STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365324	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens of Belden Village	5005 Higbee Avenue NW Canton, OH 44718

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, facility policy review and interview, the facility failed to ensure Residents #64 and #66 were provided with dignity during meals. This finding affected two (Residents #64 and #66) of five residents reviewed for dignity and respect during meals. The facility census was 80.Findings include:1. Review of Resident #66's medical record revealed the resident was admitted on [DATE] with diagnoses including osteomyelitis of vertebra, dysphagia, generalized anxiety disorder, dementia, heart failure, unspecified psychosis, anemia, history of stroke, and history of venous thrombosis/embolism. Review of Resident #66's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #66's physician orders revealed an order dated 03/20/26 and again on 04/04/26 for a regular diet, mechanical soft texture with nectar thickened liquids consistency. Observation on 03/30/26 at 9:44 A.M. revealed Certified Nursing Assistant (CNA) #890 was standing beside Resident #66's bed feeding the resident eggs, hashbrowns and oatmeal. Interview on 03/30/26 at 9:45 A.M. with Licensed Practical Nurse (LPN) #882 confirmed there was a chair in the resident's room to sit down and assist the resident with the breakfast meal. 2. Review of Resident #64's medical record revealed the resident was admitted on [DATE] with diagnoses including hemiplegia, major depressive disorder and vascular dementia. Review of Resident #64's physician orders revealed an order dated 08/14/25 for a regular diet, regular texture with thin liquids consistency. Review of Resident #64's MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Observation on 03/31/26 at 7:56 A.M. revealed CNA #912 was standing beside Resident #64's bed feeding the resident eggs, hashbrowns and oatmeal. Interview on 03/31/26 at 8:00 A.M. with CNA #912 confirmed there was no chair in the resident's room to sit down and assist the resident with the breakfast meal. Review of the Assistance with Meals policy revised 07/2017 revealed residents shall receive assistance with meals in a manner that meets the individual needs of each resident. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365324	A. Building B. Wing	04/07/2026

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint Numbers 2725826 and 2579366.

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	365324	A. Building B. Wing	04/07/2026

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to revise the care plan to accurately reflect the status of Resident #26. This affected one (Resident #26) out of three residents reviewed for catheter use. The facility census was 80.Findings include: Review of the medical record for Resident #26 revealed an admission date of 10/09/25 with diagnoses including cellulitis of abdominal wall, chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, morbid obesity, depression, heart failure, chronic kidney disease (CKD) Stage III, gastro-esophageal reflux disease (GERD), hypothyroidism, restless legs syndrome, post-traumatic stress disorder (PTSD), generalized anxiety disorder, and bipolar disorder.Review of the catheter care plan dated 01/28/26 revealed Resident #26 had an indwelling catheter related to urinary retention. Interventions included 16 French 10 milliliter catheter with bag and tubing positioned below the level of the bladder and away from the entrance room door implemented 01/28/26, check tubing for kinks each shift implemented 01/28/26, maintain dignity cover over indwelling urinary catheter bag implemented 01/28/26, monitor and document intake and output per facility policy implemented 01/28/26, monitor for signs and symptoms of discomfort implemented 01/28/26, monitor and document for pain due to catheter implemented 01/28/26, and monitor and record signs and symptoms of urinary tract infections (UTI) and report to the physician implemented 01/28/26.Review of the progress note dated 02/26/26 at 1:04 P.M. revealed Resident #26's catheter balloon was out of the urethra. Resident #26 stated she was sore from having catheters placed so many times and she wanted a break.Review of the physician's orders for Resident #26 revealed the orders for urinary catheter maintenance and output monitoring were discontinued on 03/01/26, and no new catheter orders were implemented.On 04/01/26 at 2:56 P.M., an interview with Resident #26 stated she no longer had a catheter.On 04/02/26 at 9:52 A.M., an interview with Minimum Data Set (MDS) Nurse #831 verified Resident #26 had an active care plan for catheter use, and the care plan should have been discontinued because Resident #26 no longer had a catheter.This deficiency represents noncompliance investigated under Complaint Number 2725826.

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	365324	A. Building B. Wing	04/07/2026

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, facility policy review and interview, the facility failed to ensure Resident #64's eyes were free of debris and Resident #26 received showers as scheduled. This finding affected two (Residents #26 and #64) of four residents reviewed for activities of daily living (ADL). The facility census was 80.Findings include:1. Review of the medical record for Resident #26 revealed an admission date of 10/09/25 with diagnoses including cellulitis of abdominal wall, chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, morbid obesity, depression, heart failure, chronic kidney disease (CKD) Stage III, gastro-esophageal reflux disease (GERD), hypothyroidism, restless legs syndrome, post-traumatic stress disorder (PTSD), generalized anxiety disorder, and bipolar disorder. Review of the care plan dated 10/20/25 revealed Resident #26 had a self-care deficit related to decreased functional mobility. Interventions included grooming and hygiene assistance of one staff implemented 10/20/25, set up bath items and put out clothes as needed implemented 10/20/25, and provide transfer assistance of one to two staff as required implemented 10/20/25. Review of the care plan dated 10/20/25 revealed Resident #26 had an ADL self-care performance deficit related to decreased functional mobility. Interventions included bathing or showering and avoiding scrubbing dry sensitive skin implemented 10/20/25, provide sponge bath when a full bath or shower could not be tolerated implemented 10/20/25, and washing hair once weekly per resident preference implemented 03/25/26. Review of the paper shower sheets for Resident #26 revealed preferred bathing days were Tuesdays and Fridays and bathing was performed on 01/02/26, 01/06/26, 01/17/26, 01/30/26, 02/01/26, 02/06/26, 02/10/26, 02/22/26, 03/04/26, 03/10/26, 03/11/26, 03/13/26, 03/18/26, 03/24/26, 03/28/26, and 03/30/26. Review of the shower documentation under the nurse aide tasks in the electronic medical record (EMR) revealed showering or bathing was marked as not applicable on 03/08/26, 03/12/26, 03/16/26, 03/22/26, 04/04/26, and 04/05/26, and there were no documented showers, tub baths, bed baths, or refusals documented in previous 30 days. There was no evidence of bathing performed on or around 01/09/26, 01/13/26, 01/20/26, 01/23/26, 01/27/26, 02/13/26, 02/17/26, 02/27/26, 03/06/26, and 03/20/26. The showering and bathing documentation provided by the facility indicated bathing was performed for Resident #26 on 16 days out of 26 scheduled opportunities between 01/01/26 and 03/31/26. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had no cognitive impairment and was dependent on staff for showering and bathing. Review of the progress notes from 01/01/2026 through 03/30/2026 revealed no evidence of Resident #26 refusing showers. On 04/01/26 at 2:47 P.M., an interview with Resident #26 stated she had concerns with receiving bathing and hygiene assistance. On 04/06/26 at 9:22 A.M., an interview with Assistant Director of Nursing (ADON) #893 verified the showering and bathing documentation for Resident #26. ADON #893 claimed Resident #26 got a bed bath every day and staff must not have documented it. (continued on next page)

