| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365991 | A. Building<br>B. Wing | 02/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Addison Healthcare Center | 8055 Addison Road SE<br>Masury, OH 44438 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973<br><br>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.<br><br>Based on interview, record review, review of the facility Self-Reported Incident (SRI) and related facility investigation, and policy review, the facility did not ensure Residents #2, #4, #23, and #35 were free from the misappropriation of their controlled substance narcotic pain medication. This affected four residents (Resident #2, #4, #23, and #35) out of four residents reviewed for misappropriation of property. This had the potential to affect 14 residents (#1, #2, #4, #8, #11, #21, #23, #26, #32, #33, #35, #36, #39, and #153) the facility identified as residing on the A unit and had orders for controlled substances. The facility census was 48.<br><br>Findings included:<br><br>1. Review of the SRI dated 01/03/25 revealed the facility reported an incident of misappropriation. The report revealed Licensed Practical Nurse (LPN) #332 arrived at the facility on 01/03/25 at 3:00 A.M. and was unable to find Former Registered Nurse (RN) #602 as well as seven controlled substance cards were missing from the A unit medication cart including: ten tablets of Oxycodone (narcotic pain medication) 15 milligram (mg), 23 tablets of Percocet (narcotic pain medication) 5-325mg, six tablets of Morphine Sulfate (MS) Contin (narcotic pain medication), seven tablets of Percocet 10-325mg, 82 tablets of Xanax (anti-anxiety medication) 0.5 mg (combined on two cards), and 13 tablets of Oxycodone 5mg. The report revealed the police were notified and residents were assessed for any adverse effects, and none were noted. The report revealed Police Officer #603 had responded and initiated an investigation including driving to Former RN #602's home address but she was not there. Police Officer #603 returned to the facility on [DATE] at approximately 5:00 A.M. and found Former RN #602's vehicle in the facility parking lot. Police Officer #603 then proceeded to complete a facility search and found Former RN #602 unresponsive in the employee bathroom with a cup of pudding, spoon, water bottle and the missing medication cards belonging to Residents #2, #4, #23, and #35. The report revealed Former RN #602 was administered Narcan (medication given to reverse opioid overdose) per Police Officer #603 and was sent to the hospital. The pharmacy was notified and immediately replaced all residents' medications. The facility unsubstantiated the incident.<br><br>(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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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Police Report dated 01/03/25 revealed Police Officer #603 was dispatched to the facility on [DATE] at 3:21 A.M. regarding the theft of drugs from the facility. Police Officer #603 was informed that Former RN #602 had left the facility without telling anyone and she had stolen resident's medications from the medication cart. The following medications were missing per the report: ten tablets Oxycodone 15mg, 23 Percocet 5-325mg tablets, six Morphine Sulfate Contin tablets, seven Percocet 10-325mg, 82 tablets Xanax 0.5mg, and 13 tablets Oxycodone 5mg. Police Officer #603 left to go to Former RN #602's home address and later returned back to the facility at which time searched the facility and found Former RN #602 in the employee bathroom leaned up against the wall hunched over. There were two full packs of Xanax in her hand and the other medication cards were empty in the trash can next to her. Police Officer #603 administered Narcan and she was transported to the hospital by emergency rescue service (EMS). The report revealed after collecting all the medication packs for evidence it was determined Former RN #602 had ingested 81 tablets of the following: 10 tablets of Oxycodone 15mg, 23 tablets of Percocet 5-325mg, six tablets of MS Contin, seven tablets of Percocet 10- 325mg, 22 tablets of Xanax .5mg, and 13 tablets of Oxycodone 5mg.<br><br>Review of Employee Termination Checklist dated 01/06/25 and completed by the Director of Nursing (DON) revealed Former RN #602 was terminated as she stole controlled substances from residents and overdosed in the facility bathroom.<br><br>Interview on 02/24/25 at 9:46 A.M. with the Administrator and Director of Nursing (DON) verified Former RN #602 misappropriated the above controlled substances belonging to Residents #2, #4, #23, and #35.