STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366041	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Heights Health and Rehabilitation Center	3600 Butz Rd Maumee, OH 43537

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure an accurate system for the dispensing, administration, reconciliation and destruction of controlled substances. The facility identified 34 residents receiving controlled pain medications. The facility census was 73. Findings include:Review of the medical record for Resident #161 revealed an admission date of 10/22/25. Diagnoses included malignant carcinoid tumor of the bronchus and lung, chronic obstructive pulmonary disease, malignant neoplasm of the liver, and low back pain. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was independent for all activities of daily living. The resident had frequent pain.Review of physician orders dated 12/29/25 revealed an order for Oxycodone 30 milligrams (mg), one tablet by mouth every four hours as needed for pain, discontinue when new medication arrives for 20 mg.Review of the physician orders dated 12/30/25 revealed an order for Oxycodone 20 mg, two tablets by mouth three times a day for pain and give two tablets by mouth every four hours as needed for pain. The medication orders for the scheduled medication and as needed medication were on the same medication card. Review of a pharmacy invoice packing slip dated 12/30/25 revealed the facility had received three cards of Oxycodone 20 mg. Each card contained 30 tablets. Review of the Medication Administration Records (MAR) dated 12/30/25 through 01/02/26 revealed the resident had received 26 tablets of Oxycodone. Further review of the MAR from 01/09/26 at 9:00 A.M. through 01/11/26 at 5:12 P.M. revealed the resident was administered 28 tablets of Oxycodone. Review of the controlled substance medication monitoring/control records from 12/09/25 through 01/20/26 revealed there were no control records in the resident's medical record for the Oxycodone administered 12/30/25 through 01/02/26 and from 01/09/26 through 01/11/26. Review of the controlled substance medication monitoring/control records dated 12/25/25 through 01/03/26 revealed on 01/03/26 two tablets of the discontinued Oxycodone 30 mg were removed from the medication card at 3:00 A.M. Review of the MAR and nurse's notes revealed no documentation the medication was administered, disposed of or wasted. Further review of the MAR dated 01/04/26 revealed the resident was administered two tablets of Oxycodone 20 mg at 2:56 A.M. Review of the control record for the Oxycodone revealed the medication had not been removed from the medication card to administer on 01/04/26. Review of the nurse's notes for 01/04/26 revealed no documentation why the medication was documented as administered when it had not been removed from the medication card. Review of the control record revealed the Oxycodone medication count on 01/03/26 was 18 tablets at 9:00 P.M. and 16 tablets on 01/04/26 at 9:00 A.M. when the medication was administered again. Review of the control substance record of disposal dated 01/13/26 revealed nine Oxycodone 30 mg tablets received on 12/17/25 had been destroyed for Resident #161. Review of the Oxycodone control record dated 12/25/25 through 01/03/26 revealed there were only four tablets of Oxycodone remaining. Further review of the control record revealed a crossed out entry for the destruction of nine (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxycodone 30 mg tablets with the number four written next to the number nine. Interview on 01/20/26 at 2:04 P.M., Resident #161 revealed the facility had not administered pain medication per his request. Resident #161 revealed he had notified management. Interview on 01/21/26 at 10:47 A.M., the Administrator revealed Resident #161 was horsing around in a wheelchair and the nurse questioned if the resident really needed his pain medication which upset the resident. Interview on 01/21/26 at 3:31 P.M., with the Assistant Director of Nursing (ADON) #323 and Risk Management Registered Nurse (RMRN) #505 revealed they had been searching everywhere for the Oxycodone control records and were not able to find all the resident's Oxycodone control records. RMRN #505 verified the Oxycodone orders for the scheduled Oxycodone and the orders for the as needed Oxycodone were on the same order and same medication card and should have been two separate orders. Interview on 01/22/26 at 10:35 A.M., the Director of Nursing (DON) verified nine Oxycodone 30 mg tablets were incorrectly documented as destroyed on the record of disposal form dated 01/13/26. Interview on 01/22/26 at 2:20 P.M. with the Assistant Director of Nursing (ADON) #323 revealed if a controlled substance medication was not given then a progress note should be documented and a second nurse should witness the destruction of the medication. ADON #323 revealed if a medication was pulled and not administered then the nurse should have made a progress note and notified management. Further interview with ADON #323 verified the facility could not locate the Oxycodone control records for Resident #161. ADON #323 revealed staff were required to put control records in her mailbox so she could review the records. ADON #323 revealed she had not reviewed the missing control records as she would have noted the discrepancies and followed up with staff. ADON #323 also verified the nurses were not documenting and initialing the shift change controlled substance inventory count sheet when controlled substance medication cards and control records were removed from the controlled substance binder. ADON #323 revealed the nursing staff had been educated two times on controlled substance procedures and would now require further in-person education. Review of the facility policy Administering Medications, revised 12/2012, revealed the Director of Nursing would supervise and direct all nursing personnel who administer medications and/or have related functions. Medication must be administered in accordance with the orders, including any required time frame. Review of the facility policy Controlled Substances, revised 11/2022, revealed the facility would comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medication listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976. Further review of the policy revealed an individual resident would have a controlled substance record with only one prescription per page. This record would contain the name of the resident, name and strength of the medication, quantity received, number on hand, name of prescribers, prescription number, name of issuing pharmacy, date and time received, time of administration, signature of person receiving the medication and the signature of the nurse administering the medication. Controlled substance inventory would be monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The system of reconciling the receipt, dispensing, and disposition of controlled substance would include records of personnel access and usage, medication administration records, declining inventory records, and destruction, waste and return to pharmacy records. The Director of Nursing Services documents irreconcilable discrepancies in a report to the administrator. This deficiency represents non-compliance investigated under Complaint Number 2718640.