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	365324	A. Building B. Wing	04/07/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/06/26 at 10:57 A.M., an interview with the Director of Nursing (DON) confirmed the paper documentation provided for Resident #26 included a paper shower sheets with multiple bathing days documented that spanned from the beginning of January 2026 through the end of February 2026 and a second paper shower sheet with multiple bathing days documented that spanned from the beginning of March 2026 through the end of March 2026. The DON claimed there must be missing documentation. On 04/06/26 at 11:08 A.M., an interview with Regional Clinical Director (RCD) #952 verified the bathing documentation provided for Resident #26. RCD #952 also stated Resident #26 received a bed bath as part of the daily ADL care and staff were not documenting it every day, they were only documenting it on scheduled shower days. RCD #952 also confirmed there were no documented refusals of bathing for Resident #26. Review of the facility's policy titled Giving a Bed bath, dated October 2010, revealed the purpose of the procedure was to promote cleanliness and provide comfort to the resident. In preparation, staff were to review the resident's care plan to assess for any special needs including information about the type of bath to be provided, amount of assistance needed, limitation in positions or activity, skin care products to use, and any other special considerations. The date and time the bed bath was performed, the name and title of the staff performing the bed bath, assessment data obtained during the bed bath, the resident's tolerance of the bed bath, refusals of bed baths as applicable, and the signature and title of the person recording the bed bath should all be documented in the resident's ADL record and the medical record. 2. Review of Resident #64's medical record revealed the resident was admitted on [DATE] with diagnoses including muscle weakness, essential hypertension and major depressive disorder. The resident resided on the secured memory care unit (SMCU). Review of Resident #64's physician orders revealed an order dated 03/01/25 for refresh eye ointment at bedtime for both eyes for dry eyes; and an order dated 02/23/26 to instill baby shampoo infant care products in both eyes every morning and at bedtime for dry eyes. Apply to eyelids, dilute and use to clean eyes. Review of Resident #64's Annual MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. She was dependent on staff for personal hygiene and bathing. Observation on 03/30/26 at 8:28 A.M. revealed Resident #64 was sitting in the television area in a wheelchair. The resident's bilateral eyes appeared matted with debris. Interview at the time of the observation with Regional Director of Operations (RDO) #916 confirmed the observation. Observation on 03/31/26 at 8:43 A.M. revealed Certified Nursing Assistant (CNA) #825 was transporting the resident into the common lounge area in a wheelchair. The resident's bilateral eyes appeared matted. Interview on 03/31/26 at 8:44 A.M. with CNA #825 revealed she would clean the resident's eyes later because the nurse was putting ointments on the resident's eyes. Interview on 03/31/26 at 8:45 A.M. with Registered Nurse (RN) #867 confirmed Resident #64's bilateral eyes were to be cleaned with baby shampoo which the CNAs could perform. Resident #64 confirmed the resident had matted eyes and it was a chronic condition. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/01/26 at 8:13 a.m. revealed Resident #64 was seated in a wheelchair in the television area of the SMCU. Both eyes appeared crusted. The resident did not exhibit behaviors. Review of the Giving a Bed bath policy revised 10/2010 revealed to place a towel over the resident's chest, make a mitten out of the washcloth, wash the resident's eyes from the nose to the outside of the face using water only, after washing one eye, fold the wash cloth and wash the other eye, wash the resident's face. This deficiency represents non-compliance investigated under Complaint Numbers 2725826, 2721789 and 1282446 (OH00166150).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 medical record review, observation, hospital record review, review of guidance from the American Diabetes Association (ADA), review of guidance from the Centers for Disease Control and Prevention (CDC), review of guidance from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), review of guidance from the National Institutes of Health (NIH) and National Library of Medicine's MedlinePlus information, facility policy review and interviews, the facility failed to adequately monitor Resident #42's diabetes; failed to ensure medications were available for Resident #99's use; failed to ensure adequate indication for blood sugar testing (finger sticks) for Resident #33; failed to ensure skin assessments and treatments were in place for Residents #27, #35 and #62; failed to ensure testing instructions were followed for Resident #7; and failed to ensure urinalysis lab testing was completed as ordered for Resident #6. This affected eight (Residents #42, #99, #33, #27, #35, #62, #7, and #6) of 36 residents reviewed for quality of care. The facility census was 80.Findings include: 1. Review of the medical record for Resident #42 revealed an admission date of 01/09/26 with diagnoses including type two diabetes mellitus, acute kidney failure, chronic kidney disease (CKD) Stage III, vascular dementia, and cognitive communication deficit. Review of the hospital records dated 12/29/25 through 01/09/26 (prior to admission) revealed Resident #42 had blood sugar levels ranging from 100 to 294 milligrams per deciliter (mg/dL), had a urine glucose reading of 3+, received insulin glargine (long-acting insulin)10 units daily at bedtime, insulin lispro (rapid-acting insulin) 0 to 5 units sliding scale with meals, and blood sugar Accu-Chek (finger stick blood sugar monitoring) four times daily before meals and at bedtime. The hospital nurse practitioner's note dated 12/31/25 at 5:29 P.M. indicated Resident #42's Jardiance (oral medication to manage blood sugars) and Glipizide (oral medication to manage blood sugars) were on hold and were to be resumed upon discharge. Review of the hospital Discharge summary dated [DATE] indicated Resident #42's home medications were resumed upon discharge to skilled nursing facility. There was no Hemoglobin A1C (laboratory test that measures average blood sugar levels over the past two to three months, indicating the percentage of hemoglobin coated with sugar) in the hospital records. Review of the care plan created 01/12/26 revealed Resident #42 was at risk for hypoglycemia and hyperglycemia related to diabetes mellitus. Interventions included providing diabetes medications as ordered and monitoring for side effects and effectiveness implemented 01/12/26, educating the resident and family on the correct protocol for glucose monitoring and insulin injections effective 01/12/26, collect fasting serum blood sugars as ordered effective 01/12/26, identify areas of non-compliance or other difficulties in resident diabetic management effective 01/12/26, monitor and document the resident and family's ability to manage the treatment program effective 01/12/26, monitor and document any signs or symptoms of hyperglycemia or hypoglycemia effective 01/12/26, and monitor and document compliance with diet and document any problems effective 01/12/26. Review of the physician's note dated 01/19/26 indicated Resident #42 was doing okay, diabetic with good control, medications included Glyburide (oral medication to manage blood sugars) 5 milligrams (mg) and Metformin (oral medication to manage blood sugars) 500 mg, and the weight listed on the physician's note was 149 pounds obtained 08/22/14. The physician's assessments included hypertension, acute kidney failure, and anxiety disorder with the plan to continue with present care. There was no assessment or plan listed for diabetes monitoring. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had moderately impaired cognition. A modification of the quarterly MDS assessment captured (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #42's diagnosis of diabetes mellitus. Review of the physician's note dated 02/14/26 indicated Resident #42 was seen for a monthly follow-up, diabetic with good control, medications included Glyburide 5 mg and Metformin 500 mg, and the weight listed on the physician's note was 149 pounds obtained 08/22/14. The physician's assessments included vascular dementia, hypertension, and hypothyroidism with the plan to continue with present care. There was no assessment or plan listed for diabetes monitoring. Review of the physician's note dated 03/04/26 indicated Resident #42 was seen for a follow-up, doing okay, diabetic with good control, medications included Glyburide 5 mg and Metformin 500 mg, and the weight listed on the physician's note was 149 pounds obtained 08/22/14. The physician's assessments included vascular dementia, anxiety disorder, and hypertension with the plan to continue with present care. There was no assessment or plan listed for diabetes monitoring. Review of the physician's note dated 03/10/26 indicated Resident #42 was seen for a follow-up, diabetic with good control, medications included Glyburide 5 mg and Metformin 500 mg, and the weight listed on the physician's note was 149 pounds obtained 08/22/14. The physician's assessments included vascular dementia, hypertension, and hypothyroidism with the plan to continue with present care. There was no assessment or plan listed for diabetes monitoring. Review of the physician's note dated 03/16/26 indicated Resident #42 was seen for a follow-up, diabetic with good control, medications included Glyburide 5 mg and Metformin 500 mg, and the weight listed on the physician's note was 149 pounds obtained 08/22/14. The physician's assessments included vascular dementia, anxiety disorder, and hypertension with the plan to continue with present care. There was no assessment or plan listed for diabetes monitoring. Review of the physician's note dated 03/23/26 indicated Resident #42 was seen for a cough and shortness of breath, diabetic with good control, medications included Glyburide 5 mg and Metformin 500 mg, and the weight listed on the physician's note was 149 pounds obtained 08/22/14. The physician's assessments included cough with plan for chest x-ray and Mucinex (expectorant) for five days, and hypertension and hypothyroidism with the plan to continue with present care. There was no assessment or plan listed for diabetes monitoring. Review of the physician's orders for Resident #42 revealed there were no orders for blood sugar checks or anti-diabetic medications (including insulin, Glyburide, Metformin, Jardiance, and Glipizide) from 01/09/26 through 03/23/26. Further review of the physician's orders revealed blood sugar checks twice daily was ordered 03/24/26, insulin glargine 20 units injected daily at bedtime was ordered 03/26/26, and Farxiga (oral medication to manage blood sugars) 10 mg once daily by mouth was ordered 03/26/26. Review of the vital signs for Resident #42 revealed there were no blood glucose readings obtained from 01/09/26 through 03/23/26. On 03/24/26, Resident #42's blood glucose was 582 mg/dL. Review of the laboratory results for Resident #42 revealed the sample collected on 03/23/26 and resulted on 03/24/26 indicated a blood glucose of 425 mg/dL, which the report indicated was high compared to the normal range of 65 to 99 mg/dL for fasting results and 65 to 125 mg/dL for non-fasting results; a hemoglobin A1C of 16.7%, which the report indicated was high compared to the normal range of 4.1% to 6.1%; and the mean blood glucose was 433 mg/dL, which was flagged as high compared to the normal range of 70 to 120 mg/dL. The report indicated the hemoglobin A1C result (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was verified by repeat analysis. Further review of the laboratory results for Resident #42 revealed the sample collected on 03/25/26 and resulted on 03/26/26 indicated a blood glucose of 447 mg/dL, which the report indicated was high compared to the normal range of 65 to 99 mg/dL for fasting results and 65 to 125 mg/dL for non-fasting results; a hemoglobin A1C of 17.0%, which the report indicated was high compared to the normal range of 4.1% to 6.1%; and the mean blood glucose was 441 mg/dL, which was flagged as high compared to the normal range of 70 to 120 mg/dL. The report indicated the hemoglobin A1C result was verified by repeat analysis. Review of the progress note dated 03/26/26 at 7:44 P.M. revealed Resident #42's A1C was 17% and Physician #950 was notified. New orders were provided for insulin glargine 20 units once daily at bedtime and Farxiga 10 mg once daily. On 03/31/26 at 9:19 A.M., an interview with Assistant Director of Nursing (ADON) #893 stated it was standard protocol for diabetics to get finger stick blood sugars. On 03/31/26 at 4:15 P.M., an interview with Regional Director of Operations (RDO) #916 and Regional Clinical Director (RCD) #952 stated the hospital had discontinued all of Resident #42's diabetes medications and insulin prior to sending the resident to the facility, and there were no hospital discharge orders for blood sugar checks. On 04/01/26 at 8:52 A.M., an interview with Physician #950 stated it was his protocol that anyone who admitted with a diagnosis of diabetes got blood sugar checks upon admission, and that should have been established for Resident #42. Physician #950 further stated Resident #42 should have been getting blood sugars since admission to establish a baseline. On 04/01/26 at 9:30 A.M., an interview with ADON #893 verified Resident #42 did not have any blood sugar checks prior to 03/24/26. ADON #893 claimed she misspoke previously because it was not the protocol to do blood sugar checks on all diabetics. On 04/01/26 at 1:46 P.M., an interview with RDO #916 verified Physician #950's notes (01/19/26 through 03/23/26) all indicated Resident #42 had good control of diabetes, indicated Resident #42 had medications including Glyburide and Metformin, and there was no evidence that diabetes monitoring occurred until Resident #42's A1C was obtained and resulted at 17%. On 04/01/26 at 1:48 P.M., an interview with RCD #952 stated Physician #950 did not have any standing orders at the facility and ADON #893 had reported that Physician #950 verbally instructed her of standing orders. RCD #952 also stated because of the concern identified with Resident #42's diabetes management, a full audit was conducted on all residents with diabetes to assess for any concerns with blood sugar control. RCD #952 confirmed Physician #950's notes for Resident #42 had discrepancies including listing Glyburide and Metformin under the medications, listing the most recent weight as 149 pounds obtained in 2014 and not addressing the change of condition that occurred with Resident #42. RCD #952 said the facility was in the process of looking for a new house physician because of Physician #950's discrepancies and lack of documentation. Review of the urinalysis results dated 04/02/26 revealed Resident #42 had a urine glucose reading of 4+, which had increased from the 3+ obtained in the hospital prior to admission to the facility. (continued on next page)

