

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4748 Olde Pump Street Walnut Creek, OH 44687	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record reviews, reviews of a facility investigation, review of self-reported incidents (SRIs), and review of a facility policy, the facility failed to ensure residents were free from misappropriation. This affected two (#4 and #47) of two residents reviewed for misappropriation. The facility census was 47.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #4 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure, and depression. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 was unable to be interviewed and was dependent on staff for activities of daily living (ADLs).</p> <p>Review of the physician's orders for December 2024 revealed Oxycodone (narcotic pain medication) 20 milligrams (mg) given every six hours routinely and a as needed (PRN) order for five mg of Oxycodone every two hours.</p> <p>Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses including cerebral palsy, major depressive disorder, and generalized anxiety disorder. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #47 had intact cognition and was dependent on staff for ADLs.</p> <p>Review of the physician's orders for December 2024 revealed Oxycodone five mg twice daily and a as needed (PRN) order for five mg of Oxycodone every four hours.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SRI dated 01/09/25 revealed Licensed Practical Nurse (LPN) #108 signed out as needed (PRN) Oxycodone immediate release (IR) five milligrams (mg) for Resident #4 on 12/31/24 at 7:20 P.M. and 9:50 P.M. and on 01/01/24 at 4:00 A.M. on one narcotic count card and on another narcotic card for Resident #4 revealed Oxycodone IR 20 mg signed out at 7:20 P.M. on 12/31/24 as well as 12:00 A.M. and 5:00 A.M. on 01/01/25 in the narcotic count book. Resident #4's medication administration records (MARs) for December 2024 and January 2025 did not reveal that the PRN five mg. Oxycodone IR was administered to Resident #4 by LPN #108. Further review of the MARs for 12/31/24 and 01/01/25 revealed that they were not signed off and that Oxycodone IR 20 mg was not due at the times when taken from cart. Resident #4 was unable to verify she received it. Resident #4's habit was to sleep through the night and normally does not get the Oxycodone IR five mg at night.</p> <p>Additionally, the SRI revealed LPN #108 signed out PRN Oxycodone IR five mg for Resident #47 out at 7:00 P.M. and 11:10 P.M. on 12/31/24 and 3:14 A.M. on 01/01/25 on a card in the narcotic count book. Resident #47's MARs for December 2024 and January 2025 did not reveal that the PRN five mg. Oxycodone IR was administered to Resident #47 by LPN #108. Resident #47 denied that she was woken up to receive PRN Oxycodone through the night. Resident #47 verified that she received her routine medication at 9:00 A.M. and 5:00 P.M. by LPN #109. Resident #47's habit was to sleep through the night and normally does not get Oxycodone five mg at night. The facility's investigation revealed after LPN #108 left for the day, LPN #102 looked closer at the narcotic sheets for Resident #4 and found discrepancies which prompted the investigation. The facility substantiated the SRI and reported LPN #108 to the Ohio Board of Nursing (OBN), Ohio Board of Pharmacy (OBP), and the Local Police Department (LPD).</p> <p>An interview on 03/12/25 at 1:00 P.M. with the Administrator stated she was in training when the incident occurred and verified LPN #108 misappropriated Residents #47 and #4's narcotic medications.</p> <p>Review of the facility policy titled Controlled Substance Administration and Accountability Policy, dated 04/08/23 revealed the facility will have safeguards in place to prevent loss, diversion or accidental exposure.</p> <p>The deficient practice was corrected on 01/23/25 when the facility implemented the following corrective actions:</p> <p>On 01/01/25 at 10:00 A.M. all residents on North Hall were assessed for pain and accuracy of narcotics and no further issues were noted by the Former Director of Nursing (FDON) #110.</p> <p>On 01/01/25 at 10:30 A.M. the Medical Director #112 was notified and it was discussed her next steps in notification.</p> <p>On 01/01/25 at 11:00 A.M., FDON #108 reported the incident to the agency that LPN #108 was employed and put on the do not return list.</p> <p>On 01/02/25 at 2:00 P.M., FDON #108 notified the OBN asking for additional guidance to ensure all appropriate entities were notified.</p> <p>On 01/02/25 at 3:10 P.M., FDON #108 reported the incident to the local police department. Report #25HC00022.</p> <p>(continued on next page)</p>		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/23/25, all nurses and medication technicians were in-service on controlled substance policy, and medication administration policy. This was an incidental finding during the course of the complaint investigation.		