STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366443	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belpre Landing Nursing and Rehabilitation	1915 Hill Street Belpre, OH 45714

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility investigations, observations, interviews, and policy review, the facility failed to ensure residents' controlled narcotic medications were not misappropriated. This affected two (#8 and #50) of three residents reviewed for misappropriation of medications. Findings include: 1. Review of Resident #8's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, dysphagia (difficulty swallowing), amputation of the left leg below the knee, and osteoarthritis. Review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and her cognition was moderately impaired. She was coded on the MDS assessment as having had pain in the past five days she rated as a 4 on a 1-10 scale. She received both scheduled and prn pain medication for her pain. The medication section of the MDS assessment (Section N) did not indicate that she had received opioid medications during the seven day assessment period (11/09/25- 11/15/25). Review of Resident #8's physician's orders revealed the resident had an order to receive Morphine Sulfate 20 milligrams (mg)/ milliliter (ml) with directions to give 0.25 ml by mouth (po) every four hours as needed (prn) for pain or shortness of breath. The order originated on 05/19/25, after she was placed under the care and services of hospice on 05/16/25. Review of Resident #8's medication administration records (MAR's) from May 2025 through November 2025 revealed the resident's prn order to receive Morphine Sulfate was included on the MAR's each month during that seven month period. There was no documented evidence of any prn doses of Morphine Sulfate having been administered to the resident for any complaints of pain or shortness of breath, since the order originated on 05/19/25. Review of Resident #8's Controlled Drug Receipt/ Record/ Disposition Form for her Morphine Sulfate revealed 30 ml of the liquid Morphine was filled by the facility's contracted pharmacy on 05/28/25. The form was blank and did not show any doses of the Morphine Sulfate had been used for the resident, since it was filled by the pharmacy. Review of a facility investigation file pertaining to Resident #8's liquid Morphine Sulfate revealed the facility obtained personal witness statements and/ or conducted phone interviews with facility nurses regarding the resident's Morphine Sulfate. A hand written statement from Licensed Practical Nurse (LPN) #115 dated 11/14/25 revealed she was doing the controlled narcotic drawer count when she noted a discrepancy with a Morphine Sulfate bottle for Resident #8. The contents of the bottle was below the 30 ml (approximately 27-28 ml's) that it should have been. She asked two other nurses (LPN #166 and LPN #350) when they started giving Resident #8 Morphine Sulfate and both denied knowledge of the resident ever receiving it. The resident just had the bottle on hand in case she needed it. She then informed the two nurses the bottle was low and some of the medication had been removed. The bottle appeared to be sealed, but when turned upside down, a drop of the liquid Morphine formed at the top of the bottle on the seal. She then noticed a very small hole in the seal. The plunger top and syringe for the liquid Morphine Sulfate bottle were still in the plastic packaging and had not been used. She checked another resident's liquid Morphine Sulfate bottle (Resident #50) and noted it too had a puncture hole in the seal at the top of the bottle, just like Resident #8's did. It appeared that the other resident's bottle contained the full amount of the 30 ml that it should have had in it. She called the unit manager (LPN #260) about her findings, who in turn instructed her to call the DON immediately. The unit manager also informed her that they would probably need statements from everyone. The previous shift's nurses had already left the facility. She called the DON, as instructed, at 6:26 A.M. and left him a voicemail. When the unit manager came in, she showed the two bottles to the unit manager and informed her that she had already called the DON. On 11/19/25 at 1:25 P.M., an interview with the DON revealed he had been made aware of the discrepancy with Resident #8's Morphine Sulfate on 11/14/25 (Friday). He reported an oncoming day shift nurse (LPN #115) had placed Resident #8's bottle of Morphine Sulfate on top of the medication cart, when doing a controlled medication reconciliation with the off-going night shift nurse (LPN #166), and noted that the Morphine Sulfate bottle had about 3.5 ml less than it should have had. It was not documented on her Controlled Drug Receipt/ Record/ Disposition form, as having been used, since it had been filled by the pharmacy on 05/28/25. There was not a discrepancy noted during the previous controlled medication reconciliation count that was completed at shift change between the off-going day shift nurse (LPN #300) and the oncoming night shift nurse (LPN #166) on 11/13/25 (the shift change before the discrepancy was noted). He confirmed LPN #115 notified him of the discrepancy on the morning of 11/14/25. Once he had been made aware, he