

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Highland Square Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1211 W Market St Akron, OH 44313	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure residents attended physician ordered follow-up appointments status-post hospitalization and failed to ensure treatment orders were written for wound care. This affected one resident (Resident #65) of three residents reviewed for appointments and one resident (Resident #49) of four residents reviewed for wound care. The facility census was 64. Findings include: 1. Review of the closed medical record for Resident #65 revealed an admission date of 02/20/25 and a discharge date of 07/14/25. Diagnoses included congestive heart failure (CHF), ischemic cardiomyopathy, atherosclerotic heart disease, history of sudden cardiac arrest, and presence of coronary angioplasty implant and graft.</p> <p>Review of the progress note dated 06/10/25 at 12:41 P.M. revealed the Licensed Practical Nurse (LPN) #372 received a call from the nurse at the hospital regarding Resident #65 returning to the facility. The resident was admitted on [DATE] for shortness of breath (sob) and CHF exacerbation. Resident #65 was being treated with intravenous (IV) Lasix (diuretic) and would be receiving oral torsemide (diuretic) at the facility. Resident #65's pick up time from the hospital was at 1:00 P.M.</p> <p>Review of the hospital discharge summary with a discharge date of 06/10/25 revealed under future appointments was a follow-up appointment with cardiology in two weeks.</p> <p>Review of the physician orders revealed a follow-up with cardiology in two weeks dated 06/10/25.</p> <p>Further review of Resident #65's medical revealed no documentation that the follow-up cardiology appointment was scheduled or the resident went to the cardiology appointment.</p> <p>Interview on 08/20/25 at 10:51 A.M. with LPN #372 verified he was the nurse on duty when Resident #65 returned from the hospital on [DATE]. LPN #372 verified he entered the physician order into the medical record on 06/10/25 for the cardiology follow-up appointment but could not recall if he scheduled the appointment or if the resident went to the appointment.</p> <p>Interview on 08/20/25 at 12:22 P.M. with the Director of Nursing (DON) revealed she was unable to verify Resident #65's cardiology follow-up appointment was scheduled or if he went to an appointment with cardiology.</p> <p>2. Review of the medical record for Resident #49 revealed an admission date of 06/17/25 with diagnosis including traumatic brain injury and multiple fractures after being hit by a motor vehicle.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission minimum data set (MDS) assessment dated [DATE] revealed moderate cognitive impairment, and the resident required set-up for assistance for eating, and the resident was dependent upon staff for all activities of daily living (ADLs) performance. Additionally, the resident had bilateral upper and lower extremity range of motion impairment and was frequently incontinent of bowel and bladder.</p> <p>Review of facility provided list of residents receiving wound care revealed Resident #49 was receiving wound care for an open area on his left shin.</p> <p>A review of the care plan for Resident #49 revealed no evidence of any impaired skin integrity or treatment to the resident's left shin.</p> <p>A review of wound care notes from the visiting wound care service dated 07/31/25 revealed Resident #49 had an open area on his left shin. The wound service noted the open area was a reopening of a surgical wound from surgical repair of their left tibia fracture. The wound service recommended daily cleansing of wound, apply mesalt, and cover with a super absorbent dressing.</p> <p>An observation on 08/20/25 at 9:13 A.M. for Resident #49's wound care with Wound Nurse (WN) #315 revealed the nurse cleansed the wound with normal saline, place mesalt on the wound and covered it with a super absorbent pad. After the wound care was performed, it was verified there was no order in the medical record for Resident #49 to receive wound care.</p> <p>An interview on 08/20/25 at 3:15 P.M. with WN #315 verified the order for wound care was not in the medical record and was not addressed in Resident #49's comprehensive care plan. WN #315 shared she knew what the visiting wound services wanted for a treatment to the resident's shin because she rounded with them weekly, received the wound care notes and put the orders into the medical record. Further interview with WN #315 shared they missed putting the order for wound care into the system.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number 2579281 and Complaint Number 2575188.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>Based on closed record review and interview the facility failed to ensure adequate follow-up regarding optometry services. This affected one resident (#65) of three residents reviewed for ancillary services. The facility census was 64. Findings include: Review of the closed medical record for Resident #65 revealed an admission date of 02/20/25 and a discharge date of 07/14/25. Diagnoses included congestive heart failure (CHF), ischemic cardiomyopathy, atherosclerotic heart disease, history of sudden cardiac arrest, and presence of coronary angioplasty implant and graft. Further review of Resident #65's medical record including care plan revealed no documentation related to vision or optometry services. Interview on 08/20/25 at 11:05 A.M. with Social Services Director (SSD) #369 verified Resident #65 received glasses from the facility's contracted optometry service. SSD #369 stated she personally gave Resident #65 his glasses and initially he had no concerns. SSD #369 stated sometime later she was informed by Resident #65's family that he was unable to see out of the glasses. SSD #369 stated she contacted the contracted optometry service to add the resident to the list to be seen at the next visit. SSD #369 stated she did not follow-up with the resident and was unsure if he was seen by the contracted optometry services the next time they were in the facility. SSD #369 stated she had not documented anything related to Resident #369's glasses in his medical record. SSD #369 also stated she had not received any of the visit reports from the contacted optometry service since she started working at the facility at the end of March 2025. This deficiency represents non-compliance investigated under Complaint Number 2575188.