STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365290	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirtland Woods of Journey	9685 Chillicothe Rd Kirtland, OH 44094

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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on a review of personnel files, the Social Services Director job description, the Facility Assessment, and staff interviews, the facility failed to employ a qualified fullˆtime licensed social worker (LSW) as required. This deficiency had the potential to affect all 58 residents living in the facility.Findings include:Interviews conducted on 04/28/26 at 2:50 P.M. with the Director of Nursing (DON) #526 and Regional Nurse #568 confirmed that the facility, licensed for 180 beds, had not employed an LSW since 11/05/25. The DON stated that, following the departure of LSW #571, department heads had been performing social work duties. She also reported reaching out to a Social Worker at another facility for guidance; however, this off-site Social Worker did not complete or sign any work for the facility. Both the DON and the Regional Nurse confirmed that no LSW had provided services in any capacity since 11/05/25.A review of the personnel record for Former LSW #571 showed her last day worked was 11/05/25.The Facility Assessment updated on 01/05/26 indicated that the facility recognized the need for a full-time Social Worker as part of the interdisciplinary team to address resident care needs.A review of the job description for the Social Services Director (Licensed Social Worker), updated 08/25, revealed the position was responsible for overseeing the development, implementation, supervision, and ongoing evaluation of the Social Services Department, including ensuring medically related social services were provided in accordance with State and Federal regulations.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on record review and staff interview, the facility failed to notify residents or their responsible parties when resident personal fund accounts reached within $200 of the Medicaid resource limit, as required by regulation. This failure affected four of the six residents reviewed for personal funds (Residents #1, #22, #50, and #59). The facility census was 58.Findings include:1. Review of banking records for Resident #1 showed a balance of $20,702.70, exceeding the Medicaid resource limit of $2,000 as of 05/01/26.No documentation was found indicating the resident or responsible party was notified of the need to spend down funds.2. Review of the banking records for Resident #22 showed a balance of $6,007.89, exceeding the Medicaid resource limit as of 05/01/26.No documentation was found indicating the resident or responsible party was notified of the need to spend down funds.3. Review of the banking records for Resident #50 showed a balance of $24,237.64, exceeding the Medicaid resource limit as of 05/01/26.No documentation was found indicating the resident or responsible party was notified of the need to spend down funds.4. Review of the banking records for Resident #59 showed a balance of $4,280.00, exceeding the Medicaid resource limit as of 05/01/26.No documentation was found indicating the resident or responsible party was notified of the need to spend down funds.During an interview on 05/04/26 at 2:30 P.M., the Business Office Manager (BOM) #530 acknowledged awareness of residents' high personal fund balances. She stated the facility did not have a social worker to prepare and send spendˆdown letters and no other staff were assigned to complete this responsibility. She also stated no spendˆdown notifications were issued, and the facility lacked a process to assist residents in managing excess funds.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, review of the Housekeeping Daily Checklists, staff and resident interviews, and review of facility policies, the facility failed to provide residents with a clean, safe, sanitary, and homelike environment as required. The facility did not ensure Resident #36's room was maintained in a clean condition, as evidenced by a stained window curtain that remained unaddressed despite multiple resident requests and observations by staff. Additionally, the memory care unit dining and common areas were kept clean, sanitary, and properly maintained. This affected one resident (#36) being directly affected out of seven residents reviewed for physical environment and had the potential to impact all 23 residents (#4, #6, #7, #10, #12, #13, #15, #16, #18, #22, #23, #25, #26, #28, #32, #33, #43, #46, #50, #52, #54, #55, and #58) in the memory care unit. The facility census was 58.Findings include:1. During an interview on 04/27/26 at 10:52 A.M., Resident #36 reported that his window curtain was dirty. He stated he had requested multiple times that staff clean the curtain, but no action was taken. Resident #36, who had lived in the room for approximately four months, noted that the curtain was already soiled when he moved