STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365927	A. Building B. Wing	12/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regina Health Center	5232 Broadview Rd Richfield, OH 44286

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** 34297 Based on record review, interview, and policy review, the facility failed to ensure Resident #10's narcotic pain medications were not misappropriated. This finding affected one (Resident #10) of three residents reviewed for medication administration. Findings include: Review of Resident #10's medical record revealed the resident was admitted on [DATE] with diagnoses including pain in the right toes, muscle weakness, rheumatoid arthritis and unspecified dementia without behavioral disturbance. Review of Resident #10's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #10's physician orders revealed an order dated 10/24/24 (discontinued 12/10/24) for oxycodone pain tablet 5 mg (milligrams) give one tablet by mouth every six hours as needed for pain; and a physician order dated 12/10/24 for oxycodone 5 mg give one tablet by mouth every six hours as needed for pain. Review of Resident #10's medication administration records from 10/01/24 to 12/21/24 revealed the last dose of Resident #10's oxycodone pain medication was administered on 10/30/24 at 8:00 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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NAME OF PROVIDER OR SUPPLIER Regina Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5232 Broadview Rd Richfield, OH 44286	

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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	Review of facility investigation dated 12/06/24 revealed Licensed Practical Nurse (LPN) Agency #809 misappropriated 14 oxycodone narcotic pain medications out of twenty-five oxycodone narcotic pain medications remaining on the narcotic card which were available for Resident #10's use as of 11/23/24. The narcotic card from Resident #10 was located on the 1C Hall medication administration cart in the locked narcotic drawer. This incident occurred when LPN Agency #809 worked 10:30 P.M. to 7:00 A.M. on 11/23/24. LPN Agency #809 worked a total of four shifts in the facility including 03/19/24, 07/19/24, 11/15/24 and 11/23/24. The investigation determined Resident #10's oxycodone narcotic pain medication card had the sides of the card slit open and the oxycodone narcotics were only taken from the edges and replaced with Topamax migraine medication. The Administration staff revealed LPN Agency #809 had left a bottle labeled amoxicillin with her name on it at the nursing station. Upon inspection of the bottle, an unknown amount of Topamax was in the bottle. On 12/06/24, LPN Agency #810 (second shift) and LPN Agency #808 were doing the end of shift narcotic counts and the nurses determined there was an issue with Resident #10's oxycodone narcotic card. The investigation and the pharmacy had determined the glue which was used to reseal Resident #10's oxycodone narcotic pain medication card after switching the oxycodone with Topamax had came undone on the tampered narcotic medications and that why LPN Agency #808 noticed the edges of the card pulling apart. When LPN Agency #808 inspected the card further it was determined 14 of the oxycodone tablets did not have the correct medications in the plastic bubble slots intended for the oxycodone. The oxycodone was replaced by Topamax migraine medication. The facility identified one resident in the facility who was administered Topamax which were a different brand that the Topamax found in the oxycodone card, but the same tablets which were found in LPN Agency #809's amoxicillin bottle she had left at the nursing station. Review of the Facility Theft or Loss Documentation form dated 12/06/24 revealed 14 tablets of Resident #10's oxycodone narcotic pain medications were missing with an unexplained theft or loss. The suspect's name was LPN Agency #809. The pharmacy, State Board of Nursing and Law Enforcement were notified. There was no mention of notification to the State Survey Agency. Interview on 12/21/24 at 7:20 A.M. with LPN #804 indicated the misappropriation happened on the 1C Hall medication cart. She stated the third shift agency nurse (LPN Agency #808) was counting with the second shift agency nurse (LPN Agency #809) when the third shift nurse noticed Resident #10's oxycodone pain medication card had been tampered with. Interview on 12/21/24 at 7:38 A.M. with RN Supervisor #803 indicated the oncoming nurse on 12/06/24 (LPN Agency #808) counted the narcotics with another staff member during shift change when a discrepancy was identified with Resident #10's oxycodone narcotic card. LPN Agency #808 flipped over Resident #10's oxycodone narcotic card and there was a slit on the back of some of the narcotic pain medications. When she examined the card, she found that some of the medications in the plastic bubbles of the narcotic card were different than other pills in the card. She reported these concerns to the administrative staff. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/21/24 at 8:01 A.M. with RN Assistant Director of Nursing (ADON) #806 indicated LPN Agency #808 had noticed Resident #10's card looked tampered with when she was doing narcotic count on 12/06/24 with another staff member. She refused to take the keys and called the administrative staff. During the investigation, it was determined that Resident #10's oxycodone narcotic card had 14 oxycodone pain tablets replaced with Topamax (for seizures and migraine headaches). Further investigation revealed a bottle labeled amoxicillin was found at the nursing station with LPN Agency #809's name on the label. The bottle was filled with Topamax when reviewed by the pharmacy. RN ADON #806 stated the facility called the police, the Board of Nursing, their pharmacy and did audits but did not identify any other residents with missing narcotic pain medications. RN ADON #806 also indicated Resident #10 had not received oxycodone narcotic pain medications since 10/24 and no concerns were identified with the resident was assessed for pain. A telephone interview was attempted on 12/21/24 at 9:55 A.M. with LPN Agency #809 and was unsuccessful with no answer obtained. A message was left on the voicemail. No call back from LPN Agency #809 was received. Review of the facility's Narcotic Policy dated 07/05/24 revealed to not scratch off and scribble on mediation narcotic tracking sheets; sheets must remain legible at all times; all narcotics were to be signed off as they were removed from the cart and administered; shift to shift counts must be completed by all nurses when transferring keys and medication carts; narcotic cards were to be assessed for proper numerical count, card integrity, expiration date and signs of tampering; and two nurses were required for transferring narcotics in and out of each medication cart. This deficiency represents noncompliance investigated under Complaint Number OH00160593.

