

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview and review of facility policy the facility failed to dispose of expired medications and/or unlabeled medications. The had the potential to affect all 76 residents residing in the facility. Findings include: Observation on 07/30/25 at 7:49 A.M. of the second floor medication storage room revealed the following expired medications: Two Incruse Ellipta inhalers 6.25 micrograms (mcg) in a sealed foil package, removed from box with expiration dates of 10/24 and 02/25. No label attached. Lovenox 100 milligrams/milliliter (mg/ml) injection with an expiration date of 05/25. No label attached Cipro 400 mg 2 mg/ml intravenous (IV) kit with a dispensed date of 03/14/19 and a discard after 04/18/25 date. Acetylcysteine 20% 200 mg/ml 23 vials with an expiration date of 5/2025. Interview on 07/30/25 at 7:55 A.M. with Registered Nurse (RN) #246 verified the medications were expired and stored in the medication room. Review of facility policy titled Medication Storage revealed unused medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs policy.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, review of dishwasher temperature log, review of manufacture guidelines, and policy review the facility failed to ensure the dishwasher and three compartment sink were in proper working order to prevent the potential spread of food borne pathogens. This had the potential to affect all 76 residents residing in the facility. Findings include: Observation on 07/30/25 at 9:34 A.M., of the three compartment sink with Dietary Manger #199 and [NAME] #216 revealed the sink was leaking and water was noted running down the hoses and faucet into the second compartment of the sink (rinse water). There was sediment observed in the water. The Dietary Manger #199 confirmed the sink was used for items that could not be ran through the dishwasher. [NAME] #216 was washing the blender in the sink, preparing for the next pureed food item. The Dietary Manger confirmed findings during observation. Observation on 07/30/25 at 10:14 A.M., of the dishwasher with Dietary Manger #199 revealed the label indicated the dishwasher was a hot temperature dishwasher. The Dietary Manger confirmed the dishwasher was high temperature and the label indicated the wash cycle was 155-160 degrees Fahrenheit and rinse was 180-195 degrees Fahrenheit to disinfect the dishes. The first observation the wash was 110 degrees Fahrenheit and rinse was 186 degrees Fahrenheit. The second and third observation revealed the same temperatures. Review of the daily dishwasher temperature logs dated 07/27/25 to 07/30/25 with the Dietary Manger #199 revealed on 07/27/25 the dishwasher temperature in the A.M. was 183 degrees Fahrenheit for the wash and 132 Fahrenheit for the rinse and P.M. was 178 Fahrenheit Fahrenheit for the wash and 160 Fahrenheit for the rinse. On 07/28/25 the A.M. wash was 132 Fahrenheit, and rinse was 170 Fahrenheit and the P.M. wash was 173 Fahrenheit, and the rinse was 181 Fahrenheit. On 07/29/25 the A.M. wash was 180 Fahrenheit, and the rinse was 130 Fahrenheit and the P.M. the wash was 170 Fahrenheit and the rinse 184 Fahrenheit. On 07/30/25 the A.M. wash 130 Fahrenheit and the rinse was 170 Fahrenheit. The Dietary Manger confirmed findings during the review of the log. Interview on 07/30/25 at 10:14 A.M. and 10:39 A.M., with the Dietary Manger #199 confirmed the wash should be 155-160 degrees F and the rinse should be 180-195. The Dietary Manger confirmed she was not aware the dishwasher temperatures were not meeting recommendations. There had been issues with the water pressure and last night the Maintenance Director had cleaned the filters in the dishwasher and three compartment sinks. The Dietary Manger confirmed staff had been using regular dining ware, however she would have staff use disposable dining ware until the sink and dishwasher were fixed. Interview and observation on 07/30/25 at 10:24 A.M., with Maintenance Director (MD) confirmed she had cleaned the filters in the three compartments sink last night due to there being no water pressure. The MD confirmed the sink was leaking and there was sediment in the rinse water. The MD confirmed she was not aware the dishwasher temperatures were not meeting the recommended temperatures. Review of the facility's policy and procedures manual titled Dishwashing undated revealed the dish machine temperatures are logged at each of meal on the dish machine temperature log. Minimum temperatures, as required by the manufacturer are wash 150-160 F and rinse 180-195. Staff should check the dish machine gauges throughout the cycle to assure properly temperatures for sanitation. A three-compartment sink is set up with wash, rinse, and sanitizing. Employees are trained in proper manual dishwashing procedures. Review of the owner ' s manual for the dishwasher the wash temperature must be 155 minimum. The rinse temp must be 180 minimum. NOTE: Rinse water temperature must be observed during the rinse cycle.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and policy review the facility failed to ensure infection control practices were maintained during wound care, dining, incontinence care, and medication administration. This had the potential to affect all 78 resident residing in the facility. Based on medical record review, observation, interview, and policy review the facility failed to ensure infection control practices were maintained during wound care, dining service, incontinence care, and medication administration. This affected Resident #3, #4, #9, #40, #43, #51 and #63 but had the potential to affect all 76 residents residing in the facility. Findings include: 1. Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of peripheral vascular disease, above left knee amputation, heart failure, chronic obstructive pulmonary disease, chronic kidney disease, non-pressure ulcers, neuromuscular dysfunctional bladder, diabetes, legally blind, and chronic pain. Review of Resident #4's orders dated 07/2025 revealed enhanced barrier precautions with high contact resident care activity. Review of Resident #4's wound care orders dated 07/2025 revealed cleanse right lateral foot with normal saline, pat dry, apply medihoney, collagen and calcium alginate, and cover with abdominal pad, and wrap with kerlix Tuesday, Thursday, and Saturday. The right posterior ankle order included to cleanse with normal saline, apply skin prep, cover with abdominal pad and wrap with kerlix Tuesday, Thursday, and Saturday. An. observation and interview on 07/29/25 at 10:00 A.M., revealed Licensed Practical Nurse (LPN) #122 and Wound Nurse Practitioner (WNP) #250 were observed in Resident #4's room without gowns applied while performing wound care and assessing Resident #4's wound on her right foot. LPN #122 removed the old dressing from Resident #4's right foot without evidence of a gown on. The LPN confirmed the old dressing had a scant amount of brown drainage. The WNP measured the resident's wound without a gown and reported the resident had two open areas on her right foot. The outer foot wound measured 3.2 centimeters (cm) by 0.9 cm by 0.2 cm and was treated with medihoney and alginate and the ankle was 1.1 cm by 0.2 and depth was undetermined and treated with skin prep. LPN #122 confirmed Resident #4 was on enhanced barrier precautions (EBP) because the resident had a catheter. The LPN was not aware she was required to wear a gown during wound care. The LPN confirmed the sign on the resident door indicated the resident was on EBP and provider and staff were required to wear gloves and gowns with high contract resident care activities including wound care (any skin opening requiring a dressing). There was no evidence of gowns in the cart outside the door. LPN #122 looked for gowns on the unit and could not find gowns and reported she would have to leave the unit to try to find gowns. Further observation of the room revealed there were clothing and blankets piled on the two isolation trash bins inside the resident's room and the bins were not located near the exit door. Interview on 07/29/25 at 10:12 A.M., with the Director of Nursing (DON) confirmed Resident #4 was on EBP for wounds and urinary foley catheter. The DON confirmed staff were required to wear gowns and gloves when providing wound care. