STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365412	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Skilled Healthcare	1320 Mahoning Ave NW Warren, OH 44483

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to notify the responsible party, Power of Attorney (POA) or emergency contact of resident transfers to the hospital. This affected two (Residents #10 and #51) of three residents reviewed for notification. The facility census was 75. Findings include: 1. Review of the medical record for Resident #10 revealed an admission date of 11/19/24. Diagnoses included quadriplegia, kidney disease and anemia. His sister was his emergency contact. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively intact. He required set up help for eating and was dependent on staff for toileting, showering, dressing and hygiene. Review of the nursing progress note dated 06/03/25 at 6:45 A.M. revealed Resident #10 was admitted to the hospital due to a urinary tract infection. There was no documented evidence Resident #10's responsible party, POA or emergency contact was notified. Interview on 06/11/25 at 1:14 P.M. with the Director of Nursing (DON) confirmed there was no evidence Resident #10's responsible party, POA or emergency contact was notified of Resident #10's transfer to the hospital. 2. Review of the medical record for Resident #51 revealed an admission date of 05/22/23. Diagnoses included Alzheimer's disease, kidney disease, anemia, depression and high cholesterol. Review of the quarterly MDS assessment dated [DATE] revealed Resident #51 was severely cognitively impaired. She required substantial or maximum assistance for oral care and was totally dependent on others for eating, toileting, showering and dressing. Review of the fall note dated 04/08/25 at 5:40 P.M. revealed Resident #51 was assessed for injuries and found with a laceration on her forehead. Emergency services were called, and Resident #51 was transferred to the local emergency department (ED). The DON and physician were notified. There was no documented evidence Resident #51's responsible party, POA or emergency contact was notified. Review of the hospital discharge paperwork dated 04/08/25 revealed Resident #51 was treated for a closed head injury and received stitches. (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
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/11/25 at 8:38 A.M. with Registered Nurse (RN) #206 revealed when a resident was transferred to the hospital the process included notification to the resident's POA, responsible party, or emergency contact. Interview on 06/11/25 at 1:48 P.M. with Licensed Practical Nurse (LPN) #201 confirmed there was no evidence Resident #51's responsible party, POA or emergency contact was notified of the residents' transfer to the hospital. Review of the facility policy titled Notification of Changes, dated 03/01/25, revealed the facility would promptly inform the resident, physician and the resident's representative in the event of a change such as an accident resulting in injury or a significant or acute change to the resident's health status or exacerbation of a chronic condition. If the resident was competent, the facility would still contact the resident's representative, since the resident may not be able to make the notification personally on the event of an accident or sudden illness. This deficiency represents noncompliance investigated under Complaint Number OH00165250.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to send information to the hospital regarding resident health status upon transfer. This affected two (Residents #10 and #51) of three residents reviewed for hospitalizations. The facility census was 75. Findings include: 1. Review of the medical record for Resident #10 revealed an admission date of 11/19/24. Diagnoses included quadriplegia, kidney disease and anemia. His sister was his emergency contact. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively intact. He required set up help for eating and was dependent on staff for toileting, showering, dressing and hygiene. Review of the nursing progress note dated 06/03/25 at 6:45 A.M. revealed Resident #10 was admitted to the hospital due to a urinary tract infection. 2. Review of the medical record for Resident #51 revealed an admission date of 05/22/23. Diagnoses included Alzheimer's disease, kidney disease, anemia, depression and high cholesterol. Review of the quarterly MDS assessment dated [DATE] revealed Resident #51 was severely cognitively impaired. She required substantial or maximum assistance for oral care and was totally dependent on others for eating, toileting, showering and dressing. Review of the fall note dated 04/08/25 at 5:40 P.M. revealed Resident #51 was assessed for injuries and found with a laceration on her forehead. Emergency services were called, and Resident #51 was transferred to the local emergency department (ED). The DON and physician were notified. Interview on 06/11/25 at 8:38 A.M. with Registered Nurse (RN) #206 revealed when a resident was transferred to the hospital the process included sending a transfer form which included resident demographics, physician's order and a list of medications. Interview on 06/11/25 at 1:14 P.M. with the Director of Nursing (DON) confirmed there was no documented evidence any information was sent to the hospital regarding Residents #10 and #51's hospitalizations. Review of the facility policy titled Transfer and Discharge, dated 02/12/25, revealed when a resident transferred to the hospital for immediate safety concerns, information such as Advanced Directives and transfer forms would accompany the resident for continuity of care. This deficiency represents noncompliance investigated under Complaint Number OH00165250.