in.An observation during that interview confirmed that the left window curtain panel had large reddishˆbrown stains on its underside, visible upon entering the room.A follow-up observation on 04/29/26 at 9:03 A.M. showed the same stains remained and the curtain had not been cleaned.During an interview and observation on 04/29/26 at 10:35 A.M., Certified Nursing Assistant (CNA) #517 acknowledged the curtain was soiled with an unknown substance. The CNA stated that housekeeping was responsible for cleaning resident rooms.Interview and observation on 04/29/26 at 1:48 P.M. with Maintenance Director #557 confirmed the curtain was visibly soiled, stating it was pretty obvious and anyone cleaning the room should have seen it. He explained that staff should have submitted a work order through TELS, the facility's webˆbased building management and workˆorder system. Housekeeping staff did not have access to enter information directly into TELS; however, they were expected to report such issues to maintenance for entry.A review of the Daily Housekeeping Checklist indicated that windowsills were to be cleaned daily, a task during which the stained curtain should have been noticed.Review of the Environmental Quality policy, revised 02/16/24, showed that all staff were responsible for reporting any broken, defective, or malfunctioning equipment or furnishings immediately upon identifying an issue.A review of the facility's policy titled; Resident Rights revised 02/15/24 affirmed that residents are entitled to a safe, clean, comfortable, and homelike environment, including supports for daily living delivered safely.2. Observation of the memory care dining room on 04/28/26 at 11:48 A.M. revealed the environment was not maintained in a clean or sanitary condition. One dining table had not been wiped down and contained a clear sticky substance. A red juice stain and multiple brown spillage spots resembling pudding were noted on the floor beneath another table. A damp washcloth was observed on the floor; when CNA #510 moved it, additional brown spillage was identified. CNA #510 verified these findings and stated housekeeping is responsible for cleaning the dining room after meals, while unit staff perform limited cleaning during meals. An interview on 04/28/26 at 12:00 P.M., Unit Manager (UM)/Licensed Practical Nurse (LPN) #538 reported that housekeeping services were inconsistent and did not reliably clean the dining room after meals. UM/LPN #538 further stated that at times when housekeeping was unavailable, unit staff were required to clean the dining area.Observation of the memory care common area on 04/29/26 at 10:54 A.M. revealed a carpet with frayed edges, partially secured with blue tape. Several large dark stains were also present. Registered Nurse (RN) #563 verified these findings and stated he was unsure when the carpet was last cleaned.Observation of the dining room on 04/29/26 at 12:07 P.M. revealed four dirty, stained chairs along the back left wall. Four male residents were seated at the adjacent table. CNA #510 verified the condition of the chairs and the residents' proximity. Further observation revealed a wooden table in significant disrepair: loose and hanging trim on multiple sides, a missing 4-inch section of upper trim, and tennis balls (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attached to three of the four table legs. Resident #52 was seated at this table awaiting lunch. RN #563 verified the condition of the table and the resident's presenceA review of the facility's policy titled; Resident Rights, revised 02/15/24, stated that residents have the right to a safe, clean, comfortable, and homelike environment, including supports for daily living delivered safely.A review of the policy titled; Environmental Quality, revised 02/16/24, stated the facility is to be designed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The policy further requires adequate space and furnishings in dining and activity areas, and mandates that staff report broken or malfunctioning equipment immediately upon identification.This deficiency represents non-compliance investigated under Master Complaint Number 2702909 and Complaint Numbers 2618473, 2689846 and 2567648.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and facility policy, the facility failed to ensure routine care plan conferences were conducted. This affected six residents (#11, #13, #14, #22, #32, #49) out of 25 sampled residents. The facility census was 58. Findings include:1. Resident #13 was admitted to the facility on [DATE] with diagnoses of osteoarthritis bilateral knees, squamous cell carcinoma of skin, basal cell carcinoma of face, anxiety disorder, major depressive disorder, dementia, protein-calorie malnutrition, dysphagia, need for assistance with personal care. Review of medical record revealed Resident #13's last care conference was completed on 07/02/25 by Former Licensed Social Worker (LSW) #571. No other care conferences were performed after July 2025. Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicating Resident #13 had intact cognition. The functional assessment revealed the resident required assistance and cueing with activities of daily living (ADL) including hygiene/toileting, showers, and transfer to wheelchair. Resident #13 was frequently incontinent of bowels and bladder and had no wounds. Interview with Resident #13 on 04/27/26 at 10:31 A.M. stated she has not had any care conferences at facility since July 2025. 2. Resident #14 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of endometrium, type two diabetes, major depressive disorder, anxiety, protein-calorie malnutrition, obesity, displaced comminuted fracture of left fibula, cerebral infarction, need for assistance with personal care. Review of medical record revealed Resident #14's last care conference was on 07/28/25 by Former LSW #571. No other care conferences were provided after July 2025. Review of Quarterly MDS assessment dated [DATE] revealed a BIMS score of 12/15, indicating Resident #14 had moderate cognitive impairment. The functional assessment revealed the resident required set up assistance for upper body ADL and was dependent on staff for hygiene, toileting, showers, and transfers to the wheelchair. Resident #14 was also frequently incontinent of bowels and bladder. 3. Resident #22 was admitted to facility on 01/13/23 with diagnoses of Alzheimer's disease, dementia, ulcerative colitis, protein-calorie malnutrition, and need for assistance with personal care. Review of medical record revealed Resident #22's last care conference was on 04/16/25 by Former LSW #571. No other care conferences were completed after April 2025. Review of Quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 indicating Resident #22 had severe cognitive impairment. The functional assessment revealed the resident was dependent on staff for all ADL, hygiene, and transfer/mobility needs. Resident #22 was always incontinent of bowels and bladder. 4. Resident #32 was admitted to facility on 08/28/23 with diagnoses of dementia, chronic obstructive pulmonary disease, major depressive disorder, protein-calorie malnutrition, bilateral hearing loss, post (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	traumatic subdural hemorrhage, dysphagia, and frequent falls. Review of medical record revealed Resident #32's last care conference completed on 04/08/25 by Former LSW #571. No other care conferences were completed after April 2025. Review of Quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 indicating Resident #32 had severe cognitive impairment. The functional assessment revealed the resident was dependent on staff for all ADL, hygiene, toileting, and transfers/mobility. Resident #32 was always incontinent of bowels and bladder. 5. Resident #49 was admitted to facility on 02/09/21 with diagnoses of atherosclerotic heart disease, peripheral vascular disease, osteoarthritis, dementia, protein-calorie malnutrition, dysphagia, need for assistance with personal care. Review of medical record for revealed Resident #49's the last care conference was completed on 02/13/25 by Former LSW #571. No other care conferences were completed for Resident #49 after February 2025. Review of Annual MDS assessment dated [DATE] revealed a BIMS score of 2/15, indicating Resident #49 had severe cognitive impairment. The functional assessment revealed the resident was dependent on staff for all ADL, hygiene, toileting, transfer and mobility. Resident #49 was always incontinent of bowels and bladder. Interview with Resident #49's Power of Attorney (POA)/daughter on 04/27/26 at 10:12 A.M. revealed she has not had a care conference in over a year and there was not a social worker on site for a while. The POA stated she had requested care conferences in the past but had not received one in over a year. 6.Resident #11 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, generalized muscle weakness, congestive heart failure, atrial fibrillation, malignant neoplasm of thymus, and malignant neoplasm of endometrium. Review of medical record for Resident #11 revealed the last care conference was completed on 04/29/25 by Former LSW #571. No other care conferences were completed for Resident #11 after April 2025. Review of the Significant Change MDS assessment dated [DATE] revealed a BIMS score of 15/15 indicating Resident #11 was cognitively intact. The functional assessment revealed Resident #11 was dependent on staff for toileting, required maximal assistance for showers, dressing, transfers, and required set up assistance for eating and oral hygiene. Interview with Resident #11 on 04/29/26 at 8:42 A.M. revealed she and her son used to be involved in quarterly care conferences; however, she thought it had been about two years since the last care conference. Interview with Director of Nursing (DON) and Corporate Regional Clinical Nurse (RCN) #568 on 04/28/26 at 2:50 P.M. verified the facility did not currently have a LSW or designee with LSW oversight for social worker duties since November 2025. The DON and RCN #568 provided evidence that Former LSW #571's last day worked was 11/05/25. The facility has been actively recruiting, and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the DON has taken on additional responsibilities of a LSW at the facility; however, no LSW had signed off on any evaluations or conferences. The DON also verified that care conferences have been missed on long stay residents. Review of the facility policy titled, Comprehensive Care Plans, revised 03/20/25, revealed the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. This deficient practice represents non-compliance investigated under Complaint Number 2567648.