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on 07/29/25 at 11:23 A.M., with Infection Preventionist (IP) #115 of Resident #4's room revealed there were no gowns in the protective personal equipment (PPE) cart outside the room and the isolation trash bins in the resident rooms were not located near the exit door and the bins were covered with clean clothing and blankets. The IP removed the clothing items and opened the bins, and the used PPE was in bins without a biohazard bag in-place. The IP confirmed there were no gowns readily available, the isolation trash bins were not located near the exit door, the isolation trash bins should not be covered with clothing and blankets and the bins should have red biohazard bags inside to contain the used PPE. The IP confirmed the WNP and LPN #122 should have been wearing gowns during wound care. Review of Enhanced Barrier Precautions policy and procedure dated 2025 revealed it was the facility policy to implement enhanced barrier precautions (EBP) for the prevention of transmission of multi-drug-resistant organisms (MDRO). EBP refers to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident activities. An order for EBP will be obtained for resident with any of the following: Wounds and/or indwelling medical device even if the resident was not known to be infected or colonized with a MDRO. Implementation of EBP include ensuring gowns and gloves are available immediately near or outside the resident 's room. Personal protective equipment is only necessary when performing high-contact care activities and may not need to be done prior to entering the resident 's room. Position the trash cans inside the resident 's room and near the exit for discarding PPE after removal, prior to exiting the room. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. Provide education to residents and visitors. High-contacts residents ' care activities include wound care (any skin opening requiring a dressing). 2. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE]. Diagnoses included dementia, anxiety disorder, hypertension, glaucoma, major depressive disorder, delusional disorders and bipolar disorder. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #40 had severely impaired cognition and was always incontinent of bladder and bowel. Observation of incontinence care for Resident #40 on 07/30/25 at 2:40 P.M. revealed Certified Nursing Assistant (CNA) #105 went into the adjoining bathroom and placed the clean washcloths directly into the sink to get them wet. CNA #105 then proceeded to apply liquid soap on to them, while they were lying in the sink. She took the washcloths out of the sink and began to provide perineal care to Resident #40 with the washcloths she had lying in the sink. An interview on 07/30/25 at 2:55 P.M. with CNA #105 verified she had not sanitized or cleaned the sink prior to placing the clean washcloths for perineal care for Resident #40 directly into the sink. She stated she did not have a basin to place them in. Review of the undated facility policy titled, Perineal Care, revealed it was the practice of the facility to provide perineal care to all incontinent resident during routine bath and as needed in order to promote cleanliness and comfort, prevent infections to the extent possible and to prevent and assess for skin breakdown. Step two indicated for the basin method to gather a basin and fill it no more than (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	three-fourth the way up with warm water and the second method was the disposable cleaning cloth method, which the CNA did not use. 3. Observation on 07/28/25 at 12:35 P.M. revealed Certified Nursing Assistant (CNA) #141 went into the room of Resident #3 to deliver the lunch meal tray. She moved the over-the-bed table in front of the resident after placing the meal tray on to the over-the-bed table. She proceeded to go out into the hallway to the meal cart and get another meal tray off the meal cart for Resident #28 without washing her hands. She placed the meal tray on the over-the-bed table and then picked up his dinner roll with her bare hands and broke it in half and was going to butter it. The surveyor intervened. CNA #141 then went to get another roll off the meal cart and took it back into Resident #28 and butter it without touching it. She placed his over-the-bed table in front of him, went out of the room, retrieved another tray off the meal cart and took it the room of Resident #9 without washing her hands. An interview on 07/28/25 at 12:45 P.M. with CNA #141 verified she had not washed her hands while passing meals trays and touching resident items. 4. Review of medical record for Resident #43 revealed an admission date of 07/26/25 with diagnosis including methicillin resistant staphylococcus aureus infection, type II diabetes, anxiety disorder and hypertension. Observation on 07/28/25 at 8:30 A.M. of Resident #43's room revealed an isolation cart outside of room near the doorway. Upon entering the room, two red isolation bins were observed inside the room near the door. Interview on 07/28/25 at 8:30 A.M. with LPN#209 verified Resident #43 was on contact isolation and no signage was placed at the doorway. Review of facility policy titled Transmission-Based (Isolation) Precautions revealed Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside of the residents room, wing, or facility-wide. Additionally, either the CDC category of transmission-based precautions (e.g. contact, droplet, or airborne) or instructions to see the nurse before entering will be included in the signage. 5. Medication administration observation was made on 07/29/25 at 8:29 A.M. with RN #246. RN #246 was observed to prepare Resident #51's medications, entered Resident #51's room, administered oral medications and applied gloves. RN #246 then applied a lidocaine topical patch to Resident #51's back. Upon leaving the room, RN #246 removed her gloves and went to the medication cart, signed off the administered medications and prepared oral medications for Resident #63 without performing hand hygiene. RN #246 entered Resident #63's room, administered oral medications, applied new gloves, administered insulin, and applied a lidocaine topical patch to Resident #63's back. Upon leaving the room, RN #246 removed her gloves and went to the medication cart to sign off medications. She did not perform hand hygiene. Interview on 07/29/25 at 8:35 A.M. with RN #246 verified she did not perform hand hygiene between the medication administrations with Resident #51 and resident #63. Review of facility policy titled Medication Administration revealed wash hands using facility protocol and product before and after medication administration with each Resident. