

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/04/2026
NAME OF PROVIDER OR SUPPLIER  Community Skilled Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interview, review of the facility self-reported incident (SRI) and investigation and facility policy review, the facility failed to ensure resident-to-resident abuse did not occur between Resident #52 and Resident #40. This affected two (Residents #40, and #52) of six residents reviewed for abuse. The facility census was 91. Review of the medical record for Resident #40 revealed an admission date of 04/07/16. Diagnoses included autistic disorder, developmental disorder, anxiety, hypertension and scoliosis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was severely cognitively impaired. She required substantial assistance for eating and was dependent for oral care, toileting, showering, dressing and personal hygiene. Review of the medical record for Resident #52 revealed an admission date of 03/20/25. Diagnoses included diabetes, depression, high cholesterol, depression and respiratory disorders. Review of the quarterly MDS assessment dated [DATE] revealed Resident #52 was cognitively intact. He was independent in all ADL's. Review of the care plan dated 03/24/25 revealed Resident #52 exhibited sexually inappropriate behaviors including entering female resident's rooms. Interventions included anticipating and meeting Resident #52's needs, discussing inappropriate behavior and praising progress improvement and behavior. Review of the nursing note dated 01/11/26 at 9:32 P.M. revealed Resident #52 indecently exposed himself to another resident in the hallway. Review of the facility SRI and related investigation dated 01/12/26 revealed Resident #52 was observed standing to the left of Resident #40 in the hallway. Resident #52's pants appeared to be positioned below his waist, however, no movements, physical contact or behavior suggesting any interactions of concern had taken place. Resident #40 lacked the cognitive ability to give any statement. The facility unsubstantiated an allegation of sexual abuse citing the Certified Nursing Assistant (CNA) did not establish any reasonable indication that inappropriate conduct had occurred and there was no evidence of unintentional harm or an adverse outcome. Other Resident interviews were obtained with no findings of abuse. Resident #52 was offered relocation to a hall with male peers and increased staffing for supervision. All facility staff were re-educated on the abuse policy. Review of the witness statement dated 01/11/26 provided by CNA #213 revealed she saw Resident #52 standing in front of Resident #40 exposing his genital area saying There you go, look at it. When Resident #52 saw CNA #213, he rushed back to his bedroom. CNA #213 asked Resident #40 if Resident #52 showed his genitals and the residents responded with yes. Resident #40 was taken to the nurse's station for monitoring and another CNA stayed one-to-one with Resident #52 while the nurse was notified of the incident. There was no witness statement in the investigation from a nurse. Review of the police report #26-00878 dated 01/12/26 revealed police were dispatched to the facility for a report of public indecency. Resident #52 was reportedly exposing his genitals to Resident #40. Resident #52 denied doing so. CNA #213 was interviewed and stated she witnessed resident #52 standing in front of resident #40 exposing his genitals and telling Resident #40 to look. Resident #40 was not able to provide any meaningful information regarding the account. Facility staff reported resident #52 was being discharged to the hospital. Interview on 02/26/26 at 11:20 A.M. with CNA (continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>#213 confirmed she saw Resident #52 standing near resident #40; his pants were halfway down, and his genitals were exposed in front of Resident #40. When Resident #52 saw CNA #213 he returned to his bedroom. CNA #213 revealed she told LPN #214 who confirmed knowledge Resident #52 had a history of inappropriate sexual behaviors. CNA #213 revealed Resident #40 was overheard telling another CNA (unidentified) after the incident that she was scared. CNA #213 stated after Resident #40's initial report of being scared, she showed no lasting signs of distress or any indication of psychosocial harm. She revealed Resident #40's statements were not always congruent with her mood and behaviors and there had been no mood or behavior changes since the incident. Interview on 02/26/26 at 11:45 A.M. with LPN #214 revealed she was told by CNA #213 Resident #52 exposed himself to Resident #40. She separated the residents, placed Resident #52 on 15-minute checks and notified the DON. After the incident, Resident #52's room was moved to a location which was further away from female residents. She could not confirm if she wrote a witness statement regarding the incident. Interview on 02/26/26 at 1:51 P.M. with the Administrator confirmed he recalled reporting resident #52's pants were down and his genitals were exposed to Resident #40 which was inconsistent with the conclusion of the submitted SRI. He could provide no explanation as to why the SRI contained information inconsistent with what he recorded. He also confirmed witness statements were not obtained from all staff involved in the incident, and sexual abuse could not be ruled inconclusive based on results of the investigation. Review of the facility policy titled Abuse, Neglect and Exploitation dated 01/10/26 revealed abuse was defined as the infliction of injury, intimidation, pain or mental anguish which could include resident to resident altercations. Sexual abuse was identified as a non-consensual type of sexual contact with any resident. The facility would establish a safe environment that supported consensual sexual relationships and a determination of the capacity of residents to consent to that sexual contact would be recorded. This deficiency represents noncompliance investigated under complaint #2715317.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, record reviews, review of facility Self-Reported Incidents (SRI), and review of facility policies the facility failed to ensure residents were free from misappropriation. This affected three residents (Residents #2, #26, and #94) of three residents reviewed for misappropriation. The facility census was 91. Findings include: 1. Review of Resident #2's medical record revealed an admission date of 08/12/25. Diagnoses included Alzheimer's disease, moderate protein-calorie malnutrition, generalized anxiety disorder, folate deficiency, cognitive communication deficit, hypokalemia, and insomnia. Review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively impaired and required supervision with eating for partial/moderate assistance by staff for all other Activities of Daily Living (ADLs) including medication administration. Review of physician orders for Resident #2 dated August 2025 revealed there were no orders for Haldol (an antipsychotic medication) to be administered on 08/23/25. Review of the facility Self-Reported Incident (SRI) #264503 for misappropriation revealed on 08/24/25 it was brought to the attention of the Director of Nursing (DON) by Certified Nursing Assistant (CNA) #216 on 08/23/25 around dinner time she was asked by Licensed Practical Nurse (LPN) #220 to take Resident #2 to her room so she could administer a shot of Haldol. At approximately 6:00 P.M. on 08/23/25 LPN #220 approached CNA #216 and stated Do not say anything to anyone about the shot because I got it from the stock supply for Resident #95 and did not have an order for it. Further review revealed CNA #213 was present as well and stated in a witness statement that towards dinner time Resident #2 was getting combative with the nurse, LPN #220, and LPN #220 asked her to help with the resident so she could administer a shot of Haldol. After the shot LPN #220 stated not to tell anyone because the shot was not prescribed. Additionally, a witness statement provided by CNA #204 stated herself and two other CNAs were asked to assist Resident #2 to her room and she witnessed the LPN #220 pull the residents pants down and administer an injection of Haldol and was instructed not to repeat what she saw as the medication was prescribed to another resident (Resident #95) and at one point Resident #2 had an order for it but no longer had an order. LPN #220 stated to them 'if you say something I will deny it', as it was prescribed for Resident #95. Interview on 03/02/26 at 10:15 A.M. with the DON verified LPN #220 no longer worked at the facility due to this incident, and LPN #220 gave Resident #2 a dose of Haldol 5 mg intramuscularly (injection into the muscle) that was not prescribed to her on 08/23/25. There was no documentation for this in the resident medical record. When interviewed the DON stated LPN #220 denied giving Resident #2 a dose of Haldol on 08/23/25. The DON stated the only other Resident on Haldol at this time was Resident #95. Upon counting Resident #95's Haldol it was found the pharmacy had sent a total of 10 vials on 03/08/25. Resident #95 was administered one dose on 03/10/25 and should have had 9 vials left however there were only eight vials in the cart. The DON stated it was determined LPN #220 took a vial of Resident #95's Haldol and administered it to Resident #2 on 08/23/25. The DON stated LPN #220 was terminated for administering the dose of Haldol to Resident #2 without a