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	365324	A. Building B. Wing	04/07/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/07/26 at 10:07 A.M., an interview with RCD #952 stated Resident #42's daughter informed the facility that Resident #42 had an endocrinologist that the facility could follow up with if there were concerns with Resident #42's diabetes. RCD #952 stated prior to that, the facility had no idea Resident #42 had an endocrinologist. On 04/07/26 at 10:40 A.M., an interview with the Administrator, RDO #916, and RCD #952 claimed that no harm occurred to Resident #42 because the facility nursing staff followed the physician's orders since admission and they responded appropriately when the elevated blood sugar was identified. On 04/07/26 at 12:02 P.M., an interview with Physician #950 stated there were no A1C results available for Resident #42 upon admission. Physician #950 recanted his previous statement, now claiming there was no protocol for checking blood sugars on admission for residents with diabetes unless the hospital sends them with orders to check the blood sugar. Physician #950 stated if residents with diabetes were admitted from the hospital with no orders for insulin or blood sugar checks, it was assumed their diabetes was well controlled. When asked how he knew Resident #42's diabetes was well controlled as indicated on his notes for the three months Resident #42 had been in the facility since they were not doing blood sugar checks, Physician #950 again stated if they were sent from the hospital with no orders for insulin or blood sugar checks then it was assumed they were well controlled. Physician #950 also stated he did not review the hospital documentation for Resident #42 upon admission; he only reviewed the discharge summary and discharge orders. On 04/07/26 at 12:25 P.M., an interview with Resident #42's daughter stated Resident #42 had been diabetic for many decades and was taking Jardiance and Glipizide at home to manage diabetes. Resident #42's daughter said when the resident admitted to the facility, she asked about the diabetic medications and the facility informed her Resident #42 was not ordered any diabetic medications. Resident #42's daughter stated she informed the facility which diabetic medications the resident was supposed to be on, and the facility did not implement those orders, instead claiming the facility said they were managing through diet. Resident #42's daughter stated she had been begging the facility to obtain a hemoglobin A1C since admission, and when they finally obtained it, it was off the charts. Review of the facility's policy titled Nursing Care of the Resident with Diabetes Mellitus, dated December 2015, indicated the purpose of the policy was to help residents control diabetes, prevent recurrent hyperglycemia or hypoglycemia, and recognize and manage the treatment of complications commonly associated with diabetes. Hyperglycemia was defined as a blood sugar above target levels with symptoms including lethargy and loss of appetite. Prolonged poorly controlled diabetes could lead to other complications such as cardiovascular disease, cerebrovascular disease, kidney disease, glaucoma, cataracts, retinopathy, blindness, nerve damage, foot complications, skin problems, and gastroparesis. The management of individuals with diabetes should follow relevant protocols and guidelines for glucose monitoring, the physician should order the frequency of glucose monitoring, residents whose blood sugar was poorly controlled or those taking insulin may require more frequent monitoring, finger sticks measure the current blood glucose levels with normal ranges defined as 80 to 130 mg/dL before meals and less than 180 mg/dL after meals, hyperglycemia would be anything above the target reference range, and A1C measures the average blood glucose over two to three months and was a better estimate of treatment efficacy with healthy diabetic adults having an A1C value of less than 6.5%. Review of the American Diabetes Association's (ADA's) publication titled Understanding Your A1C Test, not dated, revealed the A1C blood test indicated what the average blood sugar levels had been for the past two to three months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365324	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens of Belden Village	5005 Higbee Avenue NW Canton, OH 44718