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Social Services Director job description and interviews, the facility failed to provide medicallyˆrelated social services necessary for residents to attain or maintain their highest practicable physical, mental, and psychosocial wellˆbeing. The facility had no Licensed Social Worker (LSW) providing or overseeing required social services for more than five months, resulting in missed care conferences, absence of required resident and representative involvement in care planning and failure to notify residents or representatives when personal fund accounts exceeded Medicaid limits. This affected nine residents (#13, #14, #22, #32, #49, #11, #1, #50, and #59) of 25 sampled residents and had the potential to affect all 58 residents in the facility. The facility's census was 58.Findings include:During an interview on 04/28/26 at 2:50 P.M., the Director of Nursing (DON) #526 and Regional Nurse #568 confirmed the facility is licensed for 180 beds and the facility had not employed a LSW since 11/05/25. The interview also confirmed no LSW had completed, overseen, or signed any social services documentation, assessments, or care conferences since that date. The department heads were informally attempting to perform social services tasks without training, qualifications, or LSW oversight and an offˆsite Social Worker at another facility was contacted for advice only and did not perform or sign any work for this facility. The DON acknowledged that multiple longˆstay residents had missed required care conferences and that no system was in place to ensure completion of social services responsibilities.1. A review of Resident #13's medical record revealed an admission date of 01/13/23 with multiple medical and psychosocial needs. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview of Mental Status (BIMS) score of 15/15 which indicated intact cognition and dependence on staff for activities of daily living (ADL). The record review showed the last care conference was 07/02/25.An interview on 04/27/26 at 10:31 A.M. with Resident #13 confirmed she had not received any care conferences since July 2025.2. A review of Resident #14's medical record revealed an admission date of 06/30/22 with significant medical and psychosocial needs. A review of the Quarterly MDS assessment dated [DATE] showed a BIMS score of 12/15 which indicated moderate cognitive impairment. Further record review showed the last care conference was 07/28/25.3. A review of Resident #22's medical record revealed an admission date of 01/13/23 with dementia and total dependence for ADL. Her Quarterly MDS assessment dated [DATE] showed severe cognitive impairment (BIMS score of 00). The record review showed the last care conference was 04/16/25.4. A review of Resident #32's medical record revealed an admission date of 08/28/23 with dementia, chronic obstructive pulmonary disease, depression, dysphagia, and fall risk. Her Quarterly MDS assessment dated [DATE] showed severe cognitive impairment (BIMS score of 00). The record review showed the last care conference was 04/08/25.5. A review of Resident #49's medical record revealed an admission date of 02/09/21 with dementia and multiple chronic conditions. The Annual MDS assessment dated [DATE] showed severe cognitive impairment (BIMS score of 2). A record review showed the last care conference was 02/13/25.An interview with Resident #49's daughter on 04/27/26 at 10:12 A.M. revealed she had not participated in a care conference in over a year, despite requesting them.6. A review of Resident #11's medical record revealed and admission date of 01/16/23 with multiple chronic conditions. Review of the Significant Change MDS assessment dated [DATE] showed intact cognition (BIMS score of 15/15).An interview with Resident #11 on 04/29/26 at 8:42 A.M. stated she and her son had not participated in a care conference in approximately two years. An interview with the DON on 04/30/26 at 10:14 A.M. confirmed Resident #11 had not had a care conference in the past year, and a record review showed the last care conference was 04/29/25.7. The absence of a Social Worker also resulted in failure to notify residents or representatives when personal fund accounts exceeded Medicaid limits:- Resident #1: $20,702.70 as (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 