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility policy titled, Hand Hygiene, revealed the staff would perform hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews, review of information located on Medscape.com, and policy review the facility failed to ensure a resident had an appropriate justification for the use of an antipsychotic medication and also failed to ensure residents had stop dates for antianxiety medications. This affected four (Resident #2, #8, #5 and #35) out of five reviewed for unnecessary medication review. Findings include: 1. Medical record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including dementia, anxiety, and depression. Review of Resident #2 's medication administration records (MAR) and orders dated 04/25/25 to 07/22/25 revealed Resident #2 was administered Seroquel (antipsychotic)12.5 milligrams (mg) at bedtime for dementia. Further review of Resident #2's MAR and orders dated 04/24/25 to 07/22/25 revealed no documented evidence the resident was ordered or administered any other medication to treat anxiety, depression, or dementia. Review of Resident #2 ' s psych note dated 05/29/25 revealed the resident was stable with no behaviors noted. The plan was to continue Seroquel 12.5 mg at night for dementia. There was no documented evidence why Seroquel was determined appropriate to treat the resident ' s dementia. Review of Resident #2 ' s pharmacy reviews dated 05/25/25 and 06/22/25 no evidence any irregularities were noted with the Seroquel. Review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was receiving an antipsychotic daily and no gradual reduction was attempted. Review of Medscape information (current) revealed the indication for use was schizophrenia, bipolar, major depression, and off-label use for alcohol dependence and insomnia. There was no evidence Seroquel was indicated to use for dementia. Interview on 07/31/25 at 11:32 A.M., with the Director of Nursing (DON) confirmed the resident returned from a short hospital stay (04/15/25-04/25/25) with an order for Seroquel 12.5 mg. The facility continued the order for Seroquel from 04/25/25 to 07/22/25 for dementia, which the DON confirmed dementia was not an appropriate indication of use for Seroquel. The DON reported psych had discontinued the Seroquel on 07/22/25 due to the resident was not having any behaviors. Review of the facility ' s policy and procedure titled Use of Psychotropic Medication dated 2025 revealed the policy ensures that residents only receive psychotropic medications when other non-pharmacological medication are clinically contraindicated. Additionally, these medication should only be used to treat the resident medical symptoms and not used for the discipline or staff convenience, which would deem a chemical restraint. Adequate for indication for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident ' s condition and therapeutic goals and after any other treatments have been deemed clinically contraindicated. For psychotropic medication, without documentation in the record explaining that the practitioner had determined that other (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatments have been deemed clinically contraindicated the indication of use was inadequate. Also, adequate indication for use means that the medication administered is consistent with manufacture ' s recommendation and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review of articles that are published in medical and/or pharmacy journals. The resident medical record shall include evaluation and the rationale for chosen treatment options. This includes any indicated documentation of rationale for prescribing psychotropic medication or switching from one type of psychotropic medication, specifically an antipsychotic medication, to another category of psychotropic medication. 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE]. Diagnoses intercranial injury, vascular dementia, pseudobulbar affect, traumatic brain injury, major depression disorder, hypertension, mood disorder, hypothyroidism, right ankle contractures, frontotemporal neurocognitive disorder, generalized anxiety disorder, impulse disorders, hemiplegia and cerebral infarctions affecting the right side. Review of the physician's orders revealed Resident #8 had an order for Ativan 0.5 milligrams (anti-anxiety medication) two times daily for restlessness/anxiety and 0.5 milligrams every 12 hours as needed for restlessness dated 01/20/21. Further review revealed no documentation of a stop dated for the as needed Ativan for Resident #8. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #8 had severely impaired cognition and received an antipsychotic and an antianxiety. An interview on 07/29/25 at 2:00 P.M. with the Director of Nursing (DON) revealed all as needed psychotropic were only used for 14 days after being ordered for 14 more days then the order was written to continue. She confirmed there was no stop dated for the as needed Ativan. 3. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE]. Diagnoses included subarachnoid hemorrhage, dementia, protein calorie malnutrition, falls, osteoporosis, neoplasm of the right breast, anxiety disorder, hypertension, head contusion, depression, reduced mobility and weakness. Review of the physician's orders revealed Resident #35 had an order for Ativan 0.5 milligrams (anti-anxiety medication) every four hours as needed for anxiety dated 04/14/25. Further review of the medical record revealed no documentation of a stop dated for the as needed Ativan for Resident #35. Review of the psychiatric progress note dated 06/05/25 revealed the plan was to continue with current psychotropic medication; give Ativan 0.5 milligrams when getting ready for bed and Ativan 0.5 milligrams every four hours as needed for anxiety. The rationale was due to the resident's current psychiatric status and history of instability a gradual dose reduction (GDR) was clinically contraindicated unless otherwise noted. An interview on 07/29/25 at 2:00 P.M. with the Director of Nursing (DON) revealed all as needed psychotropic were only used for 14 days after being ordered for 14 more days then the order was written to continue. She confirmed there was no stop dated for the as needed Ativan. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #5's medical record revealed an admission date of 05/15/25 with diagnosis including chronic obstructive pulmonary disease, type 2 diabetes, chronic respiratory failure, anxiety disorder, and major depressive disorder. Review of the 06/06/25 admission Minimum Data Set (MDS) Assessment revealed the resident has intact cognition. Physician orders included: Ativan 0.5 milligrams (mg) every 8 hours as needed for dyspnea or anxiety dated 06/12/25. There was not a 14 day stop for the as needed controlled medication. The medication should have been discontinued 06/28/25. Interview on 07/30/25 at 11:19 A.M. with Director of Nursing (DON) verified the antianxiety medication did not have a 14 day stop as required. Review of the undated facility policy titled, Use of Psychotropic Medications, revealed the policy was to ensure the residents only received psychotropic medications when other nonpharmacological interventions were clinically contraindicated. Additionally, these medications should only be used to treat the resident ' s medical symptoms and not used for discipline or staff convenience. Step 16 indicated psychotropic medications used on an as needed basis must have a diagnosed specific condition and indications for the as needed use documented in the resident ' s medical record and was subject to limitations. As needed orders for psychotropic medication, excluding anti-psychotics should be limited to no more than 14 days, unless the attending physician or prescribing practitioner believed it was appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rational for the extended time period and indicated a specific duration.