physician order. Interview on 03/02/26 at 10:45 A.M. with CNA #213 revealed she confirmed LPN #220 administered a shot of Haldol to Resident #2 on 08/23/25 and stated LPN #220 told her and two other CNAs to not discuss it or say anything to anyone because she did not have an order to give it and would deny it. Interview on 03/02/26 at 12:15 P.M. with CNA #216 revealed she was present when LPN #220 administered Resident #2 a shot around dinner time due to increased resident behaviors. CNA #216 stated LPN #220 told her not to say anything to anyone about it because she did not have an order to give the resident Haldol and took it from Resident #95's supply of Haldol. CNA #216 stated LPN #220 told her if she said anything about it she would deny it. Interview on 03/02/26 at 1:09 P.M. with CNA #204 revealed herself and two other CNAs were asked to assist Resident #2 to her room and she witnessed LPN #220 pull the residents pants down and administer an injection of Haldol and was instructed not to repeat what she saw as (continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the medication was prescribed to another resident and at one point the resident had an order for it but no longer did. LPN #220 stated to them if you say something I will deny it because it was prescribed for Resident #95.2. Review of Resident #26's medical record revealed an admission date of 12/24/25. Diagnoses included attention deficit hyperactivity disorder (ADHA), drug induced secondary parkinsonism, lower back pain, bipolar disorder, cervicothoracic fusion of spine, gender identity disorder, borderline personality disorder, seizures, and Tourette's Disorder. Review of Resident #26's annual MDS assessment dated [DATE] revealed the resident was cognitively intact and was independent with all ADLs. Review of Resident #26's Physician orders dated March 2025 revealed the resident was ordered Amphetamine-Dextroamphetamine (Adderall) 20 milligrams (mg) twice daily at 8:00 A.M. and 3:00 P.M. for ADHD. Review of Resident #26's Adderall narcotic count sheets revealed on 10/17/25 at 3:00 P.M. the count of Adderall pills was 33 when LPN #219 signed out medication on 10/18/25 the count decreased from 33 to 31, at 2:12 P.M. on 10/18/25 the count decreased from 31 to 30 by LPN #219, then on 10/19/25 at 8:00 A.M. LPN #219 signed the count at 29, then at 3:00 P.M. the count went from 29 to 27 indicating on these dates and times the resident received two pills instead of the one pill as ordered. Review of the facility SRI #266258 revealed on 10/20/25 it was brought to the attention of the DON that Resident #26's count for their Adderall 20 mg capsules was not accurate. The DON informed the Administrator and the nurse in question (LPN #219) were called and suspended, the local police were notified, the pharmacy was notified, and the Medical Director was notified there were missing doses of Adderall. It was identified that LPN #219 signed out medication on 10/18/25 with the pill count decreasing from 33 to 31, at 2:12 P.M. on 10/18/25 the count decreasing from 31 to 30 by LPN #219, then on 10/19/25 at 8:00 A.M. LPN #219 signed the count at 29, then at 3:00 P.M. the count went from 29 to 27 indicating on these dates and times the resident received two pills instead of the one pill as ordered. Interview on 03/03/26 at 11:30 A.M. with the DON revealed LPN #219 was present in the facility for an interview related to the investigation for SRI 266258 and explained she did not know why the count for the Adderall for Resident #26 was not correct and explained there was one day she punched two capsules out and wasted one but could not find another nurse to witness the waste. She additionally was asked to complete a urine drug screen at the facility and LPN #219 refused to complete it and left the facility. The DON stated she called LPN #219 and spoke with her and LPN #219 asked for the drug screen to be completed at an independent drug testing center. This accommodation was provided and to be completed on 10/21/25, however, LPN #219 did not show for drug screen until 10/22/25. The results of the drug screen were negative. The DON stated it only takes two days for Adderall to clear your system so if LPN #219 took Resident #26's Adderall on 10/18/25 or 10/19/25 it would not show. The DON stated LPN #219 was allowed to return to work on 10/27/25, 10/29/25, 11/01/25, and 11/02/25 then called to the facility and informed the DON she was going to Rehab and was quitting her job. The DON confirmed LPN #219 worked in Resident #26's section and administered her medications. The DON stated there were no narcotic discrepancies on these dates. When asked why LPN #219 was permitted to return to work after refusing the in-facility drug test and not showing up to the independent drug testing center on 10/21/25 she stated because her drug test was negative and she was needed to work in the facility. The DON stated it is facility policy that if a drug test is refused or missed it is automatic termination. 