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the ADA's information on A1C and estimated average glucose (eAG), retrieved from https://diabetes.org/A1C-eag-conversion-calculator on 04/06/26, revealed an A1C level of 17% converted to an estimated average glucose of 441 mg/dL. The ADA's website indicated the A1C test gave a picture of the average blood glucose control for the previous two to three months, providing a good idea of how well diabetes was controlled. Review of the ADA's information on hyperglycemia (high blood glucose), retrieved from https://diabetes.org/living-with-diabetes/treatment-care/hyperglycemia on 04/06/26, revealed hyperglycemia could be a serious problem if left untreated. The ADA's website indicated part of managing diabetes was checking blood glucose often and treating high blood glucose early to help avoid problems associated with hyperglycemia. Review of the ADA's information on diabetes complications, retrieved from https://diabetes.org/about-diabetes/complications on 04/06/26, revealed diabetes could lead to severe and sometimes life-threatening complications, including heart, kidney, and eye disease as well as nerve damage. Review of the ADA's information on important health checks for people with diabetes, retrieved from https://diabetes.org/living-with-diabetes/newly-diagnosed/health-checks-people-with-diabetes on 04/06/26, revealed an A1C test was important for people with diabetes because it measured the average blood glucose level over the past two to three months and a high A1C was indicative of frequent high blood glucose, which increased risk for complications such as nerve damage, kidney disease, and vision impairment. The target range for A1C was less than 7% for many adults and a target of less than 8% may be appropriate for older adults who may have other health complications that require extra caution. Review of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) information on diabetes complications, retrieved from https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/all-content on 04/06/26, revealed high blood glucose from diabetes could damage the blood vessels and nerves that control the heart, cause diabetic neuropathy (nerve damage), increase risk of developing diabetic kidney disease, cause foot problems due to nerve damage, increase risk of developing diabetic eye diseases, increase risk of developing oral (mouth) diseases, and increase risk of developing urinary tract infections. Review of the Center for Disease Control and Prevention's (CDC's) information on diabetes, retrieved from https://www.cdc.gov/diabetes/about/about-type-2-diabetes.html on 04/06/26, revealed keeping blood sugar levels close to target will help prevent or delay diabetes complications. Review of the CDC's information on monitoring blood sugars with diabetes, retrieved from https://www.cdc.gov/diabetes/diabetes-testing/monitoring-blood-sugar.html on 04/06/26, revealed monitoring blood sugars was the most important thing to manage diabetes. The CDC's website indicated target ranges for blood sugars were 80 to 130 mg/dL before meals and below 180 mg/dL after meals. In addition to regular blood sugar monitoring, an A1C should be tested at least twice per year. Review of the National Institutes of Health (NIH) and National Library of Medicine's MedlinePlus information on glucose in urine testing, retrieved from https://medlineplus.gov/lab-tests/glucose-in-urine-test/ on 04/06/26, revealed urine normally (continued on next page)

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	365324	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365324	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens of Belden Village	5005 Higbee Avenue NW Canton, OH 44718