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the medical record, interview with staff and review of facility policy, the facility failed to ensure the call light was within reach of Resident #26. This affected one resident (Resident #26) of one reviewed for accommodation of need. Findings include: Review of the medical record revealed Resident #26 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, rhabdomyolysis, paroxysmal tachycardia, anxiety disorders, hypertension, major depressive disorder with psychotic symptoms, and muscle weakness. Review of the plan of care dated 08/18/20 revealed Resident #26 was at a risk for falls related to deconditioning, gait and balance problems, and psychoactive drug use. Interventions included to be sure the call light for Resident #26 was within reach and encourage resident to use it for assistance as needed. Review of the Annual Minimum Data Set assessment dated [DATE] revealed Resident #26 had moderately impaired cognition and was dependent for all Activities of Daily Living. Observation on 07/28/25 at 11:18 A.M. revealed Resident #26 was up in the tilt in space wheelchair by the left side of the bed, however her call light was still attached to the left grab bar out of reach, behind her tilt in space wheelchair. This was verified with Certified Nursing Assistant (CNA) #141 on 07/28/25 at 11:20 A.M. Review of the undated facility policy titled, Call Lights: Accessibility and Timely Response, revealed the purpose of the policy was to assure the facility was adequately equipped with a call light at each resident 's bedside, toilet, and bathing facility to allow residents to call for assistance. Staff would ensure the call light was within reach of each resident and secured as needed.		

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NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, and interview with staff, the facility failed to ensure the responsible party, physician and hospice were notified when Resident #27 spilled soup on herself causing a burn and when Resident #45 received a skin tear. This affected two residents (Resident #27 and #45) of five residents reviewed for accidents. Findings include:1. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE]. Diagnoses included heart failure, atherosclerotic heart disease, dysphagia, extended spectrum beta lactamase resistance, glaucoma, retention of urine, osteoarthritis, hypothyroidism, major depressive disorder, generalized anxiety disorder and hypertension. Review of the Significant Change Minimum Data Set assessment dated [DATE] revealed Resident #27 had moderately impaired cognition.Observation of incontinence care with Certified Nursing Assistant (CNA) #144 and #224 on 07/30/25 at 1:36 P.M. revealed Resident #27 had two large blisters to both her right and left inner thighs. CNA #224 left to get Registered Nurse (RN #183) to look at them. Observation of blisters on 07/30/25 at 1:43 P.M. with RN #183 revealed Resident #27 had large blisters to both of her right and left inner thighs. RN #183 stated she had spilled soup on herself yesterday.Review of the nurse's note dated 07/29/25 at 4:39 P.M. revealed Resident #27 was in the chair for lunch and spilled soup on her lap. The nursing assistant responded, immediately pulled clothing way, and placed cold cloths on the abdominal area. The area was slightly pink. A reassessment was completed and no indications of redness or burning were noted. (There was no documentation the physician, hospice or the responsible party was notified.)Review of the nurse's note dated 07/30/25 at 2: 14 P.M. revealed Resident #27 was noted to have blisters to the bilateral inner thighs from spilling soup on self yesterday. The blisters were intact at this time. Resident was educated the importance of keeping blisters intact to prevent infection (There was no documentation the physician, hospice or the responsible party was notified.)An interview on 07/30/25 at 3:35 P.M. with RN #183 verified the physician, responsible party or hospice were not notified of the burns to the bilateral inner thighs of Resident #27. She stated she would update them.Review of the nurse's note dated 07/30/25 at 3:43 P.M. revealed hospice was notified of burn. The physician was okay with covering blisters with Tegaderm to protect it.Review of the nurse's note dated 07/30/25 at 6:57 P.M. revealed the Power of Attorney was notified on the resident's status.Review of the undated facility policy titled, Notification of Change, revealed the purpose of the policy was to assure the facility promptly informed the resident, consult the resident's physician, and notified the resident's representative when there was a change requiring notification. Circumstances requiring notification included accidents resulting in injury or potential to require a physician's interventions.2. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE]. Diagnoses included pain due to internal orthopedic prosthetic device in the left hip and knee, osteoarthritis, dementia, anxiety disorder, cataracts, and weakness.Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #45 had moderately impaired cognition.Observation on 07/28/25 at 11:25 A.M. revealed Resident #45 had an undated dressing to her right lower leg. An interview at this time Resident #45 stated the aide threw her into bed after she told her she did not want to go to bed. She stated she hit her shin on the bedrail and got a skin tear. She stated Her Aide came in and asked her what had happened to her leg, she told her what happen then she went and got the nurse. She stated the nurse came back and put a dressing on it. She stated she does not know her name, but it happened couple weeks ago. She stated she did not know anyone's name.Review of the physician's orders revealed Resident #45 had an order to clean the right lower leg with normal saline, apply xeroform, four by four, wrap in Kerlex, change daily every evening shift and as needed dated 07/14/25 at 11:45 A.M. written by Licensed Practical Nurse #122Further review of the medical record revealed no documentation of a skin tear, physician notification, or responsible party notification.An interview (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 07/30/25 at 2:00 P.M. with the Assistant Director of Nursing (ADON) revealed the nursing assistant was getting the resident out of bed, bumped her leg on the bed and the resident got a skin tear. She verified there was no investigation, assessment, family or physician notification or documentation of the skin care in the medical record. She stated she did not know who the nursing assistant was who transferred her. She stated she has been having problems getting the nurses to document information in the medical record. An interview on 07/31/25 at 8:15 A.M. with the Director of Nursing (DON) stated she spoke to Resident #45 yesterday and the resident stated she did not believe the nursing assistant had malicious intent, but she transferred her too fast after she told her to go slow and caused a skin tear. The DON stated there were black knobs on the bed and that was what she caught her leg on. She stated Resident #45 thinks the staff were always going too fast with her. She stated the nursing assistant was Certified Nursing Assistant (CNA) #149. She stated the nurse was Registered Nurse (RN) #162. The DON stated the day shift nurse was told by the day shift aide Resident #45 had a dressing to her leg. The day shift nurse had to write an order because there was not one written. She stated she was made aware of the skin tear when she got to work on 07/14/25. She verified the nurse had not written an order, documented, assessed, filled out an incident report or notified the family or physician. An interview on 07/31/25 at 10:25 A.M. with Licensed Practical Nurse (LPN) #122 stated she has been working as the wound nurse while the wound nurse was off on leave. She stated she only worked Monday and Tuesday. She stated she had a message from RN #238 to look at the skin tear of Resident #45, so she looked at it on 07/14/25. She stated it had a dressing on it. She stated she does not know what happened she just wrote an order for a treatment. She verified at this time there was no order written but it did have a dressing on it. Review of the undated facility policy titled, Notification of Change, revealed the purpose of the policy was to assure the facility promptly informed the resident, consult the resident's physician, and notified the resident's representative when there was a change requiring notification. Circumstances requiring notification included accidents resulting in injury or potential to require a physician's interventions.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review, and interview, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASARR) was completed with a new psychiatric diagnosis. This affected one (Resident #34) of two residents reviewed for PASARR. The census was 76. Findings include: Review of Resident #34's medical record revealed an admission date of 07/15/22 with diagnosis including vascular dementia, hypertension, anxiety disorder, and paranoid personality disorder. Review revealed the last PASARR submitted for the resident dated 07/08/22 did not indicate Resident #34 had a personality disorder. Record review revealed on 05/30/23 Resident #34 had a diagnosis of paranoid personality disorder added to his list of diagnoses. Review revealed there was no evidence of a subsequent PASARR submission, for a Level II consideration, to the state agency that included the new psychiatric diagnosis. Interview 07/26/25 at 1:10 P.M. with social services #213 verified there was not a PASARR submitted to the state agency for Level II consideration after the addition of the paranoid personality disorder diagnosis.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, interview and facility policy review, the facility failed to develop a comprehensive plan of care for pain management. This affected one (Resident #38) of two residents reviewed for pain management. Facility census was 76. Findings include: Review of Resident #38 ' s medical record revealed an admission date of 05/16/25 with diagnosis including chronic systolic heart failure, type 2 diabetes, atrial fibrillation, chronic obstructed pulmonary disease, and hypertension. Review of the 05/28/25 5-day Minimum Data Set (MDS) Assessment revealed the resident received as needed pain medications and had intact cognition. Review of Resident #38 ' s physician orders revealed orders for Norco 5/325 milligrams (mg) every 6 hours as needed and Tylenol 650 mg every 6 hours as needed. Interview on 07/28/25 at 4:08 P.M. with Resident #38 revealed he always has pain and it is somewhat controlled. Further review of the medical record revealed no evidence of a pain care plan. Interview on 07/30/25 at 1:01 P.M. with MDS Nurse #104 verified there was not a comprehensive pain plan of care developed for Resident #38. Review of facility policy titled Comprehensive Care Plans revealed The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and policy review the facility failed to ensure residents who required staff assistance with activities of daily living received showers per schedule and preferences. This affected two (Resident #4 and #46) of two residents reviewed for shower preferences. Findings include: 1. Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of peripheral vascular disease, above left knee amputation, heart failure, chronic obstructive pulmonary disease, chronic kidney disease, non-pressure ulcers, neuromuscular dysfunctional bladder, diabetes, legally blind, and chronic pain. Review of Resident #4 ' s orders dated 07/2025 revealed on 05/28/25 the resident was ordered showers on Monday, Wednesday, and Fridays per the resident ' s preference. Document refusals in the progress notes. Review of Resident #4 ' s Activity of Daily Living (ADL) care plan dated 05/02/16 and revised on 06/18/2020 revealed the resident required extensive assist of one staff member with bathing/showering three times weekly on Sunday, Tuesday and Thursday dayshift and as necessary. Review of Resident #4 ' s right to make lifestyle changes plan of care dated 05/11/16 and revised 04/23/21 revealed the resident preferred showers. Review of Resident #4 ' s significant change minimum data set (MDS) dated [DATE] revealed it was very important for the resident to choose type important is it to you to choose between a tub bath, shower, bed bath, or sponge bath. Review of Resident #4 ' s quarterly MDS dated [DATE] revealed no evidence the resident had rejected care. Review of the Resident #4 ' s bathing documentation dated 07/01/25 to 07/31/25 revealed no evidence that the resident had received a shower in the last 31 days. There was no documentation the resident had refused a shower. Review of Resident #4 ' s progress notes dated 07/01/25 to 07/31/25 revealed no documented evidence that the resident had refused a shower. Review of Resident #4's hospice note dated 05/02/25 revealed the resident would be seen twice a week for bed baths. The resident was dependent on staff for activities of daily living. Interview on 07/29/25 at 10:20 A.M., with Resident #4 revealed she had only received bed baths lately and she preferred to have a shower. Interview on 07/31/25 at 11:00 A.M., with Medical Record Clerk (MRC) #112 confirmed in the last 30 days Resident #4 was not provided with a shower per the resident's preference, orders and plan of care. The MRC reported currently she had Resident #4 on the shower schedule for Monday and Fridays, due to the resident being under hospice services and the hospice aides only come twice a week on Monday and Fridays. The MRC reported she would talk to the resident and hospice to work out a schedule to meet the resident preference for showers. 