). Observation on 04/08/26 at 11:15 A.M. of Resident #1's incontinence care with Certified Nursing Assistant (CNA) #128 and #135 revealed neither staff donned personal protective equipment (PPE) while providing incontinence care. Enhanced barrier precautions (EBP) signage and equipment were located on the resident's door. The Assistant Director of Nursing (ADON) was also present in the room. Interview with ADON on 04/08 at 11:27 A.M. confirmed CNA #128 and CNA #135 did not wear PPE while providing incontinence care as they should have. Review of the facility's policy titled, Enhanced Barrier Precautions, undated, revealed EBP is an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and device care for: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care for any skin opening requiring a dressing. PPE required is gowns and gloves.

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	365629	A. Building B. Wing	04/21/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, the facility failed to notify the resident representative of a newly identified pressure wound. This affected one (Resident #4) of one resident reviewed for notification of change. The facility census was 51.Findings include:Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia, tracheostomy, gastrostomy, diabetes mellitus, hemiparesis and hemiplegia following cerebrovascular disease, anoxic brain damage, and seizures.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/11/26, revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severely impaired cognition. The MDS further revealed Resident #4 required staff assistance with activities of daily living (ADLs). Review of the admission record revealed Resident #4's mother (Family Member #208) was listed as the resident's emergency contact and medical power of attorney.Review of nursing progress note, dated 03/18/26 at 7:30 P.M. (entered as a late entry), revealed a new pressure injury noted to left, lateral ankle, unstageable. Area was cleansed with normal saline, calcium alginate and foam dressing applied. Orders placed to reflect care, nurse practitioner aware, will notify responsible party when in facility tomorrow morning.Review of the progress notes revealed no documented evidence Family Member #208 was notified of the pressure ulcer on 03/19/26 as indicated in the progress note (responsible party would be notified when in facility tomorrow morning).Interview on 04/06/26 at 3:21 P.M. with Family Member #208 revealed her son developed a pressure wound on his left ankle and she was not notified by the facility. She stated while visiting her son, she inquired why he wasn't wearing his leg brace and was told he had developed a new pressure wound, on his outer ankle, a couple of days ago.Interview with Director of Nursing (DON) on 04/13/26 at 2:27 P.M stated she did recall speaking with Family Member #208 who voiced concern regarding not being notified of a newly identified pressure wound. The DON stated the resident representative should have been notified when the new pressure wound was discovered, however, because the resident's family member typically visited daily, the nurse planned to inform her the next day during her visit.Review of the undated facility policy titled, Notification of Change in Condition, revealed the center must inform the resident, consult with the resident's medical practitioner, and/or notify the resident's representative, authorized family member, or legal power of attorney when there is a change requiring such notification. Circumstances requiring notification including but not limited to: accidents resulting in injury, accidents with the potential to require physician intervention, circumstances that require a need to alter treatment which may include a new treatment.

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	365629	A. Building B. Wing	04/21/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the as needed (prn) order for a psychotropic medication was limited to 14 days. This affected one (Resident #19) of five residents reviewed for unnecessary medications.Findings include: Medical record review revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including anxiety disorder, psychoactive substance-induced psychotic disorder, chronic pain, and fibromyalgia. Review of the annual Minimum Data Set (MDS) 3.0 assessment, dated 01/01/26, revealed the resident had intact cognition and a diagnosis of anxiety disorder. Review of the physician orders revealed an order, dated 06/17/25, for Ativan 0.5 milligrams (mg) one tablet by mouth every six hours as needed for anxiety. Review of the June and July 2025 Medication Administration Records (MAR) revealed Resident #19 received Ativan 0.5 mg one tablet by mouth on 06/17 through 06/24/25 and 06/26/25 through 06/30/25; and on 07/01/25 through 07/10/25. The prn psychotropic medication was received for a total of 23 days. Interview on 04/13/26 at 1:45 P.M. with the Director of Nursing (DON) confirmed the physician order for Ativan 0.5 mg every six hours prn for anxiety did not specify a 14-day stop date when Resident #19 received the medication for 23 days prior to the medication's discontinuation.

