Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366271	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Ridge Rehabilitation and Care Center	7055 High Mill Avenue NW Canal Fulton, OH 44614

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** 28701 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on facility self-reported incident review, medical record review, staff interview, policy review and facility investigation, the facility failed to ensure staff did not misappropriate resident narcotic medication. This affected one (Resident #44) of one residents reviewed for misappropriation of property. The facility census was 46 residents. Findings include: Review of the facility Self-Reported Incident (SRI) #245379 dated 03/18/24 revealed Resident #44's Percocet (a pain medication) tablets were reported missing. Further review of the SRI revealed Percocet tablets were reported missing when staff notified the pharmacy of the need for a refill and the pharmacy indicated there should be a two-week supply left. SRI investigation completed on 03/25/24 revealed the facility was unable to verify or determine if misappropriation of medication occurred. Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including Alzheimer's disease with dementia and radiculopathy of the lumbar region. Review of the physician's orders for Resident #44 revealed an order dated 12/11/23 for Percocet one tablet every six hours for pain. Review of the Medication Administration Record (MAR) for Resident #44 dated March 2024 revealed Percocet was signed off as given to the resident every six hours. (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	Interview on 07/31/24 at 11:00 A.M. with the Administrator, the Director of Nursing (DON), Assistant Director of Nursing (ADON) #79, Regional Nurse (RN) #81 and [NAME] President of Clinical (VP) #85 confirmed Licensed Practical Nurse (LPN) #88 had misappropriated Percocet from Resident #44. Further interview confirmed on 02/24/24 the pharmacy delivered 60 Percocet tablets for Resident #44 in two separate blistered medication packs. Staff indicated review of the controlled medication shift change log revealed on 03/11/24 LPN #88 removed and signed out two narcotic medications blister packs but did not complete the back of the form and indicate which narcotic medications blister packs were removed. Staff added that LPN #88 destroyed the sign out sheet therefore making the counts correct by eliminating the sign out sheets and recording the blister pack medication cards as removed. Staff indicated they had no proof medication was stolen due to the sign out sheets being destroyed, medication packs signed out LPN #88, but the pharmacy indicated they should have a two-week supply remaining based on amount sent and date medication delivered. Review of the controlled medication shift change log for the South unit revealed on 03/11/24 at 7:00 A.M. LPN #88 removed two medication count sheets and medication cards. Registered Nurse (RN) #91 co-signed as verifying and observing with LPN #88 as destroying/returning medication back to the pharmacy. The back side of the controlled medication shift change log did not indicate which medication cards and count sheets were removed as required. Review of the facility policy titled Medication Disposals and Returns dated 05/16/23 revealed staff should complete the controlled medication shift change log to indicate the disposition of any remaining doses. Two individuals (or as required by state regulations) should witness and document the destruction in the format required per applicable state regulations. Interview on 08/01/24 at 12:21 P.M. with the DON confirmed RN #91 signed the controlled medication shift change log for the South unit on 03/11/24 as the observer. Interview on 08/01/24 at 12:26 P.M. with RN #91 confirmed verified she had signed the controlled medication shift change log with LPN #88 as the verification and observer but did she did not observe LPN #88 discard the medications and return them to the pharmacy as per facility policy. Further review of the SRI including Abuse Neglect Misappropriation (ANM) investigation notes and reports revealed that LPN #44 was found with an outstanding warrant for stealing narcotics. Police questioned LPN #44 who then admitted to stealing 48 tablets of Percocet from Resident #44. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revision date of April 2021 indicated residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The deficient practice was corrected on 03/19/24 when the facility implemented the following corrective actions: -On 03/18/24 the Administrator initiated an SRI. -On 03/18/24 the DON interviewed Resident #44 and completed a pain assessment. -On 03/18/24 the DON and the ADON accounted for all narcotics in facility. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 03/18/24 the DON and the ADON obtained statements from all nursing staff. -On 03/18/24 the DON and the ADON educated the staff on the misappropriation policy -On 03/19/24 the Administrator and the DON notified the local police. -On 03/19/24 the DON and the ADON interviewed and completed pain assessments on all other residents who used narcotic medications. -On 03/19/24 the DON and ADON tested all nursing staff for drugs. LPN #88 tested positive for methadone and suboxone on 03/19/24. -On 03/19/24 the DON notified the Ohio Board of Nursing and the Ohio Board of Pharmacy of the incident. -On 03/19/24 the Human Resources Director reviewed background checks and board of nursing checks for nursing staff. -On 03/19/24 the facility held an emergency Quality Assurance Performance Improvement (QAPI) committee meeting with the Medical Director, the Administrator, the DON, the ADON, and all department heads. -On 03/25/24 the DON and the ADON initiated a narcotic audit which they completed twice weekly for 4 weeks until 04/22/24. -On 04/22/24 the QAPI committee reviewed the weekly narcotic audits.