<br><br>2. Review of the medical record for Resident #23 revealed an admitted [DATE] and diagnoses including rheumatoid arthritis, asthma, and bilateral knee osteoarthritis.<br><br>Review of the care plan last revised 10/16/23 revealed Resident #23 had osteoporosis and osteoarthritis. Interventions included administer medications as orders, observe for side effects and effectiveness of the medications, and report abnormal findings to medical provider.<br><br>Review of the Controlled Drug Administration Record for Resident #23 dated 12/06/24 revealed the facility received 58 MS Contin extended release (ER) 15 mg tablets from the pharmacy. The record revealed on 01/03/25 LPN #300 and LPN #332 signed on the sheet that six MS Contin tablets were missing.<br><br>Review of the Controlled Drug Administration Record for Resident #23 dated 12/26/24 revealed the facility received 30 Percocet 10-325 mg from the pharmacy. The record revealed on 01/03/25 LPN #300 and LPN #332 signed on the sheet that seven Percocet tablets were missing.<br><br>Review of January 2025 Physician Orders revealed Resident #23 orders included: MS Contin ER 15mg give one tablet by mouth two times a day for chronic pain and Percocet 10-325 mg tablet give one tablet by mouth every six hours as needed for breakthrough pain.<br><br>Review of the January 2025 Medication Administration Record (MAR) for Resident #23 revealed Resident #23 received her medications as ordered including on 01/03/25.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #23 had intact cognition, had frequent pain and received opioid medications (classification of pain medication derived from the opium poppy plant). Her medication regimen consisted of scheduled and as needed pain medication.<br><br>Interview on 02/19/25 at 4:17 P.M. with Resident #23 revealed the facility had notified her that Former RN #602 had taken her MS Contin and Percocet. She revealed there was no delay in receiving any of her medications as they had the medications on hand to replace.<br><br>3. Review of Resident #35's medical record revealed an admitted [DATE] and his diagnoses included hypertension, arthritis, chronic pain syndrome, and gout.<br><br>Review of care plan last revised 03/26/24 revealed Resident #35 had complaints of acute and chronic pain related to gout. Interventions included follow physician orders, observe for pain every shift, and pain management consult.<br><br>Review of the quarterly MDS dated [DATE] revealed Resident #35 had intact cognition, had occasional pain and received opioids. His medication regimen consisted of scheduled and as needed pain medication.<br><br>Review of the Controlled Drug Administration Record for Resident #35 dated 12/30/24 revealed the facility received 30 Percocet 5-325 mg from the pharmacy. The record revealed on 01/03/25 LPN #300 and LPN #332 signed on the sheet that 23 Percocet tablets were missing.<br><br>Review of the January 2025 Physician Orders revealed Resident #35 orders included: Oxycontin ER 15mg give one tablet by mouth two times a day for chronic pain, Percocet 5-325mg give one tablet by mouth every four hours as needed for breakthrough pain, and a one-time order for Oxycontin ER 15mg give one tablet by mouth one time only on 01/03/25.<br><br>Review of the Controlled Drug Administration Record for Resident #35 dated 01/02/25 revealed the facility received ten Oxycontin ER 15mg from the pharmacy. The record revealed on 01/03/25 LPN #300 and LPN #332 signed on the sheet that ten Oxycontin ER tablets were missing.<br><br>Review of the January 2025 MAR revealed Resident #35 received his as needed Percocet 5-325mg on 01/03/25 at 10:47 A.M. He received his Oxycontin ER 15mg per one time physician order on 01/03/25 at 12:18 P.M.<br><br>Review of the packing slip revealed on 01/03/25 Resident #35 received 10 tablets of Oxycodone ER as replacement. The slip was signed as received on 01/03/25 at 10:46 A.M.<br><br>Review of the nursing note dated 01/03/25 at 1:06 P.M. and completed by RN/ Assistant Director of Nursing (ADON) #318 revealed Medical Director/ Primary Care Physician (PCP) #600 was updated and ordered Resident #23's routine Oxycontin dose to be given at 12:00 P.M.<br><br>Interview on 02/19/25 at 4:01 P.M. with Resident #35 revealed the facility had notified him that Former RN #601 had taken his medications as well as she had taken several other resident's medications. He revealed he could not remember the exact details, including if his medications were delayed.