2. Medical record review revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including ends stage renal disease, diabetes, legally blind, difficulty walking, weakness, and history of falls. Review of the annual modification MDS dated [DATE] revealed it was very important important is it to you to choose between a tub bath, shower, bed bath, or sponge bath. Review of quarterly MDS dated [DATE] revealed no evidence of the refusal of care and the resident required partial to moderate assistance with showering. Review of Resident #46's activity of daily living plan of care initiated 01/20/25 and revised 02/26/25 revealed the resident required partial/moderate assistance with bathing. Review of Resident #46's preference plan of care dated 01/04/23 revealed the resident would participate in choosing a bathing schedule that meets my preference and needs. Review of progress notes dated 07/01/25 to 07/31/25 revealed no evidence the resident refused showers. Review of resident's shower documentation (paper and electronic medical records) dated 07/2025 revealed the resident did not get a shower on 07/06/35, 07/20/25 and 07/27/25 Interview on 07/28/2025 at 2:53 P.M. with Resident #46 revealed his shower days were Tuesday, Thursday, and Sundays, however the doesn't get them three times a week and the staff forgets about him. Interview on 08/04/25 at 8:26 A.M., with MRC #112 confirmed it may have been her fault the resident didn't receive showers on Sundays in July 2025 because she only had the resident on the shower schedule (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Tuesday and Thursday. MRC #112 confirmed there was no documented evidence the resident had received a shower on Sunday in July on 07/06/25, 07/20/25 and 07/27/25. The MRC confirmed she did not have access to the plan of care to update the resident's shower preferences. Review of the facility's policy and procedure dated 2024 revealed it was the facility's practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Resident would be provided showers as per request or as per facility schedule protocols and based up resident safety.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the medical record, interviews with staff, review of the facility policy, the facility failed to ensure treatment orders were received for burns to Resident #27's thighs and failed to comprehensively assess a skin tear to Resident #45's leg. This affected two residents (Resident #27 and #45) of five residents reviewed for accidents. Findings include: 1. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE]. Diagnoses included heart failure, atherosclerotic heart disease, dysphagia, extended spectrum beta lactamase resistance, glaucoma, retention of urine, osteoarthritis, hypothyroidism, major depressive disorder, generalized anxiety disorder and hypertension. Review of the Significant Change Minimum Data Set assessment dated [DATE] revealed Resident #27 had moderately impaired cognition. Observation of incontinence care with Certified Nursing Assistant (CNA) #144 and 224 on 07/30/25 at 1:36 P.M. revealed Resident #27 had two large blisters to both her right and left inner thighs. CNA #224 left the room to get Registered Nurse (RN #183) to look at them. Observation of the blisters on 07/30/25 at 1:43 P.M. with RN #183 revealed Resident #27 had large blisters to both of her right and left inner thighs. RN #183 stated she had spilled soup on herself yesterday. Review of the nurse's note dated 07/29/25 at 4:39 P.M. revealed Resident #27 was in the chair for lunch and spilled soup on her lap. The nursing assistant responded, immediately pulled clothing way, and placed cold cloths on the abdominal area. The area was slightly pink. A reassessment was completed and no indications of redness or burning were noted. There was no documentation the physician, hospice or the responsible party was notified. Review of the nurse's note dated 07/30/25 at 2:14 P.M. revealed Resident #27 was noted to have blisters to the bilateral inner thighs from spilling soup on self yesterday. The blisters were intact at this time. Resident #27 was educated on the importance of keeping blisters intact to prevent infection. An interview on 07/30/25 at 3:35 P.M. with RN #183 verified no treatment order was written for the blisters to both inner thighs of Resident #27. Review of the nurse's note dated 07/30/25 at 3:43 P.M. revealed hospice was notified of the burn. The physician was okay with covering the blisters with Tegaderm (clear protective film) to protect it. Review of the physician's orders revealed Resident #27 had an order to apply Tegaderm to the left and right thigh burn sites, leave in place for seven days then remove or remove if no longer clean or intact, and check site every shift dated 07/30/25. 2. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE]. Diagnoses included pain due to internal orthopedic prosthetic device in the left hip and knee, osteoarthritis, dementia, anxiety disorder, cataracts, and weakness. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #45 had moderately impaired cognition. Observation on 07/28/25 at 11:25 A.M. revealed Resident #45 had an undated dressing to her right lower leg. An interview at this time Resident #45 stated the aide threw her into bed after she told her she did not want to go to bed. She stated she hit her shin on the bedrail and got a skin tear. She stated Her Aide came in and asked her what had happened to her leg, she told her what happen then she went and got the nurse. She stated the nurse came back and put a dressing on it. She stated she does not know her name, but it happened couple weeks ago. She stated she did not know anyone's name. Review of the physician's orders revealed Resident #45 had an order to clean the right lower leg with normal saline, apply xeroform, four by four, wrap in Kerlix (medical cling wrap), change daily every evening shift and as needed dated 07/14/25 at 11:45 A.M. written by Licensed Practical Nurse (LPN) #122. Review of the nurse's notes revealed no documentation of a skin tear, physician notification, or responsible party notification. An interview on 07/30/25 at 2:00 P.M. with the Assistant Director of Nursing (ADON) revealed the nursing assistant was getting the resident out of bed, bumped her leg on the bed and the resident got a skin tear. She verified there was no investigation, assessment, family or physician notification or documentation of the skin care in the medical record. She stated she did not know who the nursing assistant was who transferred her. She (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she has been having problems getting the nurses to document information in the medical record. An interview on 07/31/25 at 8:15 A.M. with the Director of Nursing (DON) stated she spoke to Resident #45 yesterday and the resident stated she did not believe the nursing assistant had malicious intent, but she transferred her too fast after she told her to go slow and caused a skin tear. The DON stated there were black knobs on the bed and that was what she caught her leg on. She stated Resident #45 thinks the staff were always going too fast with her. She stated the nursing assistant was Certified Nursing Assistant (CNA) #149. She stated the nurse was Registered Nurse (RN) #162. The DON stated the day shift nurse was told by the day shift aide Resident #45 had a dressing to her leg. The day shift nurse had to write an order because there was not one written. She stated she was made aware of the skin tear when she got to work on 07/14/25. She stated they did not do an investigation because Resident #45 never said the nursing assistant threw her in bed she just said she went too fast. She verified the nurse had not written an order, documented, assessed, filled out an incident report or notified the family or physician. An interview on 07/31/25 at 10:25 A.M. with LPN #122 stated she has been working as the wound nurse while the wound nurse was off on medical leave. She stated she only worked Monday and Tuesday. She stated she had a message from RN #238 to look at the skin tear of Resident #45, so she looked at it on 07/14/25. She stated it had a dressing on it. She stated she does not know what happen she just wrote an order for a treatment. She verified at this time there was no order written but it did have a dressing on it.