05/01/26- Resident #22: $6,007.89 as of 05/01/26- Resident #50: $24,237.64 as of 05/01/26- Resident #59: $4,280.00 as of 05/01/26During an interview on 05/04/26 at 2:30 P.M., the Business Office Manager (BOM) #530 confirmed she was aware of high personal fund balances and no spendˆdown notifications were issued to residents. The interview also confirmed the facility had no Social Worker to send required notifications, no other staff were assigned to complete this responsibility, and the facility lacked a process to assist residents in managing excess funds.A review of the facility's Social Services Director job description (updated 08/25) confirmed that the position is responsible for ensuring the provision of medicallyˆrelated social services in accordance with State and Federal regulations. The facility had no individual fulfilling these duties.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and interview, the facility failed to ensure residents were fed in a dignified manner. This affected one resident (#19) of four residents who were identified as needing assistance with meal intake. The facility census was 58.Findings include:A review of medical records for Resident #19 revealed the date of admission as 01/12/23. Significant diagnoses included unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance mood disturbance or anxiety, unspecified protein calorie malnutrition, Alzheimer's disease, dysphasia (difficulty swallowing), and need for assistance with personal care. Significant orders included regular diet, mechanical soft texture, nectar thick liquids. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had a severe cognitive deficit and was rarely understood. The assessment also revealed Resident #19 was dependent on staff for eating.A care plan dated 02/25/26 revealed Resident #19 required assistance with activities of daily living (ADL). Interventions included Resident #19 was dependent on staff for eating.An observation on 04/27/26 at 12:43 P.M. revealed Resident #19 in the East dining room seated in his wheelchair being fed by Licensed Practical Nurse (LPN) #542. LPN #542 was standing over Resident #19 as she fed him. LPN #555 and Executive Director #505 verified the findings at the time of the observation. LPN #555 stated LPN #542 should be seated when assisting Resident #19.An observation on 04/30/26 at 12:40 P.M. revealed Resident #19 in the East dining room seated in his wheelchair being fed by Certified Nurse Aide (CNA) #517. CNA #517 was standing over Resident #19 as he was feeding him. Registered Nurse (RN) #567 verified the findings at the time of the observation.A review of the undated facility document titled; Validation Checklist-Assisting Resident with Meals revealed residents should be interacted with during mealtime. Examples include being courteous, seated next to the resident, not standing behind or over the resident, primarily conversed with the resident, and no other staff members or residents during the meal.A review of the facility policy titled; Resident Rights (revised 02/15/24) revealed the resident has a right to be treated with respect and dignity including the right to reside and receive services in the facility with reasonable accommodation of resident needs and preference.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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 record review, interview, review the Ohio Department of Health (ODH) Certification, Licensure and Survey System (CALS) website, and review of a facility self-reported incident (SRI) and policy review, the facility failed to prevent staff to resident verbal abuse. This affected one resident (Resident #6) of six residents who were reviewed for abuse. The facility census was 58.Findings include:Resident #6 was admitted on [DATE] with significant diagnoses including senile degeneration of the brain and vascular dementia with agitation, and was placed on the secured unit with behavior monitoring for anxiety, depression, agitation, physical and verbal behaviors, delusions, hallucinations, refusals, and attentionˆseeking, with interventions such as redirection, environmental changes, diversion, food and fluids, toileting, and limitˆsetting. Medication orders included multiple Depakote regimens for agitation and dementia. A care plan dated 02/03/26 showed the resident required assistance with all activities of daily living due to impaired cognition and was often resistive to care, with interventions encouraging resident choice, participation in care, praise for appropriate behavior, anticipating needs, ensuring safety during agitation, and reapproaching as needed. The resident was also at risk for adverse reactions to antiˆanxiety medications, requiring monitoring and reinforcement. An annual Minimum Data Set (MDS) dated [DATE] documented severe cognitive impairment, frequent physical behavioral symptoms such as hitting, kicking, pushing, scratching, grabbing, or sexually abusing others on four to six days