STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366122	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Mary Scott	3109 Campus Dr Dayton, OH 45406

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 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 medical record review, staff interviews, review of the Ohio Department of Health (ODH) Gateway Application, review of a facility timeline, review of a Narcotic Administration Sheet and policy review, the facility failed to report an allegation of misappropriation to the State Agency. This affected one (#79) out of three residents reviewed for misappropriation. The facility census was 77. Findings include: Review of the medical record for Resident #79 revealed an admission date of 03/05/25 with diagnoses of osteomyelitis, type 2 diabetes mellitus without complications, neoplasm of unspecified behavior of respiratory system, retropharyngeal and parapharyngeal abscess, personal history of malignant neoplasm of larynx, and tracheostomy status. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact, did not eat anything by mouth, and was independent with all activities of daily living. Review of the physician orders revealed an order dated 06/30/25 for Oxycodone Oral Solution 5 milligrams (mg)/5 milliliters (ml), give 20 ml via G-Tube every three hours as needed for pain. Interview on 08/12/25 at 11:52 A.M. with the Director of Nursing (DON) confirmed the facility accepted the liquid Oxycodone from Resident #79's daughter on 06/12/25, and the staff did not verify with the daughter the amount of oxycodone that was remaining in the bottle. Interview with the DON also confirmed on 06/20/25 the daughter reported someone had stolen Resident #79's oxycodone and called the police. Interview confirmed the facility did not report the allegation to the State Agency and accusation of theft for Resident #79 because they knew the medication was accurate. Review of the ODH Gateway Application revealed there was no self-reported incident (SRI) involving an allegation of misappropriation of medication for Resident #79. Review of a facility timeline for Resident #79 investigation revealed on 06/12/25 Resident #79's daughter had brought in a bottle of Oxycodone. Facility staff reported they couldn't accept the bottle. Resident #79 and the family were escorted to the medication cart by Licensed Practical Nurse (LPN) #294. On 06/13/25 the 7:00 P.M. to 7:00 A.M. nurse called the DON at home and stated that Resident #79's medication appeared suspicious, she described it as being light in color and appeared thin. Nurse also stated it was reported that seal was not intact when Resident #79's daughter delivered the medication. There were also questions regarding where the script was and who changed the dosage. There was no paperwork reportedly turned in by the family or resident. On 06/20/25 the police arrived at the facility on Resident #79 due to daughter making a report on missing oxycodone. LPN #294 informed police oxycodone was not missing, it was in a lock box. Review of the Narcotic Administration Sheet revealed on 06/12/25, 250 ml of Oxycodone was signed in. The Narcotic Administration Sheet does not contain any documentation that the seal was broke when the medication was received. There was not any doses documents as administered. Review of the Controlled Substances policy dated November 2022 revealed controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together, and that both individuals sign the designated controlled substance record. This deficiency represents non-compliance investigated under Complaint Number 1313950 (OH00167084).

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interviews and policy review, the facility failed to ensure tracheostomy (trach) supplies were available in accordance with the care plan and facility policy. This affected one (#77) out of three residents reviewed for trach care and services. The facility census was 77. Finding include: Review of the medical record for Resident #77 revealed an admission date of 03/06/23 with diagnoses of anoxic brain damage, epilepsy, unspecified, intractable, without status epilepticus, chronic obstructive pulmonary disease, and acute on chronic systolic (congestive) heart failure. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively impaired, was dependent on staff for all activities of daily living, and resident had a trach. Review of the care plan dated 03/07/23 revealed a care plan for trach related to impaired breathing mechanics injury with interventions of keep extra trach tube and obturator at bedside. If tube is coughed out attempt to reinsert tube. Review of the physician orders revealed an order dated 01/02/25 for trach care daily. Change inner cannula number four (#4) Shiley every day shift related to anoxic brain damage. On 08/11/25 an order was noted for trach size 4UN85H with inner canula size Shiley #4- 41C85 every shift. Observation and interview on 08/12/25 at 7:20 A.M. with Licensed Practical Nurse (LPN) #234 confirmed there was not an extra trach available if Resident #77's current trach became dislodged. Interview with LPN #234 also confirmed the facility does not always have the trach supplies that are needed for Resident #77. Interview on 08/12/25 at 8:37 A.M. with LPN Unit Manager #294 brought a trach size #4 with a cuff stating it was the trach Resident #77 used and was placing the trach at the residents beside. Interview with LPN Unit Manager #294 confirmed Resident #77 did not have a cuffed trach and did not have a physician's order for a cuffed trach. Review of the Tracheostomy Care policy dated 01/10/25 revealed a replacement trach tube must be available at the bedside at all times. This deficiency represents non-compliance investigated under Complaint Number 1313951 (OH00166239).