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	levels were ordered 25 days after Resident #33 was admitted . An interview on 04/01/26 at 11:27 A.M. MDS Nurse #831 verified the hospital records stated Resident #33 was a diabetic, but there was nothing to support Resident #33 being a diabetic. The MDS was coded as the resident not being a diabetic since there were no anti-glycemic medications ordered. An interview on 04/01/26 at 1:47 P.M. RCD #952 stated audits were being completed after it was discovered Resident #42 did not have blood glucose monitoring done. RCD #952 verified Resident #33 had a diagnosis of diabetes upon admission, and no blood glucose checks were ordered. RCD #952 also verified Resident #33's blood glucose levels were not recorded twice on 03/27/26 and once on 03/28/26. Review of the obtaining a fingerstick glucose level policy revised October 2011 revealed the person performing this procedure should record the following information in the resident's medical record: the blood sugar results. 4. Review of the medical record revealed Resident #62 was admitted on [DATE] with diagnoses that included cellulitis of right leg, type II diabetes, nondisplaced fracture of the head of the radius, and methicillin resistant staphylococcus aureus (MRSA) infection. The admission care plan dated 03/16/26 revealed Resident #62 had right ankle bruising/blister, left toes calloused, bruising to left knee and right antecubital, and a surgical wound to the left inner arm. Wound care documentation from an outside company dated 03/19/26 revealed Resident #62 was being seen for initial consultation for wound care to left foot, right foot, and right hand. Resident #62 had a diabetic ulcer to the fourth digit of the left foot that was scabbed/crusted and measured 0.5 centimeters (cm) long and 0.5 cm wide. The diabetic ulcer was to be cleansed with normal saline, painted with betadine (antiseptic), and left open to air every day and as needed. The resident had a diabetic ulcer to the right plantar foot that measured 1.0 cm long and 0.5 cm wide. The diabetic ulcer was to be cleansed with normal saline, painted with betadine, and left open to air every day and as needed. The resident also had a diabetic ulcer to the third digit of the right foot that measured 0.3 cm long and 0.3 cm wide. The diabetic ulcer was to be cleansed with normal saline, painted with betadine, and left open to air every day and as needed. Resident #62 had an arterial ulcer to the first digit of the right hand that measured 0.5 cm long and 0.5 cm wide. The wound was to be cleansed with normal saline, Skin-prep (sterile, alcohol-free wipes that create a protective barrier on skin, preventing irritation from adhesives and reducing friction) (per the resident's request) to the wound and left open to air on Monday, Wednesday, Friday, and as needed. The resident had an arterial ulcer to the second digit of the right hand that measured 0.3 cm long and 0.3 cm wide. The wound was to be cleansed with normal saline, Skin-prep (per the resident's request) to the wound and left open to air on Monday, Wednesday, Friday, and as needed. The admission MDS 3.0 assessment dated [DATE] revealed Resident #62 was cognitively intact. Resident #62 had two venous and arterial ulcers, a diabetic ulcer, and a surgical wound. Wound care documentation from an outside company dated 03/25/26 revealed Resident #62 had a diabetic ulcer to the fourth digit of the left foot that was scabbed/crusted and measured 0.8 cm long, 0.7 cm wide, and 0.3 cm deep. The diabetic ulcer was debrided with post debridement measurements of 0.5 cm long, 0.5 cm wide, and 0.3 cm deep. A new order for the ulcer to be cleansed with normal saline, petrolatum gauze (sterile, non-adherent dressing impregnated with petroleum jelly) applied, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365324	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and covered with bordered gauze dressing every Monday, Wednesday, Friday, and as needed. The resident had a diabetic ulcer to the right plantar foot that measured 1.0 cm long and 0.4 cm wide. The treatment was to continue as ordered. The resident diabetic ulcer to the third digit of the right foot was healed. Resident #62 had an arterial ulcer to the first digit of the right hand that measured 0.3 cm long and 0.3 cm wide. The treatment was to continue as ordered. The arterial ulcer to the second digit of the right hand was healed. A new diabetic ulcer to left planter foot was evaluated for the first time. The wound measured 2.5 cm long, 2.7 cm wide, and 0.2 cm deep. There was a scant amount of drainage. The ulcer was to be cleansed with normal saline, petrolatum gauze applied and covered with bordered gauze every Monday, Wednesday, Friday, and as needed. The plan of care dated 03/27/26 revealed Resident #62 was at risk for skin breakdown. Interventions included encouraging and assisting the resident to turn and reposition as tolerated and as needed and encouraging the resident to float his heels as tolerated. Resident #62 had a diabetic ulcer to fourth digit of left foot, right plantar, and right foot third digit. Interventions included monitoring/documenting the wound size, depth, margins, peri wound, skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, and gangrene, The progress of the wound healing was to be documented on an ongoing basis. Wound care documentation from an outside company dated 04/01/26 revealed Resident #62 had a diabetic ulcer to the fourth digit of the left foot that measured 0.4 cm long, 0.4 cm wide, and 0.2 cm deep. The treatment was to continue as ordered. The resident had a diabetic ulcer to the right plantar foot that was healed. Resident #62 had an arterial ulcer to the first digit of the right hand that was healed. A diabetic ulcer to left planter foot measured 1.2 cm long, 1.1 cm wide, and 0.2 cm deep. There was a light amount of drainage. The wound was debrided and the treatment was to continue as ordered. An interview on 04/01/26 at 12:20 P.M. Licensed Practical Nurse (LPN) #884 verified there were no measurements or treatments put in place for the diabetic, arterial, and venous ulcers Resident #62 had upon admission until the outside wound nurse visited on 03/19/26. LPN #884 stated it was a crazy week, and the outside wound nurse did not come on 03/18/26 as scheduled. Resident #62 was evaluated by the outside wound nurse on 03/19/26, and measurements and treatments were put into place at that time. LPN #884 stated the hospital did not put in exact orders for Resident #64's wound care, and the hospitals were awful about giving orders when they discharged residents. LPN #884 verified the nurses could have measured the areas and contacted the physician to obtain orders for the wounds. LPN #884 verified there were no treatment orders for Resident #62 until 03/20/26. An interview on 04/02/26 at 11:31 A.M. RCD #952 verified the outside wound company found the new wound to Resident #62's left foot on 03/25/26. RCD #952 could not answer why the nurses did not find the area to the planter area of the residents left foot. RCD #952 stated education had been started. 5. Review of Resident #27's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified dementia, muscle weakness and generalized anxiety. Resident #27 resides on the secured memory care unit (SMCU). Review of Resident #27's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #27's skin breakdown care plan revealed an intervention dated 03/05/26 to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365324	A. Building B. Wing	04/07/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observe skin for signs and symptoms of breakdown; document and notify the physician. Review of Resident #27's physician orders revealed an order dated 03/26/26 to cleanse the right breast with normal saline, apply triple antibiotic ointment and cover with a bordered foam dressing one time a day at 6:00 A.M. Observation 03/31/26 at 7:41 A.M. with Registered Nurse (RN) #867 revealed the resident's right breast had an undated clear Opsite (transparent film) type of dressing applied. Interview on 03/31/26 at 7:45 A.M. with RN #867 confirmed the resident was supposed to have a bordered foam dressing covering the wound and not a clear Opsite dressing on the wound. 6. Review of Resident #35's medical record revealed the resident was admitted on [DATE] with diagnoses including Alzheimer's disease, unspecified dementia and diabetes. Review of Resident #35's physician orders revealed an order dated 10/14/25 for weekly skin checks one time a day every Tuesday for skin prevention and monitoring. Complete weekly skin assessment in the electronic health record and document any new abnormal skin findings to the nurse practitioner/medical director. Review of Resident #35's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment. Review of Resident #35's MAR and treatment administration records (TAR) from 03/01/26 to 03/31/26 revealed no documented evidence weekly skin checks were completed on 03/03/26, 03/10/26, and 03/17/26. Observation on 03/30/26 at 9:06 A.M. with Certified Nursing Services (CNA) #912 revealed Resident #35 had a scabbed dime-sized open area on the right inner wrist. Interview on 03/31/26 at 7:32 A.M. with RN #867 confirmed the wound nurse was doing skin ch