reached out to his clinical legal team and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility investigations, observations, interviews, and policy review, the facility failed to ensure all allegations/ suspicions of misappropriation of resident property was reported to the State Survey Agency as required. This affected two (#8 and #50) of three residents reviewed for misappropriation of medications. Findings include: 1. Review of Resident #8's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, dysphagia (difficulty swallowing), amputation of the left leg below the knee, and osteoarthritis. Review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and her cognition was moderately impaired. She was coded on the MDS assessment as having had pain in the past five days she rated as a 4 on a 1-10 scale. She received both scheduled and prn pain medication for her pain. The medication section of the MDS assessment (Section N.) did not indicate that she had received opioid medications during the seven day assessment period (11/09/25- 11/15/25). Review of Resident #8's physician's orders revealed the resident had an order to receive Morphine Sulfate 20 milligrams (mg)/ milliliter (ml) with directions to give 0.25 ml by mouth (po) every four hours as needed (prn) for pain or shortness of breath. The order originated on 05/19/25, after she was placed under the care and services of hospice on 05/16/25. Review of Resident #8's medication administration records (MAR's) from May 2025 through November 2025 revealed the resident's prn order to receive Morphine Sulfate was included on the MAR's each month during that seven month period. There was no documented evidence of any prn doses of Morphine Sulfate having been administered to the resident for any complaints of pain or shortness of breath, since the order originated on 05/19/25. Review of Resident #8's Controlled Drug Receipt/ Record/ Disposition Form for her Morphine Sulfate revealed 30 ml of the liquid Morphine was filled by the facility's contracted pharmacy on 05/28/25. The form was blank and did not show any doses of the Morphine Sulfate had been used for the resident, since it was filled by the pharmacy. Review of a facility investigation file pertaining to Resident #8's liquid Morphine Sulfate revealed the facility obtained personal witness statements and/ or conducted phone interviews with facility nurses regarding the resident's Morphine Sulfate. A hand written statement from Licensed Practical Nurse (LPN) #115 dated 11/14/25 revealed she was doing the controlled narcotic drawer count when she noted a discrepancy with a Morphine Sulfate bottle for Resident #8. The contents of the bottle was below the 30 ml (approximately 27-28 ml's) that it should have been. She asked two other nurses (LPN #166 and LPN #350) when they started giving Resident #8 Morphine Sulfate and both denied knowledge of the resident ever receiving it. The resident just had the bottle on hand in case she needed it. She then informed the two nurses the bottle was low and some of the medication had been removed. The bottle appeared to be sealed, but when turned upside down, a drop of the liquid Morphine formed at the top of the bottle on the seal. She then noticed a very small hole in the seal. The plunger top and syringe for the liquid Morphine Sulfate bottle were still in the plastic packaging and had not been used. She checked another resident's liquid Morphine Sulfate bottle (Resident #50) and noted it too had a puncture hole in the seal at the top of the bottle, just like Resident #8's did. It appeared that the other resident's bottle contained the full amount of the 30 ml that it should have had in it. She called the unit manager (LPN #260) about her findings, who in turn instructed her to call the Director of Nursing (DON) immediately. The unit manager also informed her that they would probably need statements from everyone. The previous shift's nurses had already left the facility. She called the DON, as instructed, at 6:26 A.M. and left him a voicemail. When the unit manager came in, she showed the two bottles to the unit manager and informed her that she had already called the DON. On 11/19/25 at 1:25 P.M., an interview with the DON revealed he had been made aware of the discrepancy with Resident #8's Morphine Sulfate on 11/14/25 (Friday). He reported an oncoming day shift nurse (LPN #115) had placed Resident #8's bottle of Morphine Sulfate on top of the medication cart, when doing a controlled medication reconciliation with the off-going night shift nurse (LPN #166), and noted that the Morphine Sulfate bottle had about 3.5 ml less than it should have had. It was not documented on her Controlled Drug Receipt/ Record/ Disposition form, as having been used, since it had been filled by the pharmacy on 05/28/25. There was not a discrepancy noted during the previous controlled medication reconciliation count that was completed at shift change between the off-going day shift nurse (LPN #300) and the oncoming night shift nurse (LPN #166) on 11/13/25 (the shift change before the discrepancy was noted). He confirmed LPN #115 notified him of the discrepancy on the morning of 11/14/25

