

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/12/2025
NAME OF PROVIDER OR SUPPLIER  Regency Care of Copley		STREET ADDRESS, CITY, STATE, ZIP CODE  2631 Copley Road Akron, OH 44321	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observation, interview, review of nursing schedules for 07/15/25 through 07/21/25, review of the purchase order and receipt from facility maintenance, review of facility policies, and review of the facility investigation of self-reported incident (SRI) number 263186, the facility failed to ensure a thorough investigation and documentation was completed related to allegations of inadequate care of Resident #4 who had a tracheostomy. This affected one (Resident #4) of two residents reviewed for tracheostomy care and had the potential to affect two (Residents #4 and #23) identified by the facility with tracheostomies. The facility census was 46. Findings include: Review of the medical record for the Resident #4 revealed an admission date of 01/10/25 with diagnoses including acute respiratory failure with hypoxia, cerebral infarction, type two diabetes mellitus, atrial fibrillation, paranoid schizophrenia, post-traumatic subdural hemorrhage, lymphangioma, sepsis, encephalopathy, gastrostomy status, and encounter for attention to tracheostomy. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 07/10/25 revealed Resident #4 had severely impaired cognition and was dependent for all activities of daily living (ADL), including, bathing, dressing, personal hygiene, oral hygiene, bed mobility, and transfers. Further review of the MDS revealed Resident #4 required oxygen therapy, suctioning, and tracheostomy (trach) care. Review of all progress notes from 06/07/25 through 08/07/25 revealed no mention of the presence of maggots around the trach ties or trach stoma or of any unusual substance noted around the trach and surrounding area. Review of the assessments titled Respiratory Assessment/Vent Check completed on 07/17/25 at 7:26 A.M., 9:00 A.M., 10:36 A.M., and 2:15 P.M. revealed no mention of any unusual assessment criteria or occurrences related to Resident #4's trach or surrounding area from the previous shift (night shift on 07/16/25). There was no respiratory therapist on duty on night shifts to record assessments on the Respiratory Assessment/Vent Check form. Telephone interview on 08/07/25 at 12:59 P.M. with the Ombudsman confirmed allegations were received from two separate sources on 07/24/25 of improper care of a resident's tracheostomy (trach). The first source was anonymous and did not provide the name of the resident but included three photos which appeared to be maggots around a trach collar. The second source revealed they had been sent or shown pictures of Resident #4 with maggots around his trach ties. The Ombudsman further revealed an in-person visit was made to the facility on [DATE] where it was confirmed the facility had been informed of maggots being noted near Resident #4's trach between the night of 07/16/25 and the morning of 07/17/25 (a Wednesday night to Thursday morning shift) and the facility had not filed a SRI with the Ohio Department of Health. During the on-site visit, the Ombudsman further found that the window to Resident #4's room had no screen at the time of the incident, and staff reported a wasp had previously been observed entering that window. Review of the facility incident log from 06/01/25 through 08/07/25 revealed no incidents or unusual occurrences were logged regarding trach care for Resident #4. Interview on 08/07/25 at 2:11 P.M. with the Licensed Nursing Home Administrator (LNHA) confirmed being alerted by the previous Director of Nursing (DON) #399 on the morning of 07/17/25 that there were some maggots noted on Resident #4 but that she had not seen them and did not see the picture of the maggots until shown by the Ombudsman on 07/24/25. During the interview, the LNHA confirmed the facility had not filed a SRI until after the Ombudsman was at the facility on 07/24/25. The LNHA confirmed a witness statement was never obtained from the nurse who initially discovered and reported the maggots, Licensed Practical Nurse (LPN) #325, and that previous DON #399 failed to do a proper investigation before employment ended at the facility. Review of the nursing scheduled from 07/15/25 through 07/17/25 confirmed LPN #325 worked the 7:00 P.M. to 7:00 A.M. shift on 07/15/25, 07/16/25, 07/19/25, and 07/20/25. Further review of the nursing schedules revealed a total of two nurses, Registered Nurse (RN) #337 and LPN#325) and six Certified Nurse Aides (CNAs #302, #326, #340, #375, #379, and #383) worked nightshift on 07/16/25. Review of the SRI investigation revealed only three witness statements, including an undated statement from LPN #366 who was not on duty the night of the alleged incident but noted an unsuccessful attempt to contact LPN #325, a statement from respiratory Therapist (RT) #385, who was not on duty on 07/16/25 or 07/17/25 and had not observed or include knowledge of any maggots, and a third statement, also written by LPN #366, detailing an interview conducted with LPN #321, who was on duty for day shift on 07/17/25. There was no witness statements obtained from any staff scheduled from 7:00 P.M. on 07/16/25 to 7:00 A.M. on 07/17/25 and no