Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365264	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Neill Healthcare Bay Village	605 Bradley Rd Bay Village, OH 44140

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure a safe and homelike environment. This affected two residents (#26 and #81) of 26 sampled residents. The facility census was 117. Findings include: Observation on 01/15/26 at 9:42 A.M. of Resident #26's room revealed a rolled towel which was placed at the base of the room window next to the bed. Cold air was felt from the base of the closed window. Interview on 01/15/26 at 10:05 A.M. with Resident #26 revealed that cold air comes through the window and is uncomfortable, and that is why the rolled towel is placed.Observation on 01/15/26 at 9:45 A.M. of Resident #81's room revealed a gap above the air conditioner unit below the window. Cold air was felt through the gap.Interview on 01/15/26 at 9:42 A.M. with Resident #81 revealed the resident stated he was cold in his room and was uncomfortable.Interview and environmental rounds on 01/15/26 at 2:25 P.M. with the Director of Ancillary Services (DAS) #645 confirmed the above findings.This deficiency represents non-compliance investigated under Complaint Numbers 2642470, 1266873 (OH00165876), and 1266871 (OH00165428).

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to comprehensively assess a newly identified skin alteration to Resident #8's sacral/buttock area and ensure the resident's care plan for pressure ulcer prevention and treatment was timely revised. This affected one resident (#8) of two residents reviewed for pressure ulcers. The facility census was 117.Findings include:Resident #8 was admitted on [DATE] which included diagnoses of senile degeneration of brain, emphysema, heart block, emphysema, obstructive and reflux uropathy, hyperlipidemia, heart failure, and atrial fibrillation.Review of the admission Nursing Data Collection Tool dated 11/11/25 at 6:30 P.M. revealed Resident #8 had no pressure areas upon admission. The skin condition on admission revealed scattered bruising to the bilateral upper extremities, a right chest abrasion, a left groin abrasion, bruising and scabs to the right trochanter (hip), scabs to the right forearm, and a surgical incision to the front left shoulder. The resident had a pain score of zero (no pain) upon admission to the facility. Review of the Braden Scale for Predicting Pressure Sore Risk dated 11/11/25 at 7:19 P.M. revealed a total score of 12 (high risk for skin breakdown). The resident was assessed as very limited in sensory perception, very moist (skin if often but not always moist), chairfast (ability to walk severely limited or non-existent), mobility very limited (makes occasional slight changes in body or extremity position to unable to make frequent or significant changes independently), probably inadequate nutrition, and potential problem for friction and shear. Review of the nutrition assessment in the progress notes dated 11/13/25 at 1:01 P.M. in the electronic medical record revealed Resident #8 was on a regular diet, mechanical soft texture, and required feeding by the staff. Recent labs reviewed and were noted to be unremarkable. The diet was adequate to meet the resident's needs. The resident was at risk for skin breakdown but had no pressure ulcers were identified. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had no pressure ulcers and was dependent on staff for all activities of daily living (ADL) care. Resident #8 had an indwelling urinary catheter (a device to collect urine) and was incontinent of bowel. The social services assessment on 11/18/25 at 5:41 P.M. revealed a Brief Interview for Mental Status (BIMS) score of 9 (moderate impairment).Review of the electronic medical record progress note by Licensed Practical Nurse (LPN) #575 revealed Resident #8 sustained an unwitnessed fall on 11/19/25 at 1:45 P.M. The progress note revealed LPN #575 found Resident #8 on the floor sitting on his bottom. Resident #8 stated that he did have pain on his bottom and upon assessment, and an injury on his coccyx (buttocks) was noted (a skin tear and redness on coccyx). Resident #8 was then assisted back into his wheelchair. Further review of the medical record revealed no evidence that the skin tear suffered by Resident #8 as a result of the fall on 11/19/25 was measured, assessed, or a treatment was implemented. Review of the facility Fall Report dated 11/19/25 at 1:45 P.M. by LPN #575 revealed the resident had an injury on his coccyx, and a skin tear and redness was noted to the coccyx Injury locations at the time of the fall were a bruise to coccyx, a bruise to right cheek, and a skin tear to the coccyx.Review of the facility weekly wound documentation for the right buttock and coccyx dated 11/19/25 revealed there was