

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Beeghly Oaks Center for Rehabilitation & Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 6505 Market Street Youngstown, OH 44512	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565</p> <p>Based on record review, staff interview, review of the State of Ohio Gateway system, and facility policy review, the facility failed to timely report possible misappropriation of narcotic medications to the appropriate state agency. This affected two residents (#83 and #106) of three residents reviewed for misappropriation of narcotic medications and had the potential to affect 33 additional residents (#1, #4, #7, #8, #13, #17 #18, #15, #21, #23, #24, #27, #33, #34, #36, #38, #39, #40, #45, #46, #48, #49, #50, #70, #72, #77, #79, #80, #88, #90, #93, #96, and #99) identified as being on narcotic medications. The facility census was 104.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #83 revealed an admitted [DATE]. Significant diagnoses included altered mental status, presence of left artificial knee joint, and arthritis of unspecified cite. Significant orders included tramadol 50 milligrams (mg) (opioid pain medication) one tablet every 12 hours as needed for pain.</p> <p>A review of the medication administration record (MAR) and the controlled drug disposition form for Resident #83 dated 09/01/24 through 09/30/24 revealed the following discrepancies:</p> <p>On 09/02/24 at 7:00 A.M. one 50 mg tramadol tablet was signed out on the controlled drug disposition form by Licensed Practical Nurse (LPN) #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/05/24 at 7:10 A.M. one 50 mg tramadol tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/08/24 at 7:00 A.M. three 50 mg tramadol tablets were signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/12/24 at 7:00 A.M. one 50 mg tramadol tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 9/16/24 at 7:00 A.M. one 50 mg tramadol tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 09/16/24 at 8:30 P.M. one 50 mg tramadol tablet was signed out on the controlled drug disposition form by LPN #323. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>2. A review of the medical record for Resident #106 revealed an admitted [DATE] with diagnoses including unspecified convulsions, cerebral infarction, and inflammatory disorder of the scrotum. Resident #106 had a physician's order for oxycodone 5 mg (opioid pain medication) give one tablet every six hours as needed for pain.</p> <p>A review of the MAR and the controlled drug disposition form for Resident #106 dated 09/01/24 through 09/30/24 revealed the following discrepancies:</p> <p>On 09/04/24 at 2:30 P.M. one 5 mg oxycodone tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/05/24 at 7:00 A.M. two 5 mg oxycodone tablets were signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/07/24 at 3:40 P.M. one 5 mg oxycodone tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/07/24 at 8:00 P.M. one 5 mg oxycodone tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/09/24 at 4:00 P.M. one 5 mg oxycodone tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/09/24 at 9:30 P.M. one 5 mg oxycodone tablet was signed out on the controlled drug disposition form by LPN #323. (LPN #323 stated it was her name but not her signature, and her name was misspelled). There was no documented evidence on the MAR that the tramadol was administered. A review of staff schedules revealed LPN #323 was not working on 09/09/24 at 9:30 P.M.</p> <p>On 09/10/24 at 8:00 A.M. one 5 mg oxycodone tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/11/24 at 8:00 A.M. one 5 mg oxycodone tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/12/24 at 8:00 A.M. one 5 mg oxycodone tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/17/24 at 9:00 A.M. one 5 mg oxycodone tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>Interview on 10/28/24 at 10:10 A.M. with LPN #323 revealed she told the Director of Nursing (DON) on 09/27/24 that LPN #420 forged her signature on the controlled drug disposition on 09/09/24 (this was the first she was aware of it, and her name was misspelled).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the State of Ohio Gateway for facility self-reported incidents (SRI) on 10/28/24 revealed the facility did not report the allegation of misappropriation of narcotics on 09/27/24 as required.</p> <p>On 10/30/24 at 4:10 P.M. an interview with the DON revealed an incident of a nurse (LPN #420) signing another nurse's name (LPN #323) on the controlled drug disposition form and discrepancies with the controlled drug disposition forms and the MARs was reported to her on the evening of 09/27/24. The DON verified the allegation of misappropriation of narcotic medication was not reported to the state agency as required.</p> <p>Review of the time sheet for LPN #420 revealed the last day she worked at the facility was 09/30/24.</p> <p>Review of the policy titled; Freedom of Abuse, Neglect, and Exploitation dated 10/2022 revealed a definition of misappropriation as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings. This included diversion of a resident's medication including controlled substances, for staff use or personal gain. The policy also stated immediate reporting of all alleged violations to the state agency and all other required agencies.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158476.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565</p> <p>Based on record review, interview and facility policy review, the facility failed to ensure accurate narcotic medication administration was recorded for two residents (#83 and #106) three residents reviewed for administration of narcotic medications and had the potential to affect 33 additional residents (#1, #4, #7, #8, #13, #17 #18, #15, #21, #23, #24, #27, #33, #34, #36, #38, #39, #40, #45, #46, #48, #49, #50, #70, #72, #77, #79, #80, #88, #90, #93, #96, and #99) identified as being on narcotic medications. The facility census was 104.</p> <p>Findings include:</p> <p>1. A review of the medical record for Resident #83 revealed an admitted [DATE] with diagnoses including altered mental status, presence of left artificial knee joint, and arthritis of unspecified cite. Resident #83 had a physician's order for tramadol 50 milligrams (mg) (opioid pain medication) one tablet every 12 hours as needed for pain.</p> <p>A review of the medication administration record (MAR) and the controlled drug disposition form for Resident #83 dated 09/01/24 through 09/30/24 revealed the following discrepancies:</p> <p>On 09/02/24 at 7:00 A.M. one 50 mg tramadol tablet was signed out on the controlled drug disposition form by Licensed Practical Nurse (LPN) #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/05/24 at 7:10 A.M. one 50 mg tramadol tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/08/24 at 7:00 A.M. three 50 mg tramadol tablets were signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/12/24 at 7:00 A.M. one 50 mg tramadol tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 9/16/24 at 7:00 A.M. one 50 mg tramadol tablet was signed out on the controlled drug disposition form by LPN #420. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>On 09/16/24 at 8:30 P.M. one 50 mg tramadol tablet was signed out on the controlled drug disposition form by LPN #323. There was no documented evidence on the MAR that the tramadol was administered.</p> <p>2. A review of the medical record for Resident #106 revealed an admitted [DATE] with diagnoses including unspecified convulsions, cerebral infarction, and inflammatory disorder of the scrotum. Resident #106 had a physician's order for oxycodone 5 mg (opioid pain medication) give one tablet every six hours as needed for pain.</p> <p>(continued on next page)</p>

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