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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, staff interview, resident interview and facility policy review, the facility failed to ensure residents received baths or showers per resident preference. This affected three (Resident #35, Resident #67, and Resident #69) out of six residents reviewed for activities of daily living (ADL) care. Findings include: 1. Resident #69 was admitted to the facility on [DATE] with diagnoses including dysphasia (a language disorder that affects a person's ability to speak following cerebrovascular disease (stroke), aphasia (a disorder that impacts ability to speak, understand, read, or write) following cerebrovascular disease (stroke), and contracture (deformities caused by tightening or shortening of muscles) of arms. Interview with Resident #69 and family on 06/10/25 at 10:33 A.M. revealed the resident does not bathing per their preferred method or frequency. Resident #69 and family noted their preferred bathing method is a tub bath. Resident #69's family indicated they have voiced concerns to floor staff and facility administration. Review of preferences dated 07/30/24 revealed Resident #69 preferred a tub bath three times a week. Review of Minimum Date Set (MDS) assessment dated [DATE] revealed the Resident #69 was severely cognitively impaired and was totally dependent on staff for care. The MDS assessment dated [DATE] noted it's very important for Resident #69 to choose between tub bath, shower, or sponge bath. Review of the paper shower sheets from 04/18/25 to 06/10/25 for Resident #69 revealed on 04/18/25, 05/04/25, 05/08/25, 05/12/25, and 05/19/25 bed baths were provided. On 05/28/25 and 06/10/25 showers were provided. Review of the bathing documentation in the electronic medical record for Resident #69 revealed no documented evidence bathing or showers occurred at all. 2. Interview with Resident #35 on 06/10/25 at 1:24 P.M. revealed the resident does not get bathed according to their preferences, and aides have said they don't have enough people to give showers to residents. Resident #35 noted their bathing preference was a bath once a week. Resident #35 was admitted to the facility on [DATE]. Diagnoses include parainfluenza virus pneumonia (lung infection), sepsis (blood infection), end stage renal disease, chronic respiratory failure, acquired absence of left leg below knee, and heart failure. Review of Resident 35's preference for bathing dated 07/30/24 indicated a bath was preferred once a week. Review of the care plan for Resident #35 revised on 10/16/2024 revealed the resident was at risk for pressure ulcer development and or alteration in skin integrity with an intervention dated 07/11/22 that resident's preferences on bath and shower and on what days will be addressed. (continued on next page)

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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	Review of the paper shower sheets from 03/10/25 to 05/26/25 for Resident #35 revealed that on 03/10/25, 03/17/25, 03/21/25, 04/25/25, 05/09/25, 05/12/25, and 05/23/25 paper shower sheets were not filled out. The shower sheet on 03/24/25 indicated the resident had a shower. The shower sheet on 03/31/25 indicated the resident had a tub bath. Review of the bathing documentation in the electronic medical record for Resident #35 revealed 05/23/25 and 05/26/25 were the only days marked as completed. Review of MDS assessments dated 05/28/25 reveals resident was cognitively intact, assessment dated [DATE] indicated the resident is fully dependent for transfers and required the use of a mechanical lift for all transfers, and assessment dated [DATE] indicated choosing between a tub bath, shower, or sponge bath was somewhat important. 3. Interview with Resident #67 on 06/10/25 at 1:44 P.M. revealed they don't get bathed as frequently as preferred. The resident indicated they have voiced concerns to floor staff. Resident #67 was admitted to the facility on [DATE]. Diagnoses include chronic atrial fibrillation (an abnormal heart rhythm), major depressive disorder, liver transplant, history of pulmonary embolism (blood clot in the lung), and hydroureter (a swelling of the tube that drains urine into the bladder from the kidney). Review of the care plan dated 02/06/24 revealed Resident #67 has a history of depression with an intervention dated 02/06/24 to allow participation in times for care, mealtime, baths, and bedtimes. A preference sheet for Resident #67 was unavailable for review. Review of the MDS assessment dated [DATE] revealed the Resident #67 was cognitively intact and was fully dependent on staff for bathing. The assessment dated [DATE] indicated it was very important to choose between tub bath, shower, or bed bath. Review of the paper shower sheets for Resident #67 from 05/08/25 to 06/02/25 indicated on 05/08/25, 05/15/25, 05/26/25, and 06/02/25 the resident had a shower, on 05/10/25 and 05/27/25 the sheets were not filled out, and on 05/22/23 and 06/01/25 a bed bath was provided. Review of the bathing documentation in the electronic medical record for Resident #67 revealed the bathing task marked as completed on 05/16/25, 05/25/25, and 05/27/25. Interview with Certified Nurse Aide (CNA) #200 on 06/10/25 at 8:31 A.M. revealed that resident showers don't often get done per resident preference because there were not enough staff members. Interview with CNA #203 and CNA #204 on 06/10/25 at 10:46 A.M. revealed resident showers don't get done regularly according to resident preference. Interview on 06/11/25 at 2:13 P.M. with the Director of Nursing (DON) confirmed she was aware there were issues with staffing in the facility. (continued on next page)

