STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366125	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Shane Hill	10731 State Route 118 Rockford, OH 45882

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** 35031 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, review of a facility self-reported incident (SRI), staff interview, and review of the facility misappropriation policy, the facility failed to ensure a resident was free from misappropriation of medication. This affected one (Resident #01) out of three residents reviewed for misappropriation. The facility census was 64. Findings include: Review of the medical record of Resident #01 revealed an admitted [DATE]. Diagnoses include Alzheimer's disease, dementia, moderate protein-calorie malnutrition, anxiety disorder, and supraventricular tachycardia. Review of the quarterly minimum data set assessment dated [DATE] revealed Resident #01 was severely cognitively impaired. The assessment further indicated Resident #01 was unable to respond to questions related to pain but did exhibit signs of pain to include non-verbal sound, verbal words (ouch, hurts), facial expressions, and protective body movements. Review of the Resident #01's physician orders reveaeld the resident had an order for Oxycodone (opiate) 5 milligrams (mg) one tablet by mouth two time a day for severe pain dated, dated 06/28/23. The doses were scheduled for 5:00 A.M. and 8:00 P.M. Oxycodone 5 mg give one by mouth every one hour as needed for pain, may give sublingual (SL) or by mouth (PO) dated 11/16/22 and discontinued on 11/04/24. Review of Resident #01's medication administration record (MAR) reveaeld the scheduled doses of Oxycodone were provided routinely and the resident did not usually take any as needed Oxycodone doses. The November 2024 MAR had four doses of the as needed Oxycodone documented as follows: 11/02/24 at 8:29 A.M. effectiveness unknown, 11/02/24 at 5:05 P.M. effective, 11/03/24 at 8:20 A.M. effectiveness unknown, and 11/03/24 at 3:47 P.M. effective. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Controlled Substance Record (CSR) for the Oxycodone five mg for Resident #01 revealed the medication was documented as removed from the medication cart at the following times which were not documented on the MAR or documented in the progress notes as provided to the resident on 11/02/24 at 9:45 A.M., 11:00 A.M., 12:00 P.M., 1:30 P.M., 2:30 P.M., 2:35 P.M., 3:30 P.M., and 5:30 P.M. The Oxycodone five mg was documented as removed from the medication cart at the following times which were not documented on the MAR as administered to the resident or documented in the progress notes as provided to the resident on 11/03/24 at 9:30 A.M., 11:00 A.M., 12:00 P.M., 1:30 P.M., 2:45 P.M., 4:45 P.M., and 5:30 P.M. This is 15 doses of the narcotic pain medication not documented as provided to the resident over these two days. Review of a facility self-reported incident dated 11/04/24, indicated during review of the Controlled Substance Record (CSR) it was discovered an agency nurse Registered Nurse (RN) #100 administered 19 doses of Oxycodone (opioid) five milligram (mg) on the CSR record for Resident #01 over two days. Only four of those 19 doses were recorded on the medication administration record (MAR) as provided to Resident #01. Resident #01 normally does not receive as needed doses of the medications. While reviewing cameras footage for a period of four hours, this nurse was not observed medicating Resident #01, despite the medication having been documented as having been administered. Attempts to contact RN #100 were unsuccessful as she failed to return any phone calls or calls from the staffing agency, who was her employer. Staff interviews revealed Resident #01 had no behaviors out of his ordinary over the time frame. Staff further stated they had not witnessed RN #100 medicate Resident #01. Staff interviewed further stated RN #100 would not be available at times during the three shifts, but none reported feeling she had been impaired. Review of the facility investigation revealed five like residents had been interviewed. None had any concerns with not receiving medications. The facility additionally interviewed two nurses and the two Certified Nursing Assistants (CNA) who had worked with RN #100, and all denied any knowledge of misappropriation. The [NAME] County Sheriff's office, the Ohio Board of Nursing, the facility pharmacy, and the staffing agency were all notified on 11/04/24 by the Administrator. Resident #01's physician was notified by the nurse who discovered the concern on 11/04/24. Review of Licensed Practical Nurse (LPN) #120's typed statement, dated 11/05/24, revealed on 11/02/24, while receiving report from RN #100, RN #100 appeared to be disorganized and unable to focus on anything for more than a few seconds. LPN #120 documented RN #100 kept reporting Resident #01 had been very combative with cares and stated Resident #01 had been hitting and kicking staff. After report the controlled substances were counted and RN #100 stated I hope I can stay awake long enough to drive home. When LPN #120 asked her why, she had stated she had been working a lot, in a defensive tone. LPN #120 reported she had told RN #100 to be careful and she would see her in the morning. LPN #120 reported RN #100 returned on 11/03/24 and during report kept trying to change the subject. LPN #120 reported she returned at 7:00 P.M. and once again RN #100 appeared very disorganized. When RN #100 reported on Resident #01 she stated she had contacted the provider as his medication was getting low and she had not wanted him to be without. RN #100 once again stated Resident #01 had been very combative with care during the day. After RN #100 left, LPN #120 asked the CNA if Resident #01 had been more combative throughout the day and she said, no more than normal. As LPN #120 was reviewing the documentation she noted Resident #01 had received the oxycodone every hour over the last two days. LPN #120 documented Resident #01 was alert and acting his normal behaviors. LPN #120 documented informing the Administrator and Director of Nursing of her concerns on 11/04/24. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the summary of investigation indicated the allegation of misappropriation by RN #100 towards Resident #01 was substantiated. Review of the Ohio Board of Nursing licensure verification revealed RN #100 held an active license as of 10/24/22. RN #100 was from a contracted staffing agency. Interview on 11/21/24 at 8:15 A.M. with the Administrator revealed RN #100 was never to return to the facility and no further incidents of misappropriation were discovered. The Administrator confirmed the facility conducted an investigation and substantiated that RN #100 misappropriated Resident #01's medications. Review of the policy titled Controlled Substance Administration & Accountability, undated, revealed the facility will have safeguards in place in order to prevent loss or diversion. The policy was followed in the events surrounding the misappropriation of Resident #01's narcotic medication by RN #100. As a result of the incident, the facility took the following actions to correct the deficient practice by 11/21/24: Immediate removal of RN #100 from the schedule on 11/04/24. All resident narcotic records and Narcotic medications were audited on 11/04/24 with no deficient practice noted. Five like residents were interviewed on 11/04/24 and had no concerns related to misappropriation. Three staff members were interviewed on 11/04/24 and one on 11/05/24 and were not aware of any misappropriation occurring while working with RN #100. All staff in the facility were in-serviced by the Administrator and the Director of Clinical Operations on the facility's abuse, neglect, and misappropriation policy by 11/21/24. RN #100 has been placed on a Do Not Return list on 11/04/24. All resident narcotic records continue to be audited weekly by the Director of Nursing and Unit Managers indefinitely. This deficiency represents non-compliance investigated under Complaint Number OH00159761.