notes indicating attempts were made to contact any of the scheduled staff</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, medical record review, review of facility policies, and review of the facility investigation of self-reported incident (SRI) number 263186, the facility failed to ensure appropriate care and services were provided to Resident #4, who had a tracheostomy. This affected one resident (Resident #4) of two residents (residents #4 and #23) who were reviewed for appropriate tracheostomy care. The facility census was 46. Review of the medical record for Resident #4 revealed an admission date of 01/10/25 with diagnoses including acute respiratory failure with hypoxia, cerebral infarction, type two diabetes mellitus, atrial fibrillation, paranoid schizophrenia, post-traumatic subdural hemorrhage, lymphangioma, sepsis, encephalopathy, gastrostomy status, and encounter for attention to tracheostomy. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 07/10/25 revealed Resident #4 had severely impaired cognition and was dependent for all activities of daily living (ADL), including, bathing, dressing, personal hygiene, oral hygiene, bed mobility, and transfers. Further review of the MDS revealed Resident #4 required oxygen therapy, suctioning, and tracheostomy (trach) care. Review of the plan of care dated 01/10/24 to 10/12/25, last reviewed 07/18/25, revealed Resident #4 had a tracheostomy secondary to encephalopathy, acute and chronic respiratory failure, subdural hygroma, and cerebrovascular accident. Interventions included ensuring the trach ties were always secured, wearing a gown and gloves when providing direct care and tracheostomy care, monitoring and documenting respiratory status per orders, and specific instructions in the event of an unplanned decannulation (trach tube out/dislodged). There were no interventions specified for routine trach care or maintenance. Review of the current physician orders revealed an order dated 07/17/25 for Resident #4 to have trach care rendered every shift and as needed (PRN). Review of the previous trach care orders revealed an order dated from 01/10/25 through 07/17/25 for trach care daily and PRN. Additional tracheostomy-related orders for Resident #4 included: Change the trach tube every month starting on 01/10/25 and continuing monthly on the 10th each month and as needed (dated 01/10/25). Change the trach ties weekly every Monday on day shift and as needed (dated 01/10/25). Suction the trach every shift as needed (dated 01/10/25). Change the inner cannula daily with trach care and as needed (dated 01/27/25). Review of the treatment administration record (TAR) for July 2025 revealed documentation that trach care was performed once daily from 07/01/25 through 07/16/25 and then every shift starting with the night shift on 07/17/25. PRN trach-related documentation included trach tie changes on 07/17/25 and on 07/21/25 and triple antibiotic ointment application to the trach as needed for redness on 07/17/25 at 6:19 A.M. There was no documentation that additional trach care was performed on an as-needed basis from 07/01/25 through 07/31/25. Review of the nurses' notes dated 07/17/25 at 6:15 A.M. revealed Resident #4 had the trach ties changed with a note indicating the site was cleansed with normal saline, dried with gauze, triple antibiotic ointment was applied to the trach site, and the area was left open to air. The note revealed no description of the trach stoma or surrounding area or reason for the additional trach tie change. Review of a follow-up note dated 07/17/25 at 8:00 A.M. revealed Physician #395 was at the facility and was notified of excoriation underneath the trach ties and an order was given for mupirocin lidocaine 2-2% ointment to be applied four times a day for 14 days and that the resident representative for Resident #4 was notified of the new order. Review of all progress notes from 06/07/25 through 08/07/25 revealed no mention of the presence of maggots around the trach ties or trach stoma or of any unusual substance noted around the trach and surrounding area. Review of the assessments titled Respiratory Assessment/Vent Check completed on 07/17/25 at 7:26 A.M., 9:00 A.M., 10:36 A.M., and 2:15 P.M. revealed no mention of any unusual assessment criteria or occurrences related to Resident #4's trach or surrounding area. Interview on 08/07/25 at 10:22 A.M. with Registered Nurse (RN) #396 confirmed viewing video footage of maggots crawling around the neck, the trach, and under the trach ties on both sides of the neck of Resident #4 during the night shift on 07/16/25. RN #396 further stated the video was recorded by Licensed Practical Nurse (LPN) #325 and forwarded to the previous Director of Nursing (DON) #399 and the Licensed Nursing Home Administrator (LNHA). RN #396 revealed during the interview that the maggots were able to be removed by staff on duty, new trach ties were applied after cleaning Resident #4, and the physician was notified that maggots were found around the trach and neck of Resident #4. Telephone interview on 08/07/25 at 12:59 P.M. with the Ombudsman confirmed allegations were received from two separate sources on 07/24/25 of improper care of a resident's tracheostomy (trach). The first source was anonymous and did not</p>		