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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	Review of the policy titled Activities of Daily Living, dated 2024, indicated bathing would be consistent with a resident's choices. Under the section titled Policy Explanation and Compliance Guidelines it is indicated that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain grooming and personal hygiene. Review of the policy titled Resident Showers, dated 2024, indicated the facility will assist resident with bathing and to maintain proper hygiene. Under the section titled Policy Explanation and Compliance Guidelines it is indicated residents will be provided with showers as per request. This deficiency represents noncompliance investigated under Master Complaint Number OH00165769 and Complaint Number OH00165368.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review, the facility failed to ensure physician orders to prevent skin breakdown were being followed. This affected one resident (Resident #9) out of three residents that were sampled for skin breakdown. The facility census was 75. Findings include: Resident #9 was admitted to the facility on [DATE]. Diagnoses included encounter for palliative care, cerebral atherosclerosis (narrowing of the arteries supplying blood to the brain from fat build up), vascular dementia, chronic obstructive pulmonary disease, and atherosclerotic heart disease (a narrowing of the arteries supplying blood to the heart from fat build up). Review of the care plan revealed on 07/12/24 Resident #9 had potential for pressure ulcer development and or alteration in skin integrity related to decreased mobility and fragile skin and an intervention to reposition on rounds and as needed. Review of the Minimum Data Set (MDS) assessment noted the following: Section C dated 04/10/25 revealed Resident #9 is severely cognitive impaired, Section GG dated 04/11/25 revealed Resident #9 is totally dependent on staff for all care needs, Section H dated 04/15/25 revealed Resident #9 is always incontinent of urine and bowel. Review of Resident #9's physician's orders revealed on 05/29/25 at 1:07 P.M. an order written to apply a foam dressing daily with protective cream and change when soiled and an order dated 05/29/25 at 7:00 P.M. to turn and reposition the resident every two hours side to side with the wedge only. Observation of Resident #9 incontinence care on 06/10/25 at 9:06 A.M. revealed a softball sized reddened non-open area on the coccyx and into the gluteal cleft. No dressings were noted to the area before or after incontinence care. Interview on 06/10/25 at 1:20 P.M. with Licensed Practical Nurse (LPN) #211 and Certified Nurse Aide (CNA) #204 verified Resident #9 did not have foam dressing on coccyx. LPN #211 verified there was a physician's order for the foam dressing, and CNA #204 verified absence of foam dressing. Observations of Resident #9 on 06/10/25 at 1:52 P.M. revealed the resident was positioned on their back and purple wedge pillow was on a bedside chair. On 06/10/25 at 2:47 P.M. the resident was positioned on their back, and the purple wedge pillow was in the same position on the bedside chair. On 06/11/25 at 7:10 A.M. the resident was positioned on their back with purple wedge pillow was in the same position on the bedside chair. On 06/11/25 at 8:12 A.M. the resident was positioned on their back with the purple wedge pillow in the same position on the bedside chair. On 06/11/25 at 8:31 A.M. the resident was positioned on their back with the purple wedge pillow in the same position on the bedside chair. On 06/11/25 at 9:24 A.M. the resident was positioned on their back, and the purple wedge pillow was in the same position on the bedside chair, and 9:32 A.M. the resident was positioned on their back, and the purple wedge pillow was in the same position on the bedside chair. Interview on 06/11/25 at 9:32 A.M. with LPN #208 revealed the purple wedge pillow was used for lateral repositioning. LPN #208 verified the purple wedge pillow was on the bedside chair. (continued on next page)

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Community Skilled Healthcare	1320 Mahoning Ave NW Warren, OH 44483

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Pressure Injury and Management, dated 2024, revealed in the section title Interventions for Prevention and to Promote Healing that evidence-based interventions will be implemented for all residents who are assessed at risk for a pressure injury. Basic or routine interventions could include pressure redistribution such as repositioning. This deficiency represents noncompliance investigated under Master Complaint Number OH00165769.