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview and policy review the facility failed to ensure infection control guidelines were followed during incontinence care for Resident #7. This affected one resident (Resident #7) of three residents reviewed for activities of daily living. The facility census was 64. Findings include: A review of the medical record for Resident #7 revealed an admission date of 03/14/25 with diagnosis of left side hemiplegia, cognitive communication deficit, atrial fibrillation, and hypertension. A review of the admission minimum data set (MDS) assessment dated [DATE] revealed Resident #7 had a moderate cognitive deficit, impaired range of motion of his left upper and lower extremities, was dependent upon staff for performance of all activities of daily living, and was always incontinent of bowel and bladder. A review of Resident #7 physician orders revealed an order dated 03/25/25 for enhanced barrier precautions to be utilized during personal care due to a gastrostomy tube (G-tube) (a thin tube that is inserted through the abdomen into the stomach used for fluids and nutrition for individuals who are not able to eat or drink). A review of the care plan for Resident #7 revealed incontinence was to be managed by staff for Resident #7 and staff were to don personal protective equipment (PPE) including gloves and a gown while performing personal care. An observation on 08/19/25 at 1:38 P.M. with Certified Nursing Assistant (CNA) #388 revealed incontinence care provided to Resident #7. CNA #388 donned gloves but no gown. After removing soiled linens from the bed, and a brief soiled with fecal matter, CNA #388 placed the soiled items on the floor, next to the resident's bed. Once CNA #388 completed cleansed the resident's groin and buttocks, the CNA, while still wearing the same gloves used to remove feces from Resident #7's perineal area, touched clean linens and other surfaces in the room including the over bed table and bed controls. The CNA did not remove their soiled gloves and perform hand hygiene before touching clean linens and other surfaces in the resident's room. An interview with CNA #388 verified that they were aware that Resident #7 was on enhanced barrier precautions and they did not put on a gown to provide the resident care. Further interview verified they had placed contaminated items on the floor and did not remove their gloves and perform hand hygiene before touching clean surfaces in the resident's room. Review of facility policy titled Enhance Barrier Precaution (EBP) Policy and Procedure dated 04/01/14 revealed gown and gloves were required during high-contact resident care activities such as dressing, bathing/showering, transferring, changing linens, changing briefs or assisting with toileting, and wound care. The purpose of EBP is to minimize the spread of multidrug resistant organisms (MDRO) and are implemented for residents with wounds, indwelling medical devices regardless of MDRO. Review of facility policy titled Perineal Care last revised 10/10 revealed after cleansing the rectal area and disposing of disposable items, the caregiver is to remove their gloves and perform hand hygiene before repositioning bed linens. No instructions were given related to what to do with soiled linen and briefs once removed from the bed and resident. This deficiency is an incidental finding discovered during the complaint investigation.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observations, interview, and review of the facility policy, the facility failed to provide a clean, sanitary and well maintained environment. This affected eight residents (Resident #7, #27, #36, #37, #39, #44, #46 and #63) but had the potential to affect all residents. The facility census was 64. Findings include: 1. Observation on 08/19/25 at 10:00 A.M. of Resident #36's ceiling revealed a half basketball sized bubble of plaster/paint that was broken open in the center. At this time Assistant Director of Nursing (ADON) #336 verified the observation but stated she was not sure how long it had been there as she was rarely on this unit. 2. Tour of the facility on 08/19/25 between 10:12 A.M. until approximately 10:30 A.M. with the Administrator revealed the following observations:a. On the first floor the carpet was moderately soiled throughout. Dried pink and yellow paint was observed on the bottom part of Resident #39's door, a large pink stain on the floor near Resident #37's room and peeling wallpaper near Resident #48's room.b. Observation of Resident #36's ceiling revealed the half basketball sized bubble was no longer present but a ring of plaster/paint remained. The Administrator stated he broke the bulging piece from the ceiling. Also noted in Resident #36's room was peeling wallpaper to the left of the air conditioning unit and to the right, lower part of the wall was torn wallpaper and crumbled pieces of wall.c. Observation of Resident #44's room revealed multiple, large brown water stains and peeling paint on the ceiling in the right corner near the window. The base board behind the bed was bulging from the wall and the wallpaper behind the bed was ripped.d. Observation of the inside of the elevator on the right side was multiple long scratches in the walls and the floor of the elevator was dirty with multiple areas of missing flooring. The elevator on the left side also had multiple long scratches in the wall. The grooves in the silver entryway to both elevators were heavily soiled .e. Observation of the third floor exiting from the elevator on the left were heavy, black marks that lead from the elevator through the walk through by the nurses' station. There were several markings on the floor causing the floor to have soiled appearance. Theses marking also led into Resident #63's room. The wall of the walk through near the nurses' station was heavily scuffed with dark markings.f. Observation of the second floor revealed the wallpaper near Resident #42's room was pulling off the wall at the seams and there was a baseball size patched hole with a tear in it. The wall of the walk through near the nurses' station was heavily scuffed, scratched and dirty.Interview on 08/19/25 with the Administrator verified all the above findings at the time of the tour. 3. Observation on 08/19/25 at 12:31 P.M. of Resident #7's room revealed the base board behind his bed was barely hanging onto the wall. The wall behind the base board was crumbling with multiple holes and foam exposed. Interview on 08/19/25 at 12:39 P.M. with the Administrator verified the wall in Resident #7's room.4. Observation on 08/20/25 at 9:09 A.M. in Resident #27 and #46's room revealed a baseball sized hole in the bottom portion of the wall near the base board where the tv and tv stand were located.Interview on 08/20/25 at 9:15 A.M. with Certified Nursing Assistant (CNA) #303 verified the baseball sized hole in the wall of Resident #27 and #46 's room. Review of the policy Cleaning and Disinfection of Environmental Surfaces, revised June 2009 revealed housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.This deficiency represents non-compliance investigated under Master Complaint Number 2579281 and Complaint Number 2575188.</p>		