STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365494	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapel Hill Community	12200 Strausser St 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 a facility self-reported incident (SRI) review, medical record review, policy review and staff interview the facility failed to ensure resident narcotic medication was not misappropriated by a staff member. This affected two (Resident #23 and #73) of two residents reviewed for misappropriation of resident property. The facility census was 72. Findings include: Review of Resident #73's closed medical record revealed an admitted [DATE] with diagnoses that included spinal stenosis, dorsalgia, chronic obstructive pulmonary disease and congestive heart failure. The resident was prescribed the use of oxycodone 5 mg every eight hours as needed for pain relief. Review of Resident #23's medical record revealed an admitted [DATE] with diagnoses that included end stage renal disease with hemodialysis and congestive heart failure. The resident was prescribed the use of primidone 50 mg three times daily for tremors. Review of the facility SRI #245842 revealed on 03/31/24 Registered Nurse (RN) #119 removed Resident #73's oxycodone (narcotic opioid analgesic) medication blister card from the medication cart after the resident had discharged home. Upon inspection of the medication blister card, she observed possible tampering of the medication card and medication. The facility administrator was notified immediately, who notified the facility pharmacist. The medication blister card was locked in the RN #119's secured lock box in her office for pharmacist review. On 04/01/24 the pharmacist verified that six oxycodone five milligram (mg) pills for Resident #73 were replaced with primidone (for control of tremors) 50 mg pills from Resident #23. Local police, the State Survey Agency, Pharmacy Board and Board of Nursing were notified at this time. Facility investigation identified Licensed Practical Nurse (LPN) #121 as staff member responsible for diversion of the narcotic medications (the LPN had been documenting an increase in resident narcotic use). LPN #121 was terminated. Review of RN #119 witness statement dated 03/31/24 verified discovery of diversion of six oxycodone 5 mg tablets for Resident #73 with six primidone 50 mg tablets from Resident #23. Review of the pharmacist statement dated 04/01/24 verified diversion of six oxycodone 5 mg tablets for Resident #73 with six primidone 50 mg tablets from Resident #23. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365494	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapel Hill Community	12200 Strausser St NW Canal Fulton, OH 44614

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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	On 05/21/24 at 2:25 P.M. interview with the Director of Nursing verified six oxycodone 5 mg tablets for Resident #73 were misappropriated by LPN #121 and replaced with six primidone 50 mg tablets from Resident #23 as indicated in the SRI. On 05/21/24 at 2:50 P.M. interview with RN #119 verified she identified a tampered medication blister card for Resident #73's oxycodone and reported the concern to the administrator immediately. Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property with a revision date of 10/20/22 indicated residents have the right to be free from abuse, neglect, exploitation and misappropriation of resident property. As a result of the incident, the facility took the following actions to correct the deficient practice on 04/01/24: On 03/31/24 when the discrepancy of the narcotic medication card was identified, the incident was reviewed, the residents were interviewed to make sure their pain was managed by the DON and ADON. LPN #121 was removed from the schedule and subsequently terminated. LPN #121 was determined, through facility investigation, to have misappropriated the residents' medications. Nursing staff were re-educated by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 03/31/24 on the following procedures: narcotic counting, pain assessment and pain interventions. Facility wide audit of narcotic books and narcotic counting by DON and ADON on 03/31/24. Facility wide education for resident abuse including misappropriation of resident property by Administrator on 03/31/24. The pharmacist observed the medication blister card and determined six oxycodone were removed and replaced with six primidone on 04/01/24. The Board of Pharmacy was notified, the Board of Nursing was notified, the State Survey Agency was notified, a police report was made, nurses on that medication cart were sent to be drug tested on [DATE]. Starting on 03/31/24 monitoring and audits of all narcotic books will be conducted at a minimum of three to five times per week and a minimum of three to five staff members will be interviewed and observed on narcotic counting, pain interventions and pain assessment procedures and interventions for pain management by the DON and ADON. Results will be reviewed at Quality Assurance and Performance Improvement meetings for further intervention.