during the seven-day lookˆback period, and full dependence on staff for all activities of daily living.A review of the ODH CALS website revealed the facility created SRI tracking #269375 on 01/04/26 for staff-to-resident verbal abuse. The facility finalized the investigation on 01/10/26 and substantiated verbal abuse did occur to Resident #6.A review of SRI #269375 and subsequent facility investigation revealed the following:On 01/04/26 the facility administration became aware of an allegation involving inappropriate conduct toward a resident during hands-on care after staff reported that an audio recording existed depicting a care team member yelling at a resident. The allegation had surfaced after staff indicated that the content had been shared among employees. An immediate investigation was started, including skin assessments, resident and staff interviews.Upon notification, facility leadership immediately initiated protective measures to ensure resident safety. Nursing staff completed skin assessments on the resident involved and all residents in the memory care unit. There were no significant findings. Resident #6 was observed to be at baseline with no signs or symptoms of distress. A review of text message in the investigative file revealed Executive Director (ED) #541 made an attempt to reach an unidentified housekeeper for the audio recording on 01/04/26 at 2:41 P.M. The unidentified housekeeper denied the audio recording existed and resigned on 01/04/26 at 3:46 P.M.An investigation was conducted by the facility including staff interviews with involved staff and preservation of available information period two staff members independently reported that an audio recording had been shared with them depicting certified nurse aid (CNA) #570 using inappropriate language toward Resident #6 during care. On 01/06/26 at approximately 6:00 P.M. the reporting individual re-engaged with the administrator and provided additional information including identification of the involved CNAs and the existence of an audio recording. The audio recording was obtained and reviewed and secured by administration. CNA #570 was identified and immediately removed from resident care and placed on suspension pending investigation. Upon completion of the facility investigation and review of available evidence, the facility determined that a verbal altercation occurred during resident care involving inappropriate and unprofessional language towards Resident #6. CNA #570 was terminated. A review of the personnel file for CNA #570 revealed a date of hire as 08/13/25. The file further revealed a nurse aide registry (NAR), and all background (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365290	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirtland Woods of Journey	9685 Chillicothe Rd Kirtland, OH 44094

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checks were completed with no findings for abuse. The file revealed a final punch on 01/06/26 with an out time at 5:39 P.M.On 05/05/26 at 3:20 P.M. an interview with the Director of Nursing (DON) and ED #541 verified the findings in SRI #269375 as verbal abuse having occurred. The interview further revealed there was delay in identifying CNA #570 as the perpetrator as the unidentified housekeeper did not initially cooperate with the investigation.A review of the facility policy titled Abuse, Neglect, and Exploitation (revised 03/05/24) revealed it is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property the policy further defines verbal abuse as a means of use of oral, written or gestured communication or sounds that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.The deficient practice was corrected on 01/16/26 when the facility implemented the following corrective actions: - On 01/04/26 skin assessments were completed on all residents in the memory care unit with no findings. Resident #6 was found to be at baseline cognition with no evidence of distress.- On 01/06/26 CNA #570 was identified as the perpetrator and removed from the schedule pending investigation.- On 01/09/26 facility wide education was initiated. This education included abuse prevention policy and mandatory reporting expectations.- On 01/10/26 the investigation findings were finalized, and determination was made that a verbal altercation occurred during resident care. CNA #570 was terminated from employment.- On 01/16/26 facility wide education was completed for all staff. Staff acknowledgement of the education was obtained.- Ongoing interventions include assessment of resident number six which reveals no change in condition or behavior. Other interventions include quality assurance (QA) monitoring weekly for any resident abuse for four weeks which was concluded and then monitored monthly for three months with no findings. Staff members will continue to be educated on abuse upon hire, yearly, and as needed.This deficiency represents non-compliance investigated under Complaint Numbers 2689846, 2594525,and 1363590 (OH00164779).