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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** 34297 Based on record review, interview, and policy review, the facility failed to report an allegation of misappropriation of Resident #10's oxycodone narcotic pain medications to the State Survey Agency as required. This finding affected one (Resident #10) of three residents reviewed for misappropriation. Findings include: Review of Resident #10's medical record revealed the resident was admitted on [DATE] with diagnoses including pain in the right toes, muscle weakness, rheumatoid arthritis and unspecified dementia without behavioral disturbance. Review of Resident #10's physician orders revealed an order dated 10/24/24 (discontinued 12/10/24) for oxycodone pain tablet 5 mg (milligrams) give one tablet by mouth every six hours as needed for pain; and a physician order dated 12/10/24 for oxycodone 5 mg give one tablet by mouth every six hours as needed for pain. Review of Resident #10's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #10's Medication Administration Records from 10/01/24 to 12/21/24 revealed the last dose of Resident #10's oxycodone pain medication was administered on 10/30/24 at 8:00 P.M. Review of facility investigation dated 12/06/24 revealed Licensed Practical Nurse (LPN) Agency #809 misappropriated 14 oxycodone narcotic pain medications out of twenty-five oxycodone narcotic pain medications remaining on the narcotic card which were available for Resident #10's use as of 11/23/24. The narcotic card from Resident #10 was located on the 1C Hall medication administration cart in the locked narcotic drawer. This incident occurred when LPN Agency #809 worked 10:30 P.M. to 7:00 A.M. on 11/23/24. LPN Agency #809 worked a total of four shifts in the facility including 03/19/24, 07/19/24, 11/15/24 and 11/23/24. The investigation determined Resident #10's oxycodone narcotic pain medication card had the sides of the card slit open and the oxycodone narcotics were only taken from the edges and replaced with Topamax migraine medication. The Administration staff revealed LPN Agency #809 had left a bottle labeled amoxicillin with her name on it at the nursing station. Upon inspection of the bottle, an unknown amount of Topamax was in the bottle. On 12/06/24, LPN Agency #810 (second shift) and LPN Agency #808 were doing the end of shift narcotic counts and the nurses determined there was an issue with Resident #10's oxycodone narcotic card. The investigation and the pharmacy had determined the glue which was used to reseal Resident #10's oxycodone narcotic pain medication card after switching the oxycodone with Topamax had came undone on the tampered narcotic medications and that why LPN Agency #808 noticed the edges of the card pulling apart. When LPN Agency #808 inspected the card further it was determined 14 of the oxycodone tablets did not have the correct medications in the plastic bubble slots intended for the oxycodone. The oxycodone was replaced by Topamax migraine medication. The facility identified one resident in the facility who was administered Topamax which were a different brand that the Topamax found in the oxycodone card, but the same tablets which were found in LPN Agency #809's amoxicillin bottle she had left at the nursing station. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility Theft or Loss Documentation form dated 12/06/24 revealed 14 tablets of Resident #10's oxycodone narcotic pain medications were missing with an unexplained theft or loss. The suspect's name was LPN Agency #809. The pharmacy, State Board of Nursing and Law Enforcement were notified. There was no mention of notification to the State Survey Agency. Interview on 12/21/24 at 7:38 A.M. with RN Supervisor #803 indicated the oncoming nurse on 12/06/24 (LPN Agency #808) counted the narcotics with another staff member during shift change when a discrepancy was identified with Resident #10's oxycodone narcotic card. LPN Agency #808 flipped over Resident #10's oxycodone narcotic card and there was a slit on the back of some of the narcotic pain medications. When she examined the card, she found that some of the medications in the plastic bubbles of the narcotic card were different than other pills in the card. She reported these concerns to the administrative staff. Interview on 12/21/24 at 8:01 A.M. with Registered Nurse (RN) Assistant Director of Nursing (ADON) #806 confirmed Resident #10's oxycodone narcotic pain medications were misappropriated. Review of the facility Self-Reported Incidents (SRIs) did not reveal evidence Resident #10's misappropriation of oxycodone narcotic pain medications was reported to the State Survey Agency as required. Review of the policy Abuse, Neglect, and Misappropriation, revised 04/13/21, revealed all employees who know of or suspect abuse, neglect, or misappropriation are required to report to the Executive Director. The Executive Director or his/her designee will report all alleged violations to the Ohio Department of Health (ODH) through the ODH Application Gateway. The results of a thorough investigation must be included on the complete report within 5 working days of the incident. This deficiency represents an incidental finding of noncompliance identified while investigating Complaint Number OH00160593.