bruising measuring 4.5 centimeters (cm) x 2.6 cm. The wound bed was described as 100% purple. A skin tear to coccyx with no measurements or additional description was documented to describe the periwound area. Review of the care plan initiated on 11/19/25 revealed the resident had potential for alteration in skin integrity. Interventions included encourage the resident to turn and reposition every two hours and prn (when needed); offload and elevate the heels in bed, a pressure reducing cushion to the chair, a pressure reducing mattress to the bed, remove wet or soiled clothing or briefs, provide incontinent care and apply (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protective barrier after each incontinent episode. There was no care plan for the right buttock bruise and skin tear to coccyx that was sustained on 11/19/25. A progress note written on 11/20/25 at 1:48 P.M. by the Unit Manager (UM) #628 revealed the son of Resident #8 gave consent for the house wound team for the right buttock and coccyx. A treatment order was in place for the right buttock and coccyx. Review of the Treatment Administration Record (TAR) for November 2025 revealed a treatment to the right buttocks/coccyx was ordered on 11/20/25 at 2:01 P.M. to cleanse with normal saline, pat dry, apply Triad cream (a paste to maintain a moist wound healing environment and facilitate autolytic [breaking down of cellular components] debridement) every shift and when necessary for a skin tear related to a fall.Review of the wound team Certified Nurse Practitioner (CNP) #644 wound care notes dated 11/25/25 at 11:00 A.M. revealed the purpose of the visit was to evaluate the right buttock wound. The wound was classified as a pressure ulcer, with 100% slough (moist, stringy dead tissue and indicates the presence of a full-thickness pressure wound; slough covering the entire wound bed prohibits the wound's true depth from being accurately measured) described as yellow and soft, with a moderate amount of serous (thin and watery) drainage. The wound measured 4.5 cm by 2.5 cm by depth unable to be determined (UTD). Review of the facility weekly wound documentation for the right buttock dated 11/25/25 (no time) revealed an unstageable pressure ulcer measuring 4.5 cm x 2.5 cm x UTD, 100% slough, moderate serous drainage, with the periwound intact. The treatment was changed to apply Medihoney (ointment which supports the removal of dead tissue to aid in wound healing), calcium alginate (to absorb drainage), and cover with a dressing every day and as needed every day shift. Review of Resident #8's physician orders revealed an air mattress to the bed was ordered on 11/25/25 when the skin tear/bruise was classified as a pressure ulcer.Continued review of Resident #8's care plan dated 11/19/25 revealed there was no care plan initiated or revised to include the unstageable pressure ulcer identified on 11/25/25 or a revised intervention of an air mattress which was ordered on 11/25/25.Interview on 01/14/26 7:19 A.M. with the Director of Nursing (DON) verified the treatment to the coccyx/right buttocks bruise and skin tear was ordered on 11/20/25, and the new treatment to the same area now classified as a pressure area was ordered on 11/25/25. Interview on 01/14/26 at 9:10 A.M. with Regional Director Clinical Services (RDCS) #631 revealed he personally saw the bruise on Resident #8's right buttocks the day of the fall on 11/19/25. He described the area as a skin tear to the coccyx with bruising that extended to the right buttocks. Triad cream was ordered as a treatment every shift and as needed (PRN). RDCS #631 did not have knowledge of why a skin tear and initial bruise on 11/19/25 was classified as an unstageable pressure ulcer on 11/25/25.Interview on 01/14/26 at 12:55 P.M. with LPN #575 revealed he was at the nurse's station when he heard a crash. The Certified Nursing Assistant (CNA) notified him that Resident #8 was on the floor. Upon entering the resident room, the resident was noted in a sitting position next to his bed. LPN #575 noted a skin tear (approximately 4.0 cm by 3.0 cm, using his hands to make a shape of the approximate size) with bruising around it. Interview on 01/14/26 at 2:55 P.M. with the Minimum Data Set Coordinator (MDSC) #605 verified that the care plan was not updated to include the identification and treatment of the skin tear and bruising treatment to the right buttock and coccyx that was ordered on 11/20/25. Further, the care plan was not updated to identify or include the pressure ulcer, the new treatment to the coccyx/right buttocks ordered on 11/25/25, and additional pressure reducing interventions such as the air mattress ordered on the same date.Interview on 1/14/26 at 3:31 P.M. with the CNP #644 revealed the coccyx/right buttock was staged as a pressure ulcer on 11/25/25 because bruises