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents had a comprehensive treatment plan in place for the use of hand splints to improve or maintain mobility. This affected one (Resident #60) of one residents reviewed for mobility. The census was 76. Findings include: Review of Resident #60 ' s medical record revealed the resident was admitted on [DATE] with diagnosis including multiple sclerosis, marasmic kwashiorkor, hypertension, major depressive disorder, and obstructive and reflux uropathy. Review of Resident #60 ' s Annual Minimum Data Set (MDS) dated [DATE] revealed no restorative days or minutes for splint or brace assistance, no impairment to the resident's upper extremities. Review of Resident #60 ' s physician orders revealed a resting wrist/hand splint to the left hand once daily for up to four hours on dayshift dated 04/25/25. Review of Resident#60 ' s care plans did not identify a resting hand splint. Review of Review of Resident #60's medication administration records and treatment administration records from July 2025 revealed no documentation the left resting hand splint was applied as ordered. Interview on 07/31/25 at 2:15 P.M. with Director of Nursing (DON) verified the resting hand splint is a nursing order and staff should be putting it on and verified staff has not been signing off on administration. Observation on 07/31/25 at 2:34 P.M. with therapy #152 revealed Resident #60's left wrist was contracted with no resting hand splint in place. Therapy stated they initiate the splint and then nursing takes over after that.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, interview with staff and policy review, the facility failed to ensure fall interventions were in place for Resident #12. This affected one resident (Resident #12) of five reviewed for accidents. Findings include: Review of the medical record revealed Resident #12 was admitted to the facility on [DATE]. Diagnoses included atherosclerotic heart disease, severe protein calorie malnutrition, malignant neoplasm of the prostate, depression, peripheral vascular disease, adult failure to thrive, history of falling, transient ischemic attack, fracture of the fifth metatarsal of the left hand, emphysema, dementia, and hypertension. Review of the plan of care dated 11/01/24 revealed Resident #12 had a potential for falls related to history of falls, cachexia, and unsteady gait. Interventions did not include wearing hipsters. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #12 had moderately impaired cognition and had one fall with injury. Review of the physician 's orders revealed Resident #12 had an order for hipsters (protective hip pads) on at all times, remove every shift to check skin integrity dated 07/02/25. Observation on 07/28/25 at 9:15 A.M. and 10:58 A.M. revealed Resident #12 was in bed on his back with the sheet pulled down to expose his incontinence brief. He did not have his ordered hipsters on while in bed. An interview on 07/28/25 at 11:11 A.M. with Certified Nursing Assistant (CNA) #223 verified Resident #12 did not have his ordered hipsters on in bed. Review of the undated facility policy titled, Fall Management, revealed the facility would identify each resident who was at risk for falls and would develop a plan of care and implement interventions to manage falls, The facility would provide an environment that was free from potential hazards.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on medical record review and interview the facility failed to ensure medications for the treatment of respiratory illness were implemented timely and administered per orders and failed to ensure diagnostic testing results were timely available. This affected one (Resident #1) of one residents reviewed for respiratory care. The facility census was 76. Findings include: Medical record review revealed Resident #1 was admitted to the facility 06/29/23 with diagnoses including pneumonia, chronic respiratory failure with hypoxia, and diabetes. Review of Resident #1's chest x-ray results dated 06/30/25 revealed the resident had some opacities representing pneumonia. A computed tomography (CT) was recommended (of the chest). Review of Resident #1's plan of care revealed two pneumonia plans of care were initiated on 07/02/25 however no interventions were initiated. Review of Resident #1's nurse practitioner note dated 07/03/25 revealed the resident had respiratory failure with hypoxia. New orders to schedule CT scan. Review of Resident #1's medical record revealed on 07/03/25 a CT was ordered for pneumonia and the CT scan was completed on 07/11/25. Review of Resident #1's physician note dated 07/08/25 revealed the resident had acute respiratory failure with minimal improvement. New orders to start Prednisone 20 milligrams (mg) daily for five days. Review of the physician orders July 2025 revealed the Prednisone 20 mg daily for five days was not entered until 07/09/25. Review of Resident #1's Medication Administration Record (MAR) for July 2025 revealed the Prednisone was not started until 07/10/25, two days after it was ordered, and the resident was only administered four doses of five ordered. The CT results were completed on 07/21/25 and showed the resident had right lower lobe pneumonia, multifocal bronchitis and probable subacute, age undetermined thoracic vertebra compression fracture. Further review of Resident #1's physician orders revealed on 07/22/25 Rocephin (antibiotic) one gram (gm) intramuscularly once daily for seven days for pneumonia was ordered. Review of Resident #1's MAR for July 2025 revealed the Rocephin was not administered on 07/22/25 or 07/23/25 due to the medication was not available. The resident only received six doses from 07/24/25 to 07/29/25 and then it was discontinued. There was no documented evidence a new order was written to extend one more additional day to ensure the resident received seven days/doses of the Rocephin. Review of Resident #1's progress note dated 07/24/25 revealed the initial dose of Rocephin was administered left gluteal area. Interview on 07/31/25 at 9:50 A.M., with the Infection Preventionist (IP)/Assistant Director of Nursing (ADON) #115 confirmed Resident #1's Prednisone was ordered on 07/08/25 and not started until 07/10/25 and the resident only received four of the five doses ordered. The IP/ADON also confirmed Resident #1 had a CT done on 07/11/25, however the results were not completed and sent to the facility until 07/21/25. The IP/ADON confirmed the resident was ordered Rocephin on 07/22/25 and it was not started until 07/24/25 due to it being not available. Further interview revealed the facility only administered six days/doses of the medication (from 07/24/25 through 07/29/25) and then it was discontinued and not extended despite the delay with initiating the medication. Once the omitted dose was brought to the facility's attention through this interview, the IP/ADON got the order extended one additional day. Lastly, it was confirmed there were no care planned interventions related to the resident's pneumonia.		