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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 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, interview and review of the facility policy, the facility failed to ensure falls were thoroughly investigated. This affected two (Residents #22 and #51) of three residents reviewed for falls. The facility census was 75. Findings include: 1. Review of the medical record for Resident #22 revealed an admission date of 04/18/25. Diagnoses included diabetes, heart disease, high cholesterol, anxiety, depression and chronic back pain. Review of the fall risk assessment dated [DATE] revealed Resident #22 was at risk for falls. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact. She required set up help for eating, oral and personal hygiene and partial to moderate assistance for toileting. Review of the care plan dated 04/21/25 revealed Resident #22 was at risk for falls due to impaired safety awareness and age-related weakness. Interventions included anticipating the residents' needs, ensuring the call light was within reach and encouraging her to use it, and encouraging her to participate in activities that promoted exercise, physical activity and strengthening and improving mobility. Review of the nursing progress note dated 05/26/25 at 10:39 A.M. revealed Resident #22 was in her room when staff found her sitting on the floor. Resident #22 stated she was transferring with her walker to her closet when her incontinence brief slid down her legs and caused her to trip. Resident #22 was wearing nonskid socks at the time. Resident #22 was reminded she is supposed to call for staff assistance with transfers. No injury was noted, the resident was assessed with vital signs including a blood pressure of 160/84, temperature 98 degrees Fahrenheit (F), heart rate 100, respirations 18, oxygen saturation 96% on room air. Her range of motion was within normal limits, and she had no complaints. Review of the undated facility fall investigation revealed no witness statements were obtained from staff, there was no root cause analysis, no evidence of when Resident #22 was last toileted, and no evidence if her call light was activated, and no evidence a new intervention was implemented. 2. Review of the medical record for Resident #51 revealed an admission date of 05/22/23. Diagnoses included Alzheimer's disease, kidney disease, anemia, depression and high cholesterol. Review of the care plan dated 08/15/24 revealed Resident #51 was at risk for falls due to confusion, balance problems and lack of awareness of safety needs. Interventions included ensuring the environment was free from clutter, recording the possible root cause for falls, reviewing information on past falls and educating the family regarding causes. Review of the fall risk assessment dated [DATE] revealed Resident #51 was at risk for falls. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed Resident #51 was severely cognitively impaired. She was totally dependent on others for eating, toileting, showering, oral and personal hygiene and dressing. Review of the fall note dated 04/08/25 at 5:40 P.M. revealed Resident #51 was assessed for injuries and found with a laceration on her forehead. Vital signs were attempted; however, Resident #51 was combative. A pressure dressing was applied to Resident #51's forehead to control bleeding, she remained alert, and her orientation was within normal limits. Emergency services were called, and Resident #51 was transferred to the local emergency department (ED). The Director of Nursing (DON) and physician were notified. Review of the undated facility fall investigation revealed Resident #51 was found on the floor next to her Broda chair (chair or wheelchair that provides comfort, support, and mobility) lying on her right side with blood on the floor next to her head. There were no witnesses. The resident was trying to get out of her chair and become mobile at different times throughout the day. There were no staff statements obtained, there was no root cause analysis, no evidence of when Resident #51 was last toileted, and no evidence if the call light was activated, and no evidence that a new intervention was implemented. Review of the hospital discharge paperwork dated 04/08/25 revealed Resident #51 was treated for a closed head injury and received stitches. Interview on 06/11/25 at 1:14 P.M. with the Director of Nursing (DON) confirmed there was no evidence of a root cause analysis of the falls for Residents #22 and #51, no new interventions attempted, and no witness statements obtained. She confirmed witness statements should be obtained for all falls, particularly falls that were unwitnessed, and the fall investigations for Residents #22 and #51 did not contain all the necessary information to consider the falls thoroughly investigated. Review of the facility policy titled Fall Prevention Program, dated 03/01/25, revealed when a resident experienced a fall, the facility would complete an incident report, notify the family, review the care plan and updated as needed, document all assessments and actions and obtained witness statements in the case of injury. This deficiency represents noncompliance investigated under Master Complaint Number OH00165769 and Complaint Number OH00165250.