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	365324	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure Resident #1's oxygen tubing was stored in the proper manner when not in use. This affected one (Resident #1) out of one reviewed for respiratory care. The facility census 80. Findings include: Review of the medical record revealed Resident #1 was admitted on [DATE] with diagnoses that included acute kidney failure, congestive heart failure (CHF), transient cerebral ischemic attack, and chronic obstructive pulmonary disease (COPD). A plan of care dated 04/12/24 revealed Resident #1 received oxygen therapy. Interventions included changing oxygen tubing and oxygen settings via nasal cannula as ordered. The Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 had severely impaired cognitive skills. Resident #1 received oxygen therapy. A physician order dated 01/08/26 revealed Resident #1's oxygen saturation was to be monitored every day and night shift. A physician order dated 02/11/26 revealed Resident #1 was ordered oxygen at two liters per minute via nasal canula every day and night shift and as needed for oxygen saturation below 90%. An observation on 03/30/26 at 7:54 A.M. revealed Resident #1 was lying in bed with a blanket over her. Resident #1's oxygen tubing was observed to be under the blanket at the bottom of the bed. An observation on 03/30/2026 at 10:50 A.M. revealed Resident #1's oxygen tubing was still observed to be under the blanket at the bottom of the bed. Certified Nursing Assistant (CNA) #832 verified Resident #1 should be wearing oxygen and the oxygen tubing should not be placed on the bed. CNA #832 verified Resident #1 was not able to remove oxygen tubing and place it under the blanket at the bottom of the bed. An interview on 03/31/26 at 12:42 P.M. Regional Director of Operations (RDO) #916 revealed the facility did not have a policy for the storage of oxygen tubing. RDO verified the nasal cannula should be in the resident's nares or stored appropriately if not in use.

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	365324	A. Building B. Wing	04/07/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure Resident #100 had pain medication available. This affected one (Resident #100) out of six residents reviewed for pain management. The facility census was 80. Findings include:Review of the medical record revealed Resident #100 was admitted on [DATE] with diagnoses that included cellulitis, type II diabetes, morbid obesity, ventral hernia with obstruction, and venous thrombosis and embolism. Resident #100 was discharged to the hospital on [DATE]. Review of the discharge record from the hospital revealed a paper copy of the prescription for oxycodone (opioid for severe pain) five milligram (mg) every six hours as needed for up to three days. A general progress note dated 07/19/25 at 8:54 A.M. revealed Resident #100 arrived at the facility via a stretcher on 07/18/25 at 8:30 P.M. from the hospital. The resident complained of pain and discomfort due to an abdominal incision. The nursing admit/readmit care plan dated 07/19/25 revealed Resident #100 rated pain a three on a scale of zero to ten with ten being the worst pain. Resident #100's pain goal was zero. Resident #100's pain began after surgery and lasted on and off for a few days. The quality of pain was described as sharp with medication and rest alleviating the pain. The pain affected sleep, mood, socialization, activity of daily living, and the physical activity and mobility. An interim care plan dated 07/19/25 revealed Resident #100 was not cognitively impaired. Medications and treatments included pain medications. The pain assessment dated [DATE] revealed Resident #100 had occasional pain that made it hard to sleep at night and limited day-to-day activities during the last five days. The resident rated pain a three on a scale of zero to ten. The resident's pain goal was zero. The Medicare 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #100 had modified independence with cognitive skills and did not receive scheduled or as needed pain medication. A general progress note dated 07/20/25 at 8:45 A.M. revealed Resident #100 became agitated and stated night shift was not friendly or helpful. Resident #100 was reassured that staff would help the resident get out of bed and get a shower. A general progress note dated 07/20/25 at 11:56 A.M. revealed the pharmacy was called about pulling Resident #100's pain medication. The pharmacy stated the paper prescription had not been received. The nurse faxed the paper prescription to the pharmacy. A general progress note dated 07/20/25 at 12:38 P.M. revealed the pharmacy stated they did not receive the paper prescription. The nurse resent the prescription to the pharmacy. A general progress note dated 07/20/25 at 1:40 P.M. revealed the pharmacy stated they still did not have a paper prescription. The nurse resent the paper prescription for the third time. A general progress note dated 07/20/25 at 3:00 P.M. revealed Resident #100 stated she could not breathe. The resident's oxygen saturation was 100% on room air. The resident's family was at bedside and called 911 while the nurse was assessing the resident. Review of the medication administration record (MAR) revealed Resident #100 received no as needed pain medication. The treatment administration record (TAR) revealed Resident #100 was to have pain assessed and monitored every shift. The TAR had a checkmark the evening of 07/19/25 and the morning of 07/20/25. The TAR did not reveal what Resident #100 reported as her pain level. An interview on 04/06/26 at 3:38 P.M. Regional Clinical Director (RCD) #952 verified Resident #100 did not receive any as needed pain medication and did not have appropriate pain monitoring. RCD #952 verified the hospital had sent a paper prescription for Resident #100's oxycodone. RCD #952 verified the pharmacy could give authorization for the oxycodone to be pulled from the emergency supply with a paper prescription from the facility. This deficiency represents noncompliance investigated under Complaint Numbers 2579173 and 2579366.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365324	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to monitor and maintain adequate communication with the outside dialysis center to include vital signs and weights before and after dialysis and failed to ensure the facility had a dialysis policy. This affected one (Resident #7) of one resident reviewed for dialysis. The facility identified Resident #7 as the only resident receiving dialysis in the facility. The facility census was 80.Findings include:Review of the medical record for Resident #7 revealed an admission date of 11/28/25. Diagnoses included end stage renal disease, dependency on dialysis, type II diabetes mellitus with diabetic neuropathy, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, vascular dementia and cognitive communication deficit.Review of the physician orders for March 2026 revealed an order for hemodialysis every Tuesday, Thursday, and Saturday morning with transport pick up at 9:40 A.M. and chair time of 10:45 A.M. to an outside dialysis facility. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #7 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.Review of the dialysis communication binder for March 2026 for Resident #7 revealed on 03/03/26, 03/19/26, 03/24/26, 03/26/26, and 03/28/26 there was no communication form with the pre weight and vital signs or the post dialysis form to and from the outside dialysis facility.Interview on 03/30/26 at 2:49 P.M. with Licensed Practical Nurse (LPN) #882 confirmed the dialysis forms were not consistently sent, missing documentation from facility, and missing documentation from the outside dialysis facility. LPN #882 confirmed there were no forms for 03/03/26, 03/19/26, 03/24/26, 03/26/26, and 03/28/26. Interview on 03/30/26 at 2:54 P.M. with LPN #862 confirmed the dialysis forms were not consistently sent, missing documentation from facility, and missing documentation from the outside dialysis facility. LPN #862 confirmed there were no forms for 03/03/26, 03/19/26, 03/24/26, 03/26/26, and 03/28/26. Interview on 03/31/26 at 6:32 A.M. with Assistant Director of Nursing (ADON) #893 confirmed the dialysis forms are not consistently sent, missing documentation from facility, and missing documentation from the outside dialysis facility. ADON #893 confirmed there were no forms for 03/03/26, 03/19/26, 03/24/26, 03/26/26, and 03/28/26. Interview on 04/01/26 at 3:41 P.M. with Dialysis Registered Nurse (RN) #955 confirmed they do not receive any documentation from the facility. Dialysis RN #955 reported it was important to know his condition prior to dialysis so if there were any changes during or after dialysis. RN #955 reported they fax over the post dialysis to the facility daily.Review of the physician's orders for April 2025 revealed orders for hemodialysis in the morning every Tuesday, Thursday, and Saturday at an outside dialysis facility and to send communication the form. Interview on 04/06/26 at 2:59 P.M. with Regional Director of Operations #916 confirmed the facility had no policy for dialysis.This deficiency represents noncompliance investigated under Complaint Number 2721789.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365324	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens of Belden Village	5005 Higbee Avenue NW Canton, OH 44718