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NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review, facility policy review and interview, the facility failed to implement a comprehensive resident centered treatment plan to manage residents receiving hemodialysis. This affected one (Resident #39) of one residents reviewed for dialysis. The facility census was 76. Findings include: Review of the medical record for Resident #39 revealed an admission date of 07/02/25 with diagnosis including c-diff infection, end stage renal disease, type II diabetes, chronic obstructive pulmonary disease, atrial fibrillation, chronic systolic heart failure, and malignant neoplasm of prostate. Review of the physician orders revealed to weigh the resident before each hemodialysis treatment and after each hemodialysis treatment on Mon/Wed/ Friday and check for bruit (sound heard over an arteriovenous fistula, used for dialysis access, that indicates good bloodflow) and thrill (the pulsation felt over an arteriovenous fistula that indicates good bloodflow) to left arm fistula. The residents dialysis dates in July 2025 were as follows: 07/02/25, 07/04/25, 07/07/25, 07/09/25, 07/11/25, 07/14/25, 07/16/25, 07/18/25, 07/21/25, 07/23/25, 07/25/25, 07/28/25, and 07/30/25. Review of the July 2025 Dialysis Monitoring and Communication Forms revealed incomplete/missing forms for the month of July 2025: 07/04/25, 07/07/25, 07/11/25, 07/18/25, 07/23/25 and 07/25/25. Review of medical record revealed the following weights: 07/30/25 05:35 214.3 pounds (lbs.) 07/28/25 13:35 207.7 lbs. 07/28/25 06:18 218.6 lbs. 07/25/25 10:44 202.84 lbs. 07/25/25 05:11 215.2 lbs. 07/23/25 16:16 204.4 lbs. 07/21/25 10:56 204.6 lbs. 07/21/25 05:48 221.6 lbs. 07/18/25 16:53 205.8 lbs. 07/18/25 05:49 217.0 lbs. 07/16/25 11:44 216.0 lbs. 07/16/25 05:53 216.8 lbs. 07/14/25 11:02 209.0 lbs. 07/14/25 05:53 220.4 lbs. 07/11/25 06:03 221.2 lbs. 07/09/25 18:38 211.8 lbs. 07/09/25 17:08 211.0 lbs. 07/09/25 05:43 219.6 lbs. 07/07/25 16:58 211.0 lbs. 07/07/25 05:13 217.2 lbs. 07/04/25 04:57 217.8 lbs. There was no evidence of fistula monitoring as ordered. Interview on 07/31/25 at 11:07 A.M. with the Director of Nursing (DON) verified the missing dialysis communications forms including the weights and documentation checking the fistula. Review of facility policy titled Hemodialysis revealed the facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing assessment and oversight of the residents before, during and after dialysis treatments. The nurse will monitor and document the status of the residents access site upon return from the dialysis treatment to observe for bleeding or other complications.		

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NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	
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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to ensure antibiotic use was appropriate according to antibiotic stewardship protocols. This affected one resident (Resident #74) of three residents reviewed for antibiotics use. Facility census was 76. Findings include: Record review revealed Resident #74 an admission date of 06/22/22 with diagnosis including type II diabetes, neuralgia and neuritis, depression, anxiety and dementia. Review of the annual minimum data set (MDS) completed 04/14/25 revealed the resident had intact cognition and was frequently incontinent of urine and always incontinent of bowel. Review of the physician orders revealed a urinalysis with culture and sensitivity due to an elevated white blood cell count dated 07/17/25. The report returned on 07/21/25 with results showing 60,000-70,000 colony forming units per milliliter (cfu/ml) Escherichia Coli (E Coli) bacteria, 60-70,000 cfu/ml proteus mirabilis bacteria with possible extended-spectrum beta lactamase (ESBL). The resident started Tobramycin (antibiotic) solution 100 milligrams (mg) intramuscularly (IM) every 12 hours for seven days. Further review of the medical record revealed the McGeer Criteria (Fever or chills, new or worsening urgency, frequency, suprapubic pain, gross hematuria (blood in the urine), or dysuria (painful urination) and no more than two species of bacteria in the urine with a cfu/ml of 100,000 or greater) for Infection Surveillance Checklist-V 4 form dated 07/17/25 revealed Resident #74 did not meet criteria for antibiotic usage. The nurse practitioner was notified Resident #74 did not meet criteria; however the antibiotic was not discontinued. Interview on 08/04/25 at 2:00 P.M. with the Assistant Director Nursing (ADON) confirmed Resident #74 did not meet criteria for antibiotic usage however, the resident continued to receive the antibiotic ordered. Review of facility policy titled Antibiotic Stewardship Program revealed laboratory testing shall be in accordance with the current standards of practice. The facility uses the (CDC 's NIISN Surveillance definitions, updated McGeer criteria, or other surveillance tool) to define infections.		