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and review of the facility policy, the facility failed to ensure sufficient staffing to meet the needs of all residents. This affected three (Residents #35, #67 and #69) of six residents reviewed for showers and had the potential to affect all 75 residents in the facility. Findings include: Interview on 06/10/25 at 8:31 A.M. with certified nurse aide (CNA) #200 revealed she had several residents who required a Hoyer lift (mechanical lift) for transfer, assistance with feeding and activities of daily living (ADL) care. She revealed showers often did not get done because there was not enough staff to complete them. Interview with Resident #69 and family on 06/10/25 at 10:33 A.M. revealed the resident did not receive bathing per their preferred method or frequency. Resident #69's family indicated they have voiced concerns to floor staff and facility administration. Interview on 06/10/25 at 10:46 A.M. with CNAs #203 and #204 reviewed facility staffing was horrible. CNA #204 revealed the 300-hall had the highest acuity, and there were typically three CNAs for 27 to 28 residents, which was not enough to complete all the resident care. She revealed ADL care such as nail care, toothbrushing and nail trimming usually occurred with showers, but showers often weren't done because of poor staffing. CNA #203 revealed she often did not get a break and ended up working overtime to get her charting done. Interview with Resident #35 on 06/10/25 at 1:24 P.M. revealed she did not get bathed according to her preferences and has been told it is a result of lack of staff. Interview with Resident #67 on 06/10/25 at 1:44 P.M. revealed he did not get baths as requested. Review of the schedules for May 2025 as well as the staffing tool for the weeks of 05/11/25 and 05/18/25 revealed the facility did not meet the minimum direct care daily average of two and one-half hours of direct care and services per resident per day on 05/16/25, 05/17/25, 05/18/25 and 05/21/25. The staffing tool revealed 2.45 hours of direct resident care on 05/16/25, 2.48 hours on 05/17/25, 2.12 hours on 05/18/25 and 1.93 hours on 05/21/25. Review of the facility assessment was last updated 04/18/22. Interview on 06/11/25 at 11:59 A.M. revealed he could provide no evidence the Facility Assessment had been updated since 04/18/22. Interview on 06/11/25 at 2:13 P.M. with the Director of Nursing (DON) confirmed she was aware there were issues with staffing in the facility and confirmed the minimum requirement for daily staffing was not met on 05/16/25, 05/17/25, 05/18/25 and 05/21/25. The following resident specific findings were identified related to insufficient staffing: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Resident #69 was admitted to the facility on [DATE] with diagnoses including dysphasia (a language disorder that affects a person's ability to speak following cerebrovascular disease (stroke), aphasia (a disorder that impacts ability to speak, understand, read, or write) following cerebrovascular disease (stroke), and contracture (deformities caused by tightening or shortening of muscles) of arms. Review of preferences dated 07/30/24 revealed Resident #69 preferred a tub bath three times a week. Review of Minimum Date Set (MDS) assessment dated [DATE] revealed the Resident #69 was severely cognitively impaired and was totally dependent on staff for care. The MDS assessment dated [DATE] noted it's very important for Resident #69 to choose between tub bath, shower, or sponge bath. Review of the paper shower sheets from 04/18/25 to 06/10/25 for Resident #69 revealed on 04/18/25, 05/04/25, 05/08/25, 05/12/25, and 05/19/25 bed baths were provided. On 05/28/25 and 06/10/25 showers were provided. Review of the bathing documentation in the electronic medical record for Resident #69 revealed no documented evidence bathing or showers occurred at all. 2. Resident #35 was admitted to the facility on [DATE]. Diagnoses include parainfluenza virus pneumonia (lung infection), sepsis (blood infection), end stage renal disease, chronic respiratory failure, acquired absence of left leg below knee, and heart failure. Review of Resident 35's preference for bathing dated 07/30/24 indicated a bath was preferred once a week. Review of the care plan for Resident #35 revised on 10/16/2024 revealed the resident was at risk for pressure ulcer development and or alteration in skin integrity with an intervention dated 07/11/22 that resident's preferences on bath and shower and