don't have slough in them. CNP #644 reported she did not remember exactly what the wound looked like the first time she saw it, but if the note referenced the wound contained 100% slough, then it was for sure a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcer as bruises do not have slough. CNP #644 reported she did not recall a nurse manager informing her the resident had a recent fall, but when she saw the wound for the first time, the wound did not present as a bruise, it was a pressure ulcer. Review of the facility policy Pressure Ulcer Prevention and Treatment Protocol dated 01/2014 revealed residents with a Braden score of 12 or less will be considered high risk for pressure ulcer development. Residents who are admitted with or who develop a pressure ulcer, the following interventions occur: The resident will be evaluated by the dietitian/diet tech to ensure appropriate nutritional support and interventions are in place. The dietician/diet tech will continuing monitoring for effectiveness of interventions on a regular basis and make adjustments in interventions as needed. Interventions for wound care will be implemented per the Wound Care Protocol and/or per the MD orders. Referrals may be made, as needed, to wound care specialist or therapy to aid in treatment and healing of the wound. The care plan will be modified to reflect changes in the resident's condition. The resident or responsible party will be notified of any change in condition and orders as needed. Periwound skin will be monitored daily and the wound will be evaluated with each dressing change; the wound will be measured weekly and the status of the wound will be discussed weekly by the IDT. Adjustments to treatment measures will be made as needed. Resident's will be evaluated for pain and medicated as appropriate prior to dressing change. MD/NP will be consulted as needed for pain management. If pain is noted during the dressing change, the nurse will stop the treatment, cover the wound with a temporary dressing, provide medication and then resume the dressing change as ordered once the medication has had time to take effect. A monthly review of facility statistics of pressure ulcers admitted and developed will be completed and reviewed with the facility Medical Director; if issues are identified, an action plan will be implemented and reviewed through the facilities QAPI process. This deficiency represents non-compliance investigated under Complaint Numbers 2681855 and 2642470.

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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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, witness statements, policy review, and interview, the facility failed to ensure Resident #121 was transferred appropriately using a Hoyer mechanical lift. This finding affected one (Resident #121) of two residents reviewed for transfers. The facility census was 117. Findings include:Review of Resident #121's medical record revealed the resident was admitted on [DATE], readmitted on [DATE] and discharged on 09/05/25 with diagnoses including chronic obstructive pulmonary disease, lumbago with sciatica right and left side and chronic atrial fibrillation. Review of Resident #121's Mobility Care Plan revealed an intervention dated 11/30/23 to transfer the resident with the assistance of two staff members using a Hoyer mechanical lift and the medium purple sling. Review of Resident #121's physician orders revealed an order dated 03/01/24 for a Hoyer lift for all transfers every day and night shift. Review of Resident #121's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of the Self-Reported Incident Form Tracking Number #259111 dated 04/07/25 revealed on 04/07/25 at 8:11 A.M., the Administrator received a message from the resident's daughter with concerns because the resident complained of back pain after getting out of bed the previous evening. The resident's daughter was concerned that the back pain was related to a staff transfer. The daughter called the local police department to report the alleged incident and did not notify facility staff that she had called the police department. The patrol officer came to the facility and interviewed the resident, with no concerns or negative findings. An investigation was initiated and the staff was suspended. Review of the Police Department Investigative Report Supplement dated 04/07/25 revealed on 04/07/25 at 10:00 A.M., Resident #121's daughter spoke with an officer over an incident that occurred at the facility. The daughter stated Resident #121 called on 04/06/25 around 8:30 P.M. to report pain. The police officer spoke with the resident who was able to communicate well. The resident stated her sister and nephew were coming to visit, so she gets in her chair to be able to leave the room for a visit. Resident #121 did not know who the aide was but described her as a black female in her late 20's. Resident #121 stated she picked her up under both armpits and placed her in a wheelchair. The resident reported pain during the move from her bed to her chair. Review of Resident #121's witness statement dated 04/07/25, revealed the Administrator and Prior Director of Nursing (DON) #635 spoke with Certified Nursing Assistant (CNA) #634 by phone. The CNA confirmed that she worked dayshift on 04/06/25 on Unit 2 and cared for Resident #121. She stated she transferred the resident with another aide (CNA #633) twice on the shift from the bed to the chair then later from the chair back to the bed. CNA #634 stated that she had the gait belt but did not use it and never knew Resident #121 was a Hoyer mechanical lift and refused to get out of bed. CNA #634 also stated that the resident appeared comfortable and there was no fall or incident. Resident #121 voiced no concerns with the transfer and was excited to visit with family in the lobby. CNA #634 stated that the family was present when the resident was transferred back to bed. On 01/31/26 at 9:30 A.M., a telephone interview was attempted with CNA #634 and no answer was obtained. The staff member no longer worked in the facility. On 01/13/26 at 8:13 A.M., a telephone interview was conducted with CNA #633. When questioned about the transfer, CNA #633 stated he assisted CNA #634 with the transfer of Resident #121, and they had used a Hoyer mechanical lift and the family lied and said they did not use a Hoyer mechanical lift. The staff member no longer worked in the facility. Interview on 01/13/26 at 9:11 A.M. with the Administrator revealed Resident #121's daughter had called her office and left a voicemail. When (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the daughter was called, she had voiced that the resident was transferred inappropriately and the facility did not use a Hoyer mechanical lift as required and no injuries were noted. The Administrator confirmed both CNA #633 and CNA #634 were suspended pending the investigation, and the facility determined CNA #633 and CNA #634 had not used a Hoyer mechanical lift and instead body lifted the resident from the bed to a chair and from the chair back to the bed. The Administrator confirmed staff education was completed for all nursing staff including nurses and aides, and ongoing audits were conducted to ensure compliance and provided the corrective action plan and indicated the deficient practice was corrected as of 04/10/25. Review of the Fall policy revised 01/2024 revealed it was the policy of the facility to identify residents at risk for falls and plan appropriate care and interventions to maintain resident safety to the extent possible. The deficiency was correct on 04/10/25 when the facility implemented the following corrective actions: On 04/07/25, Resident #121 was assessed and no injuries were noted. On 04/07/25, both Certified Nursing Assistants (CNAs) #633 and #634 were suspended pending an investigation. On 04/07/25, the Administrator initiated a Self-Reported Incident (SRI) for neglect related to Resident #121. The SRI was unsubstantiated for neglect. During the investigation, like residents were identified with no concerns related to transfers. All residents were assessed with no negative findings or injuries identified. From 04/08/25 to 04/10/25, all nursing staff were educated by Prior DON #635 regarding transfers and where to find the information of how to transfer specific residents in the wall charting kiosks which included a hands-on demonstration with return demonstration related to the location of the Kardex's. Nurses were included in the demonstration. An educational review of the Activities of Daily Living policy including transfers were provided to all nurses and CNAs. On 04/15/25, CNAs #633 and #634 received a Written Warning form dated 04/15/25 on inappropriate transfers. Registered Nurse (RN) #626 conducted audits of three resident transfers three times a week for four weeks, then randomly thereafter. Any non-compliance would be addressed individually with the staff by the DON/designee. This deficiency represents non-compliance investigated under Complaint Number 2575250.