STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366329	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Woods Nursing Center, Inc	1525 East Western Reserve Road Poland, OH 44514

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** Based on record reviews, self-reported incident (SRI) review, facility policy review and interview, the facility failed to prevent the tampering with and possible diversion of resident liquid morphine. This failure had the potential to affect three residents (#18, #32, and #36) who were receiving morphine at the time of the incident of three residents reviewed for abuse, neglect and misappropriation. The facility census was 60.Findings include:1. A review of medical records for Resident #18 revealed a date of admission of 08/16/21. Significant diagnoses included senile degeneration of the brain and end stage heart failure. The resident was admitted to hospice care with a diagnosis of congestive heart failure (CHF) on 05/19/21. Resident #18 had physician's orders for Acetaminophen 650 milligrams (analgesic) by mouth every four hours as needed for pain, Morphine sulfate 20 milligrams per milliliter (opioid pain medication), give 0.5 milliliters by mouth every four hours as needed for pain and give 0.5 milliliters my mouth every four hours as needed for air hunger.A quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15, indicating moderate cognitive impairment. Section J of the assessment revealed no scheduled or as needed pain medications had been administered in the previous seven day look back period.A care plan dated 03/19/26 revealed Resident #18 was at risk for increased pain. Interventions included pain medication per doctor's order. The care plan also revealed Resident #18 had a terminal diagnosis of end stage heart failure. Interventions included assessing pain and administering pain medication as ordered.Pain assessments that were completed daily on Resident #18 were reviewed from 02/01/26 through 04/06/28 and revealed scores of zero indicating no pain.A review of the medication administration record (MAR) from 02/01/26 through 04/06/26 revealed no morphine had been administered to Resident #18.2. A review of medical records for Resident #32 revealed a date of admission of 03/15/25. Significant diagnoses included cerebral infarction, dysphasia, and anxiety. The resident was admitted to hospice care on 04/01/2. Resident #32 had a physician's order for Morphine sulfate oral solution 20 milligrams per milliliter, give 0.25 milliliters by mouth every two hours as needed for shortness of breath or pain dated 12/05/25. A review of the quarterly MDS 3.0 assessment dated [DATE] revealed BIMS score of four out of 15, indicating severe cognitive impairment. Section J of the assessment revealed no scheduled pain medications or as needed pain medications were taken in the previous seven day look back. The assessment also indicated there was no pain present.A care plan dated 03/16/26 revealed Resident #32 had a terminal diagnosis of cerebral infarction. Interventions included assessing pain and administering pain medication as ordered.Pain assessments that were completed daily on Resident #32 were reviewed from 02/01/26 through 04/06/28 and revealed scores of zero indicating no pain.A review of the MAR from 02/01/26 through 04/06/26 revealed that one dose of morphine was administered to Resident #32 on 03/04/26 with good effect.3. A review of medical records for Resident #36 revealed the date of admission as 04/17/24. Significant diagnoses included arteriosclerosis of unspecified type of bypass graph of the extremities with gangrene, peripheral vascular disease, in chronic kidney disease (CKD) Stage IV. Resident #36 was admitted to hospice care on 12/12/25. Resident #36 had a physician's order for morphine sulfate oral solution 20 milligrams per milliliter, give 0.25 milliliters by mouth every two (continued on next page)

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	hours as needed for pain or shortness of breath. A quarterly MDS 3.0 assessment dated [DATE] revealed a BIMS score of five out of 15, indicating severe cognitive impairment. The assessment also revealed no routine pain medications were given in the previous seven day look back. Pain was present with the timing listed as rare or not at all.A care plan dated 08 01/08/26 revealed Resident #36 had increased pain risk related to a wound. Interventions included pain medication per doctor's order. The care plan further revealed that Resident #36 had a terminal diagnosis of atherosclerosis with gangrene of the foot. Interventions included assessing pain and administering pain medication as ordered.Pain assessments that were completed daily on Resident #36 were reviewed from 02/01/26 through 04/06/28 and revealed scores of zero indicating no pain.A review of the MAR from 02/01/26 through 04/06/26 revealed no morphine was administered.A review of SRI tracking number 271955 dated 03/11/26 revealed on 03/07/26 at 7:00 P.M. the label on a bottle of morphine appeared to have the appearance of being wet with a smeared medication label. The medication and packaging were dry even though the packaging label looked wet. The bottle was sealed, and the controlled count was correct. On 03/08/26 at 7:00 A.M., the bottle of morphine was the same, and the controlled count was correct. The bottle of morphine remained sealed. On 03/08/26 at 7:00 P.M., the bottle of morphine remained the same; however, there was two to three milliliters of missing morphine from the bottle. The oncoming nurse (Registered Nurse (RN) #500) and the off going nurse (RN #702) signed off that the count as correct. Neither reported the discrepancy. On 03/09/26 at 7:00 A.M., Licensed Practical Nurse (LPN) #202 was the oncoming nurse, and RN #500 was the off going nurse. During the controlled substance count both noted the medication in question was wet, the packaging was wet, the label was smeared, and there was a two to three milliliter discrepancy. The sheet read 15 milliliters and should be in the sealed bottle, and there are only 12 milliliters in the sealed bottle. Both nurses notified administration as soon as possible. Administration secured the bottle and called the pharmacy. The pharmacy stated they would be out to check the bottle for manufacturer malfunction. On 03/10/26 at 7:00 P.M. an unopened bottle of morphine was noted to be unopened and sealed. The bottle was wet. The bottle was noted to contain 12 milliliters of morphine solution and should have contained a full 15 milliliters. The Director of Nursing (DON) was notified and instructed the nurses to place the bottle in sealed bag and place it in the medication room under double lock. On 03/11/26, the pharmacist came out and noted both bottles of morphine had a single puncture hole on the bottom. On 03/16/26 at 7:00 A.M. off going nurse (RN #500) and on coming nurse (LPN #212) discovered a one milliliter discrepancy on a bottle of liquid morphine. LPN #212 notified administration of the discrepancy. The DON and Assistant Director of Nursing (ADON) #112 secured the bottle of morphine into a double locked area. The pharmacist came to the facility and verified the missing one milliliter of morphine. The police were called, and all bottles of morphine were surrendered to the local police department.A review of an undated document titled; Absolute Pharmacy, Facility Theft or Loss Documentation revealed the tampered morphine bottles belonged to Resident #18 and Resident #36.On 04/06/26 at 3:38 P.M. an interview with Police Detective (PD) #702 revealed the three bottles of morphine were taken as evidence. PD #702 stated the bottles were definitely tampered with. PD #702 further stated the incident was an ongoing investigation.A review of the facility policy titled; Abuse, Alleged and/or Actual, Neglect and Misappropriation with the revision date of June 2025 revealed no employee, resident, consultant, staff, volunteer, agency serving the resident, family member, legal guardian, friend or any other individual shall knowingly abuse, mistreat, or neglect any resident of the facility or misuse the residence funds or personal property. The policy further revealed the definition of misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a residence belongings or money without the residents' consent.This deficiency represents non-compliance investigated under Complaint Number 2805300.