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure individual patient-controlled substance administration records and medication administration records were accurate for Resident #99. This affected one (Resident #99) out of six residents reviewed for unnecessary medications. The facility census was 80. Findings include: Review of the medical record revealed Resident #99 was admitted on [DATE] with diagnoses including encephalopathy, psychoactive substance abuse, obstructive hydrocephalus, nontraumatic subarachnoid hemorrhage, and schizoaffective disorder. Resident #99 was discharged home on [DATE]. The facility physician orders dated 08/03/25 revealed Resident #99 was ordered oxycodone (opioid for moderate to severe pain) 5 milligrams (mg) every eight hours as needed. The individual patient-controlled substance administration record date 08/03/25 revealed Resident #99 was ordered 1/2 tab (2.5 mg) every eight hours as needed; two half tablets (5 mg) every eight hours as needed. The medication administration record (MAR) revealed Resident #99 received oxycodone five milligrams (mg) on 08/03/25 at 9:17 A.M. and 5:19 P.M. The individual patient-controlled substance administration record revealed Resident #99 received oxycodone 2.5 mg on 08/03/25 at 8:00 A.M. and 2.5 mg five mg at 5:00 P.M. The MAR revealed Resident #99 received oxycodone 5 mg on 08/03/25 at 9:17 A.M. and 5:19 P.M. The individual patient-controlled substance administration record revealed Resident #99 received oxycodone 2.5 mg on 08/04/25 at 8:00 P.M. (signed out prior to the 9:16 A.M. dose), 5 mg at 9:16 A.M. and 5 mg at 9:01 P.M. The MAR revealed Resident #99 received oxycodone 5 mg on 08/04/25 at 9:16 A.M. and 9:01 P.M.The individual patient-controlled substance administration record revealed Resident #99 received oxycodone 5 mg on 08/05/25 at 2:00 P.M. and 7:35 P.M.The MAR revealed Resident #99 received oxycodone 5 mg on 08/05/25 at 7:33 P.M.The individual patient-controlled substance administration record revealed Resident #99 received oxycodone 5 mg on 08/06/25 at 2:00 P.M. and 2.5 mg on 10:00 P.M.The MAR revealed Resident #99 did not receive any oxycodone on 08/06/25.The individual patient-controlled substance administration record revealed Resident #99 received oxycodone 2.5 mg on 08/07/25 at 6:06 A.M.The MAR revealed Resident #99 received oxycodone 5 mg on 08/07/25 at 6:06 A.M.The individual patient-controlled substance administration record revealed Resident #99 received oxycodone 5 mg on 08/08/25 at 2:00 P.M. The MAR revealed oxycodone was discontinued on 08/07/25 at 11:59 P.M. A discharge Minimum Data Set (MDS) dated [DATE] revealed Resident #99 was cognitively intact and received opioid medication. The MDS also revealed Resident #99 received scheduled and as needed pain medication for occasional pain. An interview on 04/06/26 at 12:48 P.M. Regional Clinical Director (RCD) #952 verified that the order was entered incorrectly on the MAR for oxycodone 5 mg only and did not match the order on the oxycodone sent from pharmacy. RCD #952 verified oxycodone was sent in half tabs of 2.5 mg and sometimes the nurses gave 2.5 mg and sometimes they gave two half tablets to equal 5 mg. RCD #952 verified the individual patient-controlled substance administration record and MAR did not match when oxycodone was administered. This deficiency represents noncompliance investigated under Complaint Number 2721789.

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	365324	A. Building B. Wing	04/07/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record review, interviews, review of photos and facility policy review, the facility failed to ensure medications were not left at bedside of Resident #7. This affected one (Resident #7) of one resident reviewed for unsecured medications. The facility census was 80.Findings include:Review of the medical record for Resident #7 revealed an admission date of 11/28/25. Diagnoses included end stage renal disease, dependency on dialysis, type II diabetes mellitus with diabetic neuropathy, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, vascular dementia and cognitive communication deficit.Review of the physician orders for December 2025 revealed an order for Chlorhexidine Gluconate Mouth/Throat Solution 0.12% (antiseptic) to give 15 milliliters (ml) by mouth (PO) every morning and at bedtime for teeth extractions to swish and spit. Review of the photos provided by Resident #7's guardian, dated 12/20/25 at 7:32 A.M. revealed a medicine cup on Resident #7's over the bed tray with one capsule in it and a plastic drinking cup with yellow/pale fluid in it. Interview on 03/30/36 at 2:49 P.M. and at 2:54 P.M. with Licensed Practical Nurse (LPN) #882 and LPN #862 confirmed medications were not to be left at the bedside. Telephone interview on 04/01/26 at 10:24 A.M. with Resident #7's guardian revealed the photo dated 12/30/25 at 7:33 A.M. had a medicine cup with one capsule in it and a plastic drinking cup with yellow/pale fluid which was his oral rinse. Resident #7's guardian reported the staff were to stay until the medications were taken and his rinse was completed per physician orders.Interview on 04/02/26 at 8:49 A.M. with Regional Nurse #952 confirmed the photo had a medicine cup with one capsule in it and a plastic cup with yellow/pale fluid in it. Regional Nurse #952 confirmed medications were not to be left at the bedside.Review of the facility policy, Administering Medications, revised December 2012, revealed medications were to be administered in a safe and timely manner, and as prescribed.This deficiency represents noncompliance investigated under Complaint Number 2721789.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to dispose of expired foods in a timely manner which resulted in expired food being served to residents. This had the potential to affect all 80 residents that received food from the kitchen. The facility census was 80.Findings include: On 04/01/26 at 11:00 A.M., an observation of the kitchen revealed one unopened case of Thick and Easy apple juice that expired on 02/17/26, one unopened case of Thick and Easy cranberry juice that expired on 02/19/26, and one opened case of Thick and Easy orange juice that expired on 03/14/26. An interview at the time of observation with Dietary Manager #887 verified the expired thickened beverages. Dietary Manager #887 also confirmed that expired food had been served to residents in January 2026 when there was a winter storm and the dietary staff utilized food items from the emergency food supply, which included a case of individual cups of peaches that had been expired for several months. Dietary Manager #887 stated staff were unaware that expired food had been served to residents until someone complained about it. This deficiency represents noncompliance investigated under Complaint Numbers 2741464, 2725826, 2593694, 2592864 and 2579173.