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 02/20/25 at 11:07 A.M. with RN/ ADON #318 revealed Resident #23's replacement Oxycodone ER had arrived at the facility during the time frame to be administered on time but because Resident #35 had received his as needed Percocet so close to when the medication arrived that she had contacted Medical Director/ PCP #600 to get a one-time order to give his routine Oxycodone ER at noon which Resident #23 was in agreement. She revealed Resident #23 displayed no adverse effects because of the incident.<br><br>4. Review of medical record for Resident #4 revealed an admitted [DATE] and diagnoses included hypertension, bilateral above the knee amputations, and muscle weakness. Per the nursing notes for 01/03/25 there were no adverse effects as Resident #4 did not complain of pain that required as needed pain medication.<br><br>Review of the care plan last revised 11/24/20 revealed Resident #4 had pain to legs. Interventions included administering medications as ordered, evaluate the effectiveness of pain interventions, and document and monitor for side effects.<br><br>Review of the Controlled Drug Administration Record for Resident #4 dated 12/13/24 revealed the facility received 30 Oxycodone ER 5 mg tablets from the pharmacy. The record revealed on 01/03/25 LPN #300 and LPN #332 signed on the sheet that 13 Oxycodone tablets were missing.<br><br>Review of January 2025 physician orders revealed Resident #4 had an order for Oxycodone 5mg by mouth every eight hours as needed for pain.<br><br>Review of the quarterly MDS dated [DATE] revealed Resident #4 had intact cognition, and received as needed pain medication. She had no pain present per the assessment in the last five days.<br><br>Interview on 02/20/25 at 03:59 P.M. with Resident #4 felt she received pain medications any time she requested and never felt any of her pain medications were delayed.<br><br>5. Review of medical record for Resident #2 revealed an admitted [DATE] and her diagnoses included anxiety, panic disorder and hypertension.<br><br>Review of care plan dated 12/01/24 revealed Resident #2 used anti-anxiety medication due to her anxiety disorder. Interventions included medications as ordered, provide calm environment, observe for side effects, and maintain consistent daily routine.<br><br>Review of the undated Controlled Drug Administration Record for Resident #2 revealed the facility had received 90 Xanax tablets from the pharmacy. The record revealed on 01/03/25 LPN #300 and LPN #332 signed on the sheet that 82 Xanax tablets were missing.<br><br>Review of January 2025 Physician Orders revealed Resident #2 had an order for Xanax .5mg give one tablet by mouth three times a day for anxiety. Per January 2025 MAR Resident #2 received her Xanax as ordered including on 01/03/25.<br><br>Review of the quarterly MDS dated [DATE] revealed Resident #2 had intact cognition, and she received antianxiety medications.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 02/20/25 at 4:23 P.M. with Resident #2 revealed that she felt she always received her medications as ordered and that she had not missed any medications because of 01/03/25 incident.<br><br>Review of undated facility policy labeled, Medication Controlled Drugs and Security revealed controlled drugs were medications that pose a high risk for addiction when improperly taken, and are known to depress the respiratory system and could lead to an overdose. The policy revealed controlled substances would be kept under double lock and would be counted by the oncoming and off going nurse at the end of each shift and before keys were passed to next shift. The policy revealed drug diversion would be treated as misappropriation of resident property and the board of nursing would be notified.<br><br>Review of undated facility policy labeled, Ohio Abuse, Neglect, and Misappropriation revealed misappropriation was defined as deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent.<br><br>The deficient practice was corrected on 01/24/25 when the facility implemented the following corrective actions:<br><br>On 01/03/25 at 6:00 A.M. Medical Director #600 was notified of the incident.<br><br>On 01/03/25 the DON provided education on Controlled Medication Security and Counseling, and Stress Management for all nurses.<br><br>On 01/03/25 the DON filed an SRI with the Ohio Department of Health and reported the incident to Ohio Board of Nursing.<br><br>On 01/03/25 DON completed audits on all controlled substances for discrepancies.<br><br>On 01/06/25 Former RN #602 was terminated from the facility.<br><br>On 01/07/25 the DON audited all delivery manifests for the last 30 days for concerns prior to incident of controlled substances discrepancies.<br><br>The DON completed ongoing audits on controlled substances three times weekly for three weeks including on 01/06/25, 01/08/25, 01/10/25, 01/13/25, 01/15/25, 01/17/25, 01/20/25, 01/22/25, and 01/24/25.