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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 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 record review, observation, interviews and facility policy review, the facility failed to ensure physician orders were followed and dressing changes were performed. This affected one (Resident #35) out of four residents reviewed for pressure and non-pressure skin conditions. The facility census was 58.Findings include:Resident #35 was admitted to facility on 01/30/26 with diagnoses of non-displaced fracture of lateral malleolus right fibula (ankle fracture), chronic osteomyelitis right ankle and foot, cellulitis right lower limb, epilepsy, anxiety disorder, depression, obesity, and need for assistance with personal care.Review of Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating Resident #35 was cognitively intact. The functional assessment revealed the resident needed set up for upper body activities of daily living (ADL) and required one staff assist for lower body ADL, hygiene, transferring and mobility.Interview with Resident #35 on 04/27/2026 10:12 A.M. revealed she had not received a dressing change to her right foot in over a week, and her last dressing change occurred at the podiatrist office. She stated her provider said they should occur daily. Resident #35 also stated she had never refused any dressing changes.Record review of Resident #35's physician's orders revealed an order dated 04/07/26 to the right ankle/foot surgical wound: cleanse with wound cleanser, apply betadine (antiseptic) moisten gauze to incisions then wrap with Ace wrap every day. Review of Treatment Administration Record (TAR) for Resident #35 revealed all dressing changes were signed off as the resident had refused dressing changes on 04/22/26, 04/25/26 and 04/26/26 which the resident denied.Observation of wound care on 04/28/26 at 12:20 P.M. performed by Licensed Practical Nurse (LPN) #542 revealed Resident #35 had an open wound to anterior of right foot which had crusted serosanguinous drainage adhered to gauze wrap. LPN #542 used saline to soften and remove gauze dressing and cleansed the wound per order with wound cleanser, applied betadine moisten gauze to open area and rewrapped with gauze and Ace wrap per order.Interview with LPN #542 on 04/28/26 at 12:30 P.M. verified Resident #35's statement regarding dressing changes and confirmed they were not performed daily. LPN #542 confirmed the previous order dated 03/31/26 for the dressing not to be changed until seen in podiatry office and believed the dressing change was only to be done at provider office. LPN #542 also confirmed she had signed off the dressing changes in the electronic medical record (EMR) as completed on 04/18/26, 04/19/26, 04/23/26, 04/24/26, 04/27/26, and 04/28/26 but thought the order meant that it was intact and did not review the updated order when she signed it off.Interview with the Director of Nursing (DON) on 04/28/26 at 1:45 P.M. verified staff were not following provider's orders and the order for the dressing change was to be completed daily on day shift. The DON confirmed nursing staff were signing off completion of dressing changes when they were not being performed as ordered.Review of facility policy titled, Wound Treatment Management, revised 02/14/24, revealed wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to identify and document individualized trauma triggers and coping mechanisms for a resident with a diagnosed traumaˆrelated disorder. This affected one resident (#3) of two residents reviewed for mood/behavior. The facility census was 58.Findings include:Record review revealed Resident #3 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease, type II diabetes hypertension, congestive heart failure, non-rheumatic aorta insufficiency, and post-traumatic stress disorder (PTSD). Review of the plan revealed Resident #3 was a trauma survivor related to military service with a goal that coping mechanisms would be identified. The interventions included identifying triggers related to past trauma; however, none were identified in the care plan.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was moderately cognitively impaired and required maximal assistance for toileting and transfers and moderate assistance for dressing. Resident #11 also had PTSD listed as a psychiatric/mood disorder. Interview on 04/29/26 at 8:47 A.M. with Resident #3 revealed his triggers included certain television shows, sudden loud noises such as the fire alarm, when someone entered his room quietly and startled him because he felt like someone was sneaking up on him. Resident #3 also reported reciting The Lord's Prayer as a coping mechanism for his PTSD. Interview on 04/30/26 with the Director of Nursing (DON) confirmed triggers and coping mechanisms had not been identified for Resident #3.