STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365970	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Union City Care Center	907 East Central Street Union City, OH 45390

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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to report an allegation of misappropriation of resident property. This affected one (Resident #10) of three residents reviewed. The facility census was 36.Findings Include:Review of the closed record for Resident #10 revealed she was admitted initially 08/19/25 with re-entry 10/16/25. She was discharged [DATE]. Her diagnoses included chronic pain, protein-calorie malnutrition, major depressive disorder, rheumatoid arthritis, hypertension, metabolic encephalopathy, anemia, hyperlipidemia and gastro-esophageal reflux disease. Review of her admission Minimum Data Set (MDS) dated [DATE] revealed her Brief Interview of Mental Status (BIMS) score was eight indicating moderate cognitive impairment. She required set-up assistance for eating, moderate assistance for toileting, maximal assistance for bathing, dressing and personal hygiene. Review of her Care Plan dated 08/20/25 revealed she required healthcare monitoring related to opioid use for chronic pain syndrome and refused non-med interventions. Review of the Physician's Orders for Resident #10 revealed an order for Hydrocodone (opioid)-Acetaminophen (analgesic) 10-325 milligram one tablet every six hours as needed for pain. Interview on 12/11/25 at 12:10 P.M. with the Administrator and the Director of Nursing (DON) revealed when Resident #10 was admitted in August 2025, she arrived late in the day, and her pain medication had not arrived with the evening shipment. Resident #10 called her husband who brought in her pain medication from home. The Administrator stated she instructed the nurse regarding not being able to administer home medication. She reported the Licensed Practical Nurse (LPN) #15 stated she returned the medication to the husband but the husband stated he had not received the medication. The Administrator reported she and the DON met with the nurse and the husband together with the nurse stating she returned the medication and the husband stating she had not returned them. The Administrator confirmed no Self-Reported Incident or investigation was completed. Interviews with three Certified Nurse Aides (CNA) #24, #28 and #53 on 12/11/25 between the hours of 3:05 P.M. and 3:28 P.M. revealed they had heard Resident #10's husband had brought in medication from home for his wife and alleged the nurse had not given the medication back to him. Two of the CNA's (#28 and #53) reported they had seen LPN #15 drop narcotic medication on the floor and then place them in her pocket rather than wasting them per procedure. Interview on 12/11/25 at 4:50 P. M. with the Administrator and the DON verified the husband's signature did not match the signature on the paper supplied by the nurse when he reportedly signed for receipt of the medication. The Administrator and DON stated they had not contacted the police or nursing board, and had not drug tested the nurse as she had brought in a bottle of the same medication revealing she had her own current prescription. They reported her employment was terminated two months later for other reasons. Interview on 12/11/25 at 4:11 P.M. with Resident #10's husband revealed he had brought in about 21 Hydrocodone Acetaminophen pills when Resident #10 was admitted as the pharmacy had not yet been able to deliver this medication. He verified these pills were never returned to him. He reported they had a meeting with the nurse who stated she had given him back the pills and had a paper which she stated he signed for receipt of the medication. He stated he had never signed a paper for receiving the medication and when he signed his name during the meeting, it had not matched the signature on the paper the nurse produced. The facility told him they would take care of it, and he never heard back nor received the medication. Review of the Accident and Incident Log for 2025 revealed no documentation regarding misappropriation and no incidents involving the specified resident. Review of the facility self reported incidents (SRIs) revealed no SRI for Misappropriation for Resident #10. Review of the policy on Abuse Investigation and Reporting revised December 2017 revealed all reports of abuse, neglect or misappropriation should be promptly reported to the correct agencies and thoroughly investigated by facility management. Any employee alleged to have been involved with abuse would be immediately suspended pending the results of the investigation. If the investigation revealed the employee was guilty of abuse, their employment would be terminated, and they would be reported to the appropriate professional and licensing agency. This deficiency represents non-compliance investigated under Complaint Number 2609034.

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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 and interview the facility failed to investigate an allegation of misappropriation. The affected one (Resident #10) of three residents reviewed. The facility census was 36.Findings Include:Review of the closed record for Resident #10 revealed she was admitted initially 08/19/25 with re-entry 10/16/25. She was discharged [DATE]. Her diagnoses included chronic pain, protein-calorie malnutrition, major depressive disorder, rheumatoid arthritis, hypertension, metabolic encephalopathy, anemia, hyperlipidemia and gastro-esophageal reflux disease. Review of her admission Minimum Data Set (MDS) dated [DATE] revealed her Brief Interview of Mental Status (BIMS) score was eight indicating moderate cognitive impairment. She required set-up assistance for eating, moderate assistance for toileting, maximal assistance for bathing, dressing and personal hygiene.Review of her Care Plan dated 08/20/25 revealed she required healthcare monitoring related to opioid use for chronic pain syndrome and refused non-med interventions. Review of the Physician's Orders for Resident #10 revealed and order for Hydrocodone (opioid)-Acetaminophen (analgesic) 10-325 milligram one tablet every six hours as needed for pain. Interview on 12/11/25 at 12:10 P.M. with the Administrator and the Director of Nursing (DON) revealed when Resident #10 was admitted in August 2025, she arrived late in the day, and her pain medication had not arrived with the evening shipment. Resident #10 called her husband who brought in her pain medication from home. The Administrator stated she instructed the nurse regarding not being able to administer home medication. She reported the Licensed Practical Nurse (LPN) #15 stated she returned the medication to the husband but the husband stated he had not received the medication. The Administrator reported she and the DON met with the nurse and the husband together with the nurse stating she returned the medication and the husband stating she had not returned them. The Administrator confirmed no Self-Reported Incident (SRI) or investigation was completed related to the allegation of missing medications. Interview on 12/11/25 at 4:11 P.M. with Resident #10's husband revealed he had brought in about 21 Hydrocodone Acetaminophen when Resident #10 was admitted . He verified these pills were never returned to him. He stated the facility told him they would take care of it, and he never heard back nor received the medication. Review of the Accident and Incident Log for 2025 revealed no documentation regarding misappropriation and no incidents involving Resident #10 were documented. Review of the facility SRIs revealed no SRI for Misappropriation for Resident #10. Review of the policy on Abuse Investigation and Reporting revised December 2017 revealed all reports of abuse, neglect or misappropriation should be promptly reported to the correct agencies and thoroughly investigated by facility management. Any employee alleged to have been involved with abuse would be immediately suspended pending the results of the investigation. If the investigation revealed the employee was guilty of abuse, their employment would be terminated, and they would be reported to the appropriate professional an licensing agency. This deficiency represents non-compliance investigated under Complaint Number 2609034.