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure transportation was adequately setup for Resident #31's outside appointments. This finding affected one (Resident #31) of three residents reviewed for outside appointments. The facility census was 117. Findings include:Review of Resident #31's medical record revealed the resident was admitted on [DATE] with diagnoses including Parkinson's Disease, muscle weakness, and cognitive communication deficit.Review of Resident #31's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #31's physician orders revealed an order dated 12/02/25 for an appointment to podiatry on 12/04/25 at 11:15 A.M. and an order dated 01/05/26 for an appointment on 01/08/26 at 2:15 P.M. to the foot doctor. Review of Resident #31's medical record revealed the resident was currently insured by an Ohio managed Medicaid.Interview on 01/12/26 at 10:10 A.M. with Resident #31 revealed he had missed two appointments because the facility did not setup transportation to outside appointments timely.Interview on 01/13/26 at 2:36 P.M. with Outside Office Staff #646 revealed Resident #31 was a no show to quite a few appointments due to transportation issues and the facility staff did not call to cancel or reschedule Resident #31's appointments. Interview on 01/15/26 at 3:01 P.M. with Nurse Practitioner (NP) #647 revealed she was not notified of any missed appointments for Resident #31. NP #647 confirmed transportation was a problem.Telephone interview on 01/20/26 at 8:57 A.M. with Insurance Transportation Representative #648 revealed no transportation had been setup for Resident #31, for any past or future/upcoming appointments. Interview on 01/20/26 at 9:19 A.M. with Registered Nurse (RN) Unit Manager (UM) #626 revealed confirmation for the transport was sent to Resident #31's phone, but the phone was broken.Interview on 01/20/26 at 10:03 A.M. with Resident #31 revealed he could not receive texts due to a broken phone for the last two years. Interview 01/20/26 at 1:00 P.M. with RN UM #626 confirmed Resident #31 was not transported to the physician appointment on 01/08/26 due to transportation issues.Review of the undated Transportation Guidelines revealed for skilled residents, transportation would not be scheduled if it was not in direct relation to the resident's stay in the facility. All routine or unrelated appointments should be cancelled and/or rescheduled during a skilled stay. All Medicare transport for residents without a secondary insurance needs to be billed to the resident at the time of the booking. The form noted transports with Resident #31's specific Ohio managed Medicaid coverage should have transportation scheduled at least two days in advance and the coverage allows up to 30 round trip visits (60 one way trips) in a 12 month period.This deficiency represents non-compliance investigated under Complaint Numbers 2575250 and 2714442.

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, family interview, resident interview, and facility policy review, the facility failed to ensure foods were served at a palatable temperature and were visually pleasing. This affected sixteen (Residents #1, #4, #24, #25, #26, #28, #31, #48, #59, #65, #71, #72, #85, #98, #116, and #137) of 18 residents reviewed for dietary services. The facility census was 117. Findings include: 1. Interview with a family member of Resident #48 on 01/12/26 at 10:30 A.M. revealed multiple concerns related to food quality and temperature.2. Interview with Resident #137 on 01/12/26 at 10:55 A.M. revealed the food at the facility is always cold and Resident #137 has to ask the facility's Certified Nursing Assistants (CNAs) to warm up the food, which they do reluctantly.3. Interview with Resident #116 on 01/12/26 at 11:16 A.M. revealed the food had gone downhill.4. Interview with Resident #1 on 01/12/26 at 12:37 P.M. revealed the food at the facility is gross.5. Observation of the test tray for the breakfast meal on 01/13/26 at 8:00 A.M. with Dietary Manager (DM) #586 revealed the meal served was biscuits with sausage gravy, oatmeal, and orange juice. The biscuit was extremely hard and required significant force of a spoon to cut. The sausage gravy was bland with no seasoning and registered a luke warm temperature of 145 degrees. The oatmeal had a thick paste texture with no milk, brown sugar, or other seasonings/enhancers. DM #586 verified the findings of the test tray at the time of discovery.6. Completion of the resident council portion of the annual survey on 01/14/26 at 10:00 A.M. with Resident #4, #24, #25, #26, #28, #31, #59, #65, #71, #72, #85, #98 revealed the food at the facility is overcooked and hard and does not taste good. Review of the undated policy entitled meal service and distribution revealed Residents' meals are distributed promptly to maintain adequate temperature and appearance.This deficiency represents non-compliance investigated under Complaint Number 2703441.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to implement appropriate infection control measures during wound care. This affected one resident (#10) of three residents reviewed for wound management. The facility census was 117. Findings include: Review of the medical record revealed Resident #10 was admitted on [DATE] with diagnosis of hemiplegia, hemiparesis, type II diabetes, dysphagia, cerebral infarction a stoke, depression, anxiety, contracture right knee, hypertension heart, and heart failure.