on what days will be addressed. Review of the paper shower sheets from 03/10/25 to 05/26/25 for Resident #35 revealed that on 03/10/25, 03/17/25, 03/21/25, 04/25/25, 05/09/25, 05/12/25, and 05/23/25 paper shower sheets were not filled out. The shower sheet on 03/24/25 indicated the resident had a shower. The shower sheet on 03/31/25 indicated the resident had a tub bath. Review of the bathing documentation in the electronic medical record for Resident #35 revealed 05/23/25 and 05/26/25 were the only days marked as completed. Review of MDS assessments dated 05/28/25 reveals resident was cognitively intact, assessment dated [DATE] indicated the resident is fully dependent for transfers and required the use of a mechanical lift for all transfers, and assessment dated [DATE] indicated choosing between a tub bath, shower, or sponge bath was somewhat important. 3. Resident #67 was admitted to the facility on [DATE]. Diagnoses include chronic atrial fibrillation (an abnormal heart rhythm), major depressive disorder, liver transplant, history of pulmonary embolism (blood clot in the lung), and hydroureter (a swelling of the tube that drains urine into the bladder from the kidney). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365412	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Skilled Healthcare	1320 Mahoning Ave NW Warren, OH 44483

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the care plan dated 02/06/24 revealed Resident #67 has a history of depression with an intervention dated 02/06/24 to allow participation in times for care, mealtime, baths, and bedtimes. A preference sheet for Resident #67 was unavailable for review. Review of the MDS assessment dated [DATE] revealed the Resident #67 was cognitively intact and was fully dependent on staff for bathing. The assessment dated [DATE] indicated it was very important to choose between tub bath, shower, or bed bath. Review of the paper shower sheets for Resident #67 from 05/08/25 to 06/02/25 indicated on 05/08/25, 05/15/25, 05/26/25, and 06/02/25 the resident had a shower, on 05/10/25 and 05/27/25 the sheets were not filled out, and on 05/22/23 and 06/01/25 a bed bath was provided. Review of the bathing documentation in the electronic medical record for Resident #67 revealed the bathing task marked as completed on 05/16/25, 05/25/25, and 05/27/25. Review of the policy titled Resident Showers, dated 2024, indicated the facility would assist residents with bathing and maintaining proper hygiene and Residents would receive showers based on their preference. This deficiency represents noncompliance investigated under Master Complaint Number OH00165769 and Complaint Number OH00165590.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of the facility schedule and interview, the facility failed to ensure a Registered Nurse (RN) was in the facility for at least eight consecutive hours a day, seven days a week. This had the potential to affect all 75 residents in the facility. Findings include: Review of the schedules for May 2025 as well as the staffing tool for the weeks of 05/11/25 and 05/18/25 revealed the facility did not have an RN scheduled to work on 05/13/25. One RN worked 7.25 hours on 05/23/25. Interview on 06/11/25 at 2:13 P.M. with the Director of Nursing (DON) verified she had no other evidence to verify an RN had worked eight consecutive hours on 05/13/25 or 05/23/25. This deficiency was an incidental finding identified during the complaint investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure staffing information was posted timely and accurately. This had the potential to affect all 75 residents in the facility. Findings include: Observation on 06/10/25 at 8:31 A.M. revealed the daily posted staffing information was posted for 06/09/25 and did not identify the facility census. Interview at the time of the observation with the Certified Nurse's Aide (CNA) #200 confirmed the daily staffing information posted was for 06/09/25 and had not yet been updated for the current day. She revealed the scheduler was responsible for updating the posted staffing information, and she was on vacation as of this date. She also confirmed that a census number was not listed on the information displayed. This deficiency is an incidental finding identified during the complaint investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of the Facility Assessment and interview, the facility failed to ensure the facility assessment was updated annually. This had the potential to affect all 75 residents in the facility. Findings include: Review of the Facility Assessment revealed a date of 04/18/22. Interview on 06/11/25 at 11:59 A.M. with the Administrator revealed he forgot to change the date on the Facility Assessment. He could provide no evidence the Facility Assessment had been updated since 04/18/22. This deficiency is an incidental finding identified during the complaint investigation.