<br><br>On 01/07/25 the Quality Assurance Performance Improvement (QAPI) committee met including Medical Director #600, the Administrator and Director of Nursing to discuss the incident and ongoing monitoring of the audits.<br><br>There were no further incidents of resident property misappropriation as of the date of this survey completed on 02/25/25. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973<br><br>Based on observation, interview, record review, review of QSO-24-08-NH memorandum, and review of facility policy revealed the facility did not utilize enhance barrier precautions (EBP) when indicated for Residents #17 during the administration of medication through his percutaneous endoscopic gastrostomy (PEG) tube. This affected one Resident (#17) out of two residents observed for EBP. The facility identified 11 Residents (#3, #4, #11, #17, #22, #28, #36, #42, #38, #39, #153) who required EBP. The facility census was 48.<br><br>Findings include:<br><br>Review of the medical record for Resident #17 revealed an admitted [DATE] and diagnoses including spastic quadriplegic cerebral palsy, convulsions, dysphagia, and adult failure to thrive.<br><br>Review of the care plan last revised 05/20/21 revealed Resident #17 required a PEG tube (medical device used to provide nutrition and hydration directly into the stomach) feeding related to dysphagia. Interventions included provide tube feeding per medical provider orders, administer medications PEG tube, and head of bed elevated 30 degrees.<br><br>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #17 had impaired cognition, and he had impairment to both upper and lower extremities. He was dependent on staff for toileting hygiene, dressing, transfers, personal hygiene, rolling left and right.<br><br>Review of February 2025 Physician Orders revealed Resident #17 had an order for EBP related to the PEG tube when dressing, bathing, showering, transferring in room or therapy, personal hygiene, changing linen, changing briefs or assisting with toileting.<br><br>Review of the care plan dated 02/18/25 revealed Resident #17 required EBP for the PEG tube. Intervention included appropriate personal protective equipment would be utilized during high contact care by care givers.<br><br>Observation on 02/19/25 at 4:05 P.M. revealed on the outside of Resident #17's door there was EBP signage that revealed staff were to clean their hands including before entering and when leaving the room, wear gloves and gown for the following high contact resident care activities: dressing, bathing/ showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting and device care or use including feeding tube. Observation revealed Curriculum Practical Training (CPT) Intern Registered Nurse (RN) #201entered into Resident #17's room with mask and eye protection in place. She then donned gloves but no gown and proceeded to administer Resident #17's medication and flush through his peg tube. During the procedure her uniform came into contact with Resident #17's bedding as she leaned over. She removed her gloves and performed hand hygiene before exiting the room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 02/19/25 at 4:14 P.M. with CPT/ Intern/ RN #201 verified she did not wear a gown while administering Resident #17's medication and flush through his PEG tube. She verified there was signage on the outside of Resident #17's door indicating he was on EBP. CPT/ Intern/ Registered RN #201 revealed the signage was old as that was the sign when he had COVID-19 and that the signage should have been removed as he no longer had COVID-19. She verified she did not wear a gown for device care including administration of medications through peg tube. She revealed Resident #17 did not have an infection.<br><br>Interview on 02/19/25 at 4:26 P.M. with the Director of Nursing verified Resident #17 was to be on EBP as he had a PEG tube. She verified CPT/ Intern/ RN #201 should have worn a gown during the administration of his medications and flushes through his peg tube.<br><br>Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed enhanced barrier precautions are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24.<br><br>Review of undated facility policy labeled, Enhanced Barrier Precautions revealed EBP was defined as an infection control intervention designed to reduce transmission of multi-drug-resistant organisms. The policy revealed employees were to perform hand hygiene, gown and glove use during high contact care activities including dressing, bathing, transferring, changing linens and during device care including central line, urinary catheter, feeding tube, and tracheostomy. |