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of a facility investigation pertaining to an alleged/ suspected tampering of controlled narcotic medications, review of shift to shift controlled medication reconciliation sheets, staff interviews, and policy review, the facility failed to ensure proper pharmacy procedures were followed in regards to performing an appropriate reconciliation of all controlled medications each time keys to medication administration carts providing access to those controlled medications were exchanged between nurses. This affected two (#8 and #50) of three residents reviewed for the handling of controlled narcotic medications. Findings include: Review of a facility investigation file pertaining to the suspected tampering of Resident #8 and Resident #50's liquid Morphine Sulfate revealed an allegation of potential tampering of the controlled medication was reported to the facility's Director of Nursing (DON) on 11/14/25. As part of the facility's investigation, personal witness statements and/ or phone interviews were conducted with the facility's nurses regarding Resident #8's Morphine Sulfate. Review of a hand written statement provided by Licensed Practical Nurse (LPN) #115 on 11/14/25 revealed she was doing the controlled narcotic drawer count when she noted Resident #8's Morphine Sulfate bottle to be below 30 milliliters (ml), with approximately 27-28 ml present. She asked two other nurses (LPN #166 and LPN #350) when they started giving Resident #8 Morphine Sulfate and both denied knowledge of the resident ever receiving it. The resident just had the bottle on hand in case she needed it. She then informed the two nurses the bottle was low and some of the medication had been removed. The bottle appeared to be sealed, but when turned upside down, a drop of the liquid Morphine formed at the top of the bottle on the seal. She then noticed a very small hole in the seal. The plunger top and syringe for the liquid Morphine Sulfate bottle were still in the plastic packaging and had not been used. She checked another resident's liquid Morphine Sulfate bottle (Resident #50) and noted it too had a puncture hole in the seal at the top of the bottle just like Resident #8's did. It appeared that the other resident's bottle contained the full amount of the 30 ml that it should have had in it. She called the unit manager (LPN #260) to report her findings, who in turn instructed her to call the DON immediately. The unit manager also informed her that they would probably need statements from everyone. The previous shift's nurses had already left the facility. She called the DON, as instructed, at 6:26 A.M. and left him a voicemail. When the unit manager came in, she showed the two bottles to the unit manager and informed her that she had already called the DON. Review of a personal witness statement from LPN #100 (not dated) revealed he verified count with LPN #185 on Thursday 11/13/25 at 6:00 P.M. (the conclusion of his shift) with no discrepancies noted. He denied that he visualized Resident #8's Morphine Sulfate bottle personally when he completed the reconciliation count of the controlled medication for the 400 hall, where Resident #8 resided. Review of a typed statement provided by LPN #185 dated 11/14/25 at 5:00 P.M. revealed she did count the 400 hall medication administration cart with LPN #100. She denied that she took the bottle of Morphine Sulfate out of Resident #8's box, as she indicated it had never been used by the resident according to the controlled medication disposition sheet. She then stated she took the keys from LPN #100 and sat them down at the computer to get caught up on her residents. LPN #210 came in before 7:00 P.M. and she handed LPN #210 the keys and LPN #210 then started the medication pass on the 400 hall. She denied that she recounted the controlled medications in the medication administration cart with LPN #210, as she had just counted them with LPN #100 and was never in the cart following that. Review of a personal witness statement from LPN #210 (not dated) for an incident date of 11/13/25 revealed she arrived to the facility per request to assist with the 400 hall medication pass. LPN #100 grabbed the keys off the nurses' station desk and handed them to her. She then took the keys from LPN #100, who informed her that he and LPN #185 had already counted the narcotic drawer prior to her arrival. LPN #210 then proceeded to chart and begin the 400 hall medication pass. After she completed the 400 hall medication pass, she then handed the keys to LPN #166 (night shift nurse), who was standing at the 100 hall medication administration cart. Review of a typed phone interview with LPN #166 on 11/14/25 at 4:40 P.M. (not indicating who completed the interview) revealed LPN #185 counted the 400 hall medication administration cart with LPN #100, prior to LPN #185 taking the medication administration cart keys from LPN #100. She denied she knew what had happened between LPN #210 and LPN #185, when LPN #210 arrived. She claimed she was standing at the 100 hall medication administration cart talking with another staff member, when LPN #210 walked up and dropped the keys on the medication administration cart and saying I'm done, and everything was fine. LPN #210 then walked away, got her stuff, and left. LPN #166 reported, after she was done talking with the other employee