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #10 was cognitively impaired and dependent on staff for hygiene and transfers. The resident had a stge II pressure ulcer and moisture associated skin damage (MASD).Review of the Care Plan dated 11/13/25 stated Resident #10 required Enhanced Barrier Precautions (EBP) related to multidrug resistant organism (MDRO) infection in the right foot wound. Review of the physician orders for January 2026 revealed an order to cleanse the right fifth toe with normal saline, pat dry, apply calcium alginate (an absorbent dressing), and cover with a foam dressing.Observation on 01/14/26 at 1:16 P.M. revealed Licensed Practical Nurse (LPN) #649 providing wound care to Resident #10's right fifth toe wound. LPN #649 gathered supplies and walked into the room. The outside door to Resident #10's room revealed signage indicating the resident required EBP. The signage stated that providers and staff must wear gloves and a gown when providing wound care to any skin opening requiring a dressing. LPN #649 did not put on a gown. LPN #649 washed her hands, put on gloves, and removed the old dressing to Resident #10's right fifth toe. With the same gloves used to remove the soiled dressing, she cleansed the wound and applied calcium alginate. LPN #649 then changed her gloves and applied a foam dressing. Interview on 01/14/26 at 1:56 P.M. with LPN #649 verified she did not change her gloves after removing the dressing and prior to cleansing the wound. Further interview on 01/14/26 at 5:00 P.M. revealed LPN #649 verified Resident #10 required EBP and stated she was required to wear gloves and gown while proving wound care.Review of the facility policy titled Wound Care dated 2002 stated procedures for wound care include was and dry hands, position the resident, put on gloves and remove the dressing, wash and dry hand, put on gloves and complete the dressing and wash and dry hands,This deficiency represents non-compliance investigated under Complaint Numbers 2703441 and 2642470.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2026
NAME OF PROVIDER OR SUPPLIER O'Neill Healthcare Bay Village		STREET ADDRESS, CITY, STATE, ZIP CODE 605 Bradley Rd Bay Village, OH 44140	

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, resident interview, and staff interview, the facility failed to maintain a clean and sanitary environment. This affected 15 Residents (#4, #5, #10, #21, #26, #28, #32, #33, #40, #48, #50, #71, #78, #91, and #94) of 117 residents observed during the survey and had the potential to affect all residents residing in the facility. The facility census was 117.Findings include:Observation during environmental rounds on 01/15/2026 at 9:42 A.M. with the Director of Ancillary Services (DAS) #645 revealed the following that was verified at the time of discovery:- Resident #4's room had loose flooring under the bottom of the bed legs.- Resident #5's bottom bed sheet had a small hole and two small yellow stains at the end of the bed. There was a strong odor of urine in the room, but there was no visible urine.- Resident #10's room had an air conditioner filter that had visible dirt and debris. There was wall damage behind the bed.- Resident #26's room had loose flooring under three of four bed legs, and a dislodged floor baseboard cover and exposed heating element.- Resident #28's room had a broken windowsill ledge. Two triangular pieces of ledge were dislodged. There was a visible crack in the wall extending from the windowsill approximately 18 inches toward the floor. The inside surface of the bathroom door had an indented hole.- Resident #32's room had loose floorboards under the bed footers.- Resident #33's room had a hole in the wall behind the bed that was semi-plastered approximately seven inches long.- Resident #40's room had damage to the wall near the bed with visible paint and dry wall peeling.- Resident #48's room had a thin cover over the wall unit air conditioner vent. The cover was cold to touch. - Resident #71's room had a brown stain on the bed cover.- Residents #5, #21, #50, #78 and #91's room had a dislodged floor baseboard cover and an exposed heating element. - Resident #94's room had a damaged wall with plaster with dry wall exposed.- Dead bugs were observed in the hallway overhead lighting lids throughout the building.- An air filter unit in the hallway next to Resident #33's room had a dent in the unit with visible yellow/light brown discoloration to the outside of the unit and sticky to the touch.Interview on 01/15/26 at 9:50 A.M. with Resident #32 revealed the floor planking had been loose under her bed because of the way she is positioned in the bed.This deficiency represents non-compliance investigated under Complaint Numbers 2642470, 1266873 (OH00165876), and 1266871 (OH00165428).