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	365324	A. Building B. Wing	04/07/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and interview, the facility failed to ensure Resident #7's medical record was accurate and complete. This finding affected one (Resident #7) of three residents reviewed for accuracy of medical records. The facility census was 80.Findings include:1. Review of Resident #7's medical record revealed the resident was admitted on [DATE] with diagnoses including end state renal disease with dependence on renal dialysis, chronic obstructive pulmonary disease (COPD), and diabetes. The medical record revealed the resident's daughter was the legal guardian and power-of-attorney (POA) for health care and financial.Review of Resident #7's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #7's physician orders revealed an order dated 01/01/26 (discontinued 01/05/26) for hospice services.Review of Resident #7's Hospice Patient Medication Cover Sheet form dated 01/01/26 revealed the resident was ordered acetaminophen (analgesic), hydralazine (vasodilator to treat high blood pressure), labetalol (medication to treat high blood pressure), omeprazole (reduces stomach acid), sertraline (antidepressant), bisacodyl (laxative), polyethylene glycol (laxative), promethazine (antihistamine), hydroxyzine pamoate (antihistamine) and tramadol (narcotic pain medication). The form was signed by the legal guardian.Review of Resident #7's physician orders revealed an order dated 01/01/26 for tramadol 50 milligrams (mg) give one tablet by mouth every six hours as needed for severe pain. The order was discontinued on 01/13/26.Review of Resident #7's progress note dated 01/01/26 at 7:18 P.M. (late entry created on 01/22/26 at 11:19 A.M.) revealed a new order to discontinue the tramadol due to non-utilization per the physician.Review of Resident #7's medication administration records (MAR) from 01/01/26 to 01/13/26 revealed on 01/06/26 at 12:38 A.M., the resident received a tramadol for a pain level of seven on a pain scale of zero to ten, ten being the worst.Review of Resident #7's progress note dated 01/02/26 at 12:11 P.M. revealed the resident's daughter admitted the resident to hospice on 01/01/26 and called on this date to revoke hospice services.Review of Resident #7's Care Conference note dated 01/07/26 revealed hospice was discussed and a copy of the summary was provided to the resident's guardian (daughter). The medications were reviewed. The resident's guardian expressed concerns regarding the tramadol narcotic administration. The facility would obtain an order to discontinue the tramadol if the guardian requested.Review of Resident #7's Care Conference note dated 01/22/26 revealed Ombudsman #915 asked the resident's guardian if she had restrictions regarding medications. She stated medication decisions were at the physician discretion, provided the nephrologist agreed.Interview on 04/01/26 at 9:24 A.M. with Registered Nurse (RN) Assistant Director of Nursing (ADON) #893 revealed that the late entry progress note created on 01/22/26 for 01/01/26 stated to discontinue the tramadol on 01/01/26 and the orders stated to discontinue the tramadol on 01/13/26. The resident received a dose of tramadol on 01/07/26.Interview on 04/01/26 at 12:28 P.M. with RN Regional Clinical Director (RCD) #952 revealed Resident #7's guardian had reported some concerns about pain medications on 01/07/26. RN RCD #952 revealed the guardian was aware the resident was ordered tramadol on 01/01/26 during initiation of hospice services, and she thought when she revoked hospice services on 01/02/26, the orders would automatically revert to pre-hospice orders. RN RCD #952 indicated when the family voiced concerns about the tramadol and the possibility of addiction during the care conference on 01/07/26, the tramadol should have been discontinued, but the tramadol was not discontinued until 01/13/26. RN RCD #952 confirmed Resident #7 had only received one dose of the tramadol and that was prior to the family concern during the care conference. RN RCD #952 also confirmed she was unsure why Former Director of Nursing (DON) #951 put in a late entry to discontinue the tramadol on 01/01/26 when the order was not discontinued.Review of the Administering Medications policy, revised 02/2012, revealed medications shall be administered in a (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safe and timely manner, and as prescribed.2. Review of Resident #7's medical record revealed the resident was admitted on [DATE] with diagnoses including end state renal disease with dependence on renal dialysis, COPD, and diabetes. The medical record revealed the resident's daughter was the legal guardian and POA for health care and financial.Review of Resident #7's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #7's physician orders for March 2026 revealed an order for Total Daily fluid Restriction 2000 milliliter (ml), Dietary 1200 ml and Nursing 800 ml two times a day for fluid restriction.Review of the MAR and treatment administration records (TAR) for March 2026 revealed 03/01/26 and 03/06/26 the morning box for the Total Daily Fluid Restriction for the morning was blank for the Dietary and Nursing intake. There were no intake amounts or initials of completion.Interview on 04/02/26 at 2:49 P.M. Unit Manager Licensed Practical Nurse (LPN) #884 confirmed on 03/01/26 and 03/06/26 the MAR/TAR was not completed and left blank. Unit Manager LPN #884 reported it was to be completed and initialed. Interview on 04/07/26 at 7:00 A.M. via phone, with LPN #900 confirmed on 03/01/26 and 03/06/26, she worked and did the fluid restriction. LPN #900 reported sometimes the computer has a glitch and doesn't record it correctly. LPN #900 confirmed the boxes should have had her initials and intake amount.Review of the facility policy, Charting and Documentation, revised July 2017, revealed all services provided to the resident shall be documented in the resident's medical record. Further states the following information is to be documented in the resident medical record to include medications and treatments administered/performed. Documentation of procedures and treatments will include care-specific details, including the date and time the procedure treatment was provided.Review of the facility policy, Administering Medications, revised December 2012, revealed medications shall be administered in a safe and timely manner as prescribed to include the individual administering the medication will record in the resident's medical record the date and time the medication was administered.This deficiency represents noncompliance investigated under Complaint Number 2721789.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to ensure the laundry cart used to transport clean clothing/linens from the washing machines to the dryers did not have water dripping into them from a leak in the ceiling. This had the potential to affect all 80 residents residing in the facility. Findings include:An observation on 04/01/26 at 9:04 A.M. revealed there was water dripping from the ceiling above the washing machines. The ceiling tiles had brownish color, and the metal crossbars were rusted. Some of the water dripping was pooling in a cart used to transport clean laundry from the washers to the dryers. Several damp looking bath towels were lying on the floor. Housekeeper/Laundry Supervisor #847 verified water was dripping from the ceiling and pooling in the cart used to transport clean laundry. Housekeeper/Laundry Supervisor #847 stated the ceiling leaked when it rained. As surveyor walked from the laundry area to the dryer area, and water dripped on the surveyor's head. An interview on 04/01/26 at 11:41 A.M. Maintenance Director #854 verified the ceiling above the washers was leaking. Maintenance Director #854 stated it only leaked when it rained. Maintenance Director #854 verified the crossbars were rusted and the ceiling tiles were discolored. He also verified that the laundry room was located on the first floor, and there was a second floor over the laundry area. Maintenance Director #854 stated that the rainwater could follow the duct work and come out of the ceiling in various areas. Maintenance Director #854 stated he had tried to patch the roof, and there had been discussions about getting a new roof. This deficiency represents non-compliance investigated under Master Complaint Number 2804797 and Complaint Numbers 2741464, 2721789, 2593694, 2579366, 2579173 and 1282446 (OH00166150).