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	365629	A. Building B. Wing	04/21/2026

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, the facility failed to ensure a resident's Pre-admission Screening and Resident Review (PASRR) document accurately reflected all diagnoses. This affected one (Resident #19) of one resident reviewed for PASRR documents. The census was 52. Findings Include: Medical record review revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including anxiety disorder, psychoactive substance-induced psychotic disorder, chronic pain, and fibromyalgia. Review of the annual Minimum Data Set (MDS) 3.0 assessment, dated 01/01/26, revealed the resident had intact cognition and a diagnosis of anxiety disorder. Review of Resident #19's PASRR document, dated 02/01/24, revealed under Section E: Indications of Serious mental Illness, no was selected incorrectly indicating there was not a diagnosis of mental illness. Review of the resident's diagnoses list revealed the diagnosis of anxiety disorder and psychoactive substance-induced psychotic disorder. Interview on 04/08/26 at 3:14 P.M. with Corporate Registered Nurse #200 confirmed Resident #19's PASRR document was not accurate and did not indicate the diagnosis of anxiety disorder and psychoactive substance-induces psychotic disorder. Interview on 04/08/26 at 3:32 P.M. with Social Services Designee (SSD) #149 confirmed Resident #19's PASRR document was not accurate and did not indicate the diagnosis of anxiety disorder and psychoactive substance-inducesd psychotic disorder and that she should have updated the document.

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	365629	A. Building B. Wing	04/21/2026

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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, policy review, observation, and interview, the facility failed to ensure showers were provided as scheduled for a dependent resident. This affected one (Resident #2) of one resident reviewed for activities of daily living (ADL's). The facility census was 51. Findings include: Medical record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including dementia, chronic kidney disease, cervical disk degeneration, diabetes mellitus, chronic pain, and morbid obesity. Review of the 5-Day Minimum Data Set (MDS) assessment, dated 02/18/26, revealed Resident #2 had moderately impaired cognition and required physical staff assistance with ADL's. Review of the care plan, dated 02/28/26, revealed Resident #2 had an ADL self-care performance deficit and required physical assistance of two staff members for showers and baths. Observation and interview on 04/06/26 at 10:30 A.M revealed Resident #2 had excess oil noted in his hair and was wearing a hospital gown. The resident stated he was scheduled to receive a shower on Fridays but had not received a shower for the last couple of weeks. Interview on 04/13/2026 4:07 P.M. with Certified Nursing Assistant (CNA) #137 stated if a resident refused a bath or shower the refusal is documented in the shower binder that is kept in the nursing station and the nurse is notified of the resident's refusal. Review of the Shower Sheet Binder located at the nursing station revealed Resident #2 was scheduled to receive showers twice weekly on Tuesday and Friday. Review of Resident #2's Shower Sheet and Body/Skin Infection Forms for Nurse Aides revealed the resident last received a shower on 04/04/26; and refused showers on 04/11/26 and 04/17/26. The forms did not indicate documentation of the reason for the refusal or of a report to the nurse of the refusal per facility policy. Interview on 04/13/26 at 4:35 PM with the Director of Nursing (DON) confirmed according to the Shower Sheets, Resident #2 refused his showers on 04/07/26 and 04/11/26; however, the nurse did not follow-up with the resident and document an intervention per policy. Interview on 04/13/26 at 4:40 P.M., the DON stated she spoke with Resident #2 regarding his showers and will be moved from evening shift to day shift and twice weekly per his preference. Review or the facility's undated policy titled, Routine Resident Care, revealed routine resident care is care that is not necessarily medically or clinically based but necessary for quality-of-life promoting dignity and independence. Routine care by a nursing assistant includes but is not limited to the following: assisting or provides care including bathing, dressing, eating and hydration, and toileting.

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	365629	A. Building B. Wing	04/21/2026

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record review and Bureau of Motor Vehicles document review the facility failed to assist Resident #9 in obtaining a state photo identification. This affected one resident (Resident #9) of one residents reviewed for choices. The facility census was 51. Findings include:Review of Resident #9's medical record revealed an admission date of 09/25/23 with diagnoses that included pressure ulcer to the sacrum, diabetes mellitus and chronic kidney disease. Review of Resident #9's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed an intact and independent cognition level. Review of Ohio Department of Public Safety BMV form dated 01/08/25 revealed the BMV needed an affidavit from the provider that expressed the customer was homebound and unable to travel to the Deputy Registrar's Office. Upon receipt of the above, a license/identification card would be issued and mailed. Interview with Resident #9 on 04/06/26 at 12:59 P.M. revealed the facility still had not helped him obtain a state photo identification that was requested over a year ago.Interview with the Director of Nursing (DON) on 04/08/26 at 2:04 P.M. revealed the facility was to help the resident obtain a state issued photo ID and provided a letter from the BMV indicating the facility only needed an affidavit from the provider (dated 01/08/25) indicating he was homebound; however, a letter was never obtained and the resident still doesn't have a photo ID. The DON reported the Nurse Practitioner was present in the facility today and she would have her write a letter.

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	365629	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	135 Reichart Avenue Wintersville, OH 43953

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, the facility failed to ensure a monthly regimen review (MRR) pharmacy recommendation for a psychotropic medication's 14-day stop date was addressed by the physician. This affected one (Resident #19) of five residents reviewed for unnecessary medications.Findings include: Medical record review revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including anxiety disorder, psychoactive substance-induced psychotic disorder, chronic pain, and fibromyalgia. Review of the physician orders revealed an order, dated 04/24/25, for Ativan 0.5 milligrams (mg) one tablet by mouth every six hours as needed for anxiety. The order did not include a 14-Day stop date. The medication was discontinued on 06/15/25. Review of the Monthly Regimen Reviews (MRR), dated 05/30/25, revealed the pharmacist recommended a 14-day stop date for the use of Ativan 0.5 mg every six hours as needed (prn) for anxiety; or a documented rationale if the prescriber believed the prn order should be extended beyond 14 days. Further review of the MRR revealed the physician did not address the recommendation as the form was blank, nor was there documentation in the medical record. Review of the physician orders revealed an order, dated 04/24/25, for Ativan 0.5 milligrams (mg) one tablet by mouth every six hours as needed for anxiety. The order did not include a 14-Day stop date. The medication was discontinued on 06/15/25. Review of the May and June 2025 Medication Administration Records (MAR) revealed Resident #19 received Ativan 0.5 mg one tablet by mouth prn for anxiety on 05/01/25, 05/03/25 through 05/05/25, 05/07/25 through 05/31/25; and 06/01 through 06/06/25 and 06/08/25 through 06/14/25. Review of the annual Minimum Data Set (MDS) 3.0 assessment, dated 01/01/26, revealed the resident had intact cognition and a diagnosis of anxiety disorder. Interview on 04/13/26 at 1:35 P.M with the Director of Nursing (DON) confirmed Resident #19's MRR was not addressed timely by the physician. Review of the facility's undated policy titled, Medication Regimen Review, revealed psychotropic medication is any drug that affects brain activities associated with mental processes and behavior. The monthly medication review will be performed by a licensed pharmacist according to Federal and State regulations meeting current standards of practice. The pharmacist will report any irregularities to the attending physician and DON and these reports must be acted upon in a timely manner that meets the needs of the resident.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and review of laboratory contract the facility failed to ensure ordered urine culture and sensitivity laboratory testing was completed timely. This affected one (Resident #13) of one residents reviewed for urinary tract infection. The facility census was 51. Findings include:Record review revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes, anemia, and cellulitis. Review of Resident #13's significant change Minimum Data Set (MDS) dated [DATE] revealed the resident had an indwelling urinary catheter, occasionally incontinent of urine and frequently incontinent of bowel. The indwelling urinary catheter was discontinued 03/06/26. Review of Resident #13's urinalysis/culture dated 04/02/26 revealed on 04/02/26 the urine was collected and abnormal findings were reported on 04/03/26. The abnormal findings included: the urine was light orange in color, extra turbid (cloudy), plus one ketone, plus three blood, protein plus one, positive nitrite, plus four positive, 21-50 red blood cells, greater than 50 white blood cells, few bacteria and epithial cells, and presence of mucous and white blood cells present culture. There was no evidence the culture and sensitivity was performed. Review of Resident #13's encounter note dated 04/03/26 revealed resident was being seen for abdominal pain and no bowel movement. The resident reported she started having right side pain. She was still nauseous and vomiting and had one emesis this morning. The resident was on as needed Zofran and Phenergan for nausea. No concerns of dysuria (pain or discomfort) or hematuria (blood in the urine) at this time. She has not had a documented bowel movement in five days. Gastrointestinal: positive right flank pain, side pain to palpation. Genitourinary: There is no bladder tenderness or distention. Has urinalysis pending to rule out urinary tract infection (UTI) as cause of symptoms. Review of Resident #13's urine culture and sensitivity dated 04/09/26 (from the urine collected on 04/02/26) revealed the urine had greater than 100,000 colony forming units (CFU) per milliliter (ml) of proteus mirabilis (bacteria) and was sensitive to ceftriaxone (third generation antibiotic). Interview on 04/07/26 at 2:21 P.M., 04/08/26 at 8:37 A.M., and 04/13/26 at 7:41 A.M., with the Director of Nursing (DON) confirmed Resident #13's urine culture and sensitivity was not performed timely. The DON confirmed the urinalysis was collected on 04/02/26 and on 04/07/26 there was no evidence the culture and sensitivity was completed. The DON stated that the laboratory reported they were running behind as the reason why the culture and sensitivity was not completed until 04/09/26. Review of the laboratory contract dated 06/02/99 revealed the laboratory would report test results in a mutually agreeable manner. The nursing home ultimately bears responsibility for all services to its residents.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, review of infection control log, and policy review the facility failed to ensure an effective antibiotic stewardship program to ensure residents met criteria for antibiotic treatment. This affected one (Resident #13) of four residents reviewed for infections. The facility census was 51.Findings include: Record review revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes, anemia, and cellulitis.Review of Resident #13's significant change MDS dated [DATE] revealed the resident had an indwelling urinary catheter, occasionally incontinent of urine and frequency incontinent of bowel. The urinary catheter was discontinued 03/06/26.Review of Resident #13's urinalysis/culture dated 04/02/26 revealed on 04/02/26 the urine was collected and abnormal findings were reported on 04/03/26. The abnormal findings included: the urine was light orange in color, extra turbid (cloudy), plus one ketones, plus three blood, protein plus one, positive nitrite, 21-50 red blood cells, greater than 50 white blood cells, few bacteria and epithial cells, and presence of mucous and white blood cells in the specimen. There was no evidence the culture was obtained.Review of Resident #13's alert charting dated 04/02/26, 04/03/26, 04/04/26, 04/05/26, 04/06/26 revealed no urinary changes noted. There was an additional note on 04/03/26 and 04/04/26 that revealed the resident complained of flank pain to nurse practitioner and hospice was notified. Urine specimen was sent out. Continue to monitor and give as needed pain medications.Review of Resident #13's encounter note dated 04/03/26 revealed the resident was being seen for abdominal pain and no bowel movement. The resident reported she started having right side pain. She was still nauseous and vomiting and had one emesis this morning. The resident was on as needed Zofran and Phenergan for nausea. No concerns of dysuria (pain or discomfort with urination) or hematuria (blood in the urine) at this time. She has not had a documented bowel movement in five days. Gastrointestinal: positive right flank pain, side pain to palpation. Genitourinary: There is no bladder tenderness or distention. Has urinalysis pending to rule out urinary tract infection (UTI) as cause of symptoms.Review of Resident #13's infection surveillance criteria report dated 04/05/26 revealed the resident had a UTI, acute dysuria or acute pain, swelling, tenderness of the testes, epididymis (part of male urinary/reproductive anatomy) or prostate. Greater than 100,000 colony forming unit (cfu) per milliliter (ml) of urine of no more than two species of organisms in a voided urine sample (there was no evidence in the medical record a urine culture was obtained). The report indicated the resident met criteria for treatment. The Infection Preventionist signed the report. Review of Resident #13's order dated 04/05/26 revealed to administer one gram of ceftriaxone (antibiotic) intramuscular times one then cefpodoxime proxetil (antibiotic) oral 100 milligrams (mg) twice daily for UTI for five days. Review of Resident #13's medical administration record (MAR) dated 04/2026 revealed the resident received the one time dose of ceftriaxone intramuscular on 04/04/26 and started cefpodoxime proxetil 100 mg twice a day for UTI for five days on 04/05/26. Review of the infection control log dated 04/2026 revealed on 04/05/26 Resident #13 had flank pain and the organism was a urinary tract infection (UTI) and the resident met criteria for treatment and was ordered cefpodoxime 100 mg. Review of Resident #13's current, comprehensive plan of care revealed no evidence of plan of care for urinary tract infection.Interview on 04/07/26 at 2:21 P.M. and 04/08/26 at 8:37 A.M., with the Director of Nursing (DON) confirmed the culture had not returned at this time. The DON reported she called the laboratory, and the preliminary should be here tomorrow and final on Thursday (04/09/26). The DON confirmed the resident was started on antibiotics without meeting criteria. The DON also confirmed the Infection Preventionist (IP) had completed the criteria form and infection control log inaccurately due to the urine culture report was still pending and there was no evidence the resident had greater than 100,000 CFU/ml or met criteria for treatment. The DON reported urine cultures were usually completed within 48 to 72 hours. Interview on 04/08/26 at 9:01 AM with Infection Preventionist (IP) #120 confirmed (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13 didn't meet criteria for treatment due to the culture report was still pending. The IP confirmed she completed the criteria form inaccurately because she indicated the resident met criteria and the resident didn't. The IP reported she would reach out to lab to see why there was a delay in the culture results. The IP confirmed the provider did not provide a rationale for treatment without meeting criteria.Review the of the facility policy titled Antibiotics Stewardship dated 03/22 revealed the facility aim of the program was to optimize the treatment of infections while reducing the adverse events associated with antibiotics use in resident in the nursing home facility.