3. Review of Resident #94's medical record revealed an admission date of 08/11/25 and a discharge date of 08/22/25. Diagnoses included osteoarthritis of left knee, artificial left knee joint, COPD, acute respiratory failure with hypoxia, alcoholic hepatitis without ascites, pulmonary hypertension, essential hypertension, obstructive sleep apnea, angina pectoris, insomnia and depression. Review of Resident #94's discharge MDS assessment dated [DATE] revealed the resident had intact cognition and was independent with all ADLs. Review of Resident #94's physician orders dated August 2025 revealed the resident was ordered Oxycodone 5 mg, one tablet by mouth every four hours as needed for pain. Review of Resident #94's Medication Administration Record (MAR) dated 08/11/25 to 08/22/25 revealed there was documentation indicating the resident received a dose of (continued on next page)</p>		

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F 0602  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Oxycodone 5 mg on 08/12/25 at 7:30 P.M., 08/12/25 at 11:43 P.M., and on 08/13/25 at 2:44 A.M. all administered by Agency LPN #223. Review of Resident #94's Narcotic Count sheet for Oxycodone 5 mg tablets revealed Agency LPN #223 signed out she administered two tablets on 08/12/25, unsure of time due to someone writing over the original time multiple times, again LPN #223 signed out two tablets on 08/12/25 at 7:00 P.M., two additional tablets on 08/12/25 at 11:00 P.M., there were two notations for 08/13/25 at 3:00 A.M. with two more tablets being administered each time, and two more tablets on 08/13/25 at 7:00 A.M. Review of the facility SRI #264534 revealed while performing shift to shift narcotic count on 08/21/25 LPN #218 noticed something off with Resident #94's narcotic count sheet so she flagged it and after the count she went back and noticed a discrepancy and alerted the DON. The DON then initiated an investigation and found Agency LPN #223 had documented on the narcotic count sheet she administered two tablets of Oxycodone 5mg with each administration on 08/12/25, unsure of this time due to someone writing over the original time multiple times, on 08/12/25 at 7:00 P.M., 08/12/25 at 11:00 P.M., there were two notations for 08/13/25 at 3:00 A.M. with two more tablets being administered each time and finally on 08/13/25 at 7:00 A.M. with two tablets being administered again. Resident #94 was only ordered Oxycodone 5 mg every four hours as needed for pain. The DON notified the local police department, the facility Medical Director, the Pharmacy, the Resident and LPN #223's staffing agency of the discrepancies. Interview on 03/03/26 at 2:15 P.M. with the DON revealed LPN #223 worked for a staffing agency and had not been back to the facility since the discrepancies were identified. The DON stated she notified the staffing agency and LPN #223 was terminated. The DON stated all medications were replaced and there was no harm to the resident however the misappropriation did occur. The DON stated with all three incidents of misappropriation on SRI #264503, 264534, and 266258 although the facility unsubstantiated them, misappropriation did occur and they should have been substantiated. They took action against all three nurses including notifying the Ohio Board of Nursing and explained that the Ohio Attorney General's Office was investigating all three as well. Review of the undated facility policy titled Drug Free Safety Policy, revealed under the section titled Testing Frequency and Patterns it stated Refusal to comply with the testing requirements, failure to provide the required valid specimens, adulteration, or substitution of specimen will be considered a refusal to test and any such refusal shall be subject to immediate termination of employment. Additionally, under the section titled Discipline bullet point #2 it was the policy of the facility that No employee shall refuse to submit to a pre-employment, post-accident, reasonable suspicion, and/or follow up test. Refusal will result in termination. Review of facility LPN Job Description revealed the LPN is responsible to prepare and administer medications, enteral nutrition, and administer if licensed to do so, and treatments as ordered, as well as the ability to administer medications according to physician's orders and accurately record medicines administered, as well as providing notes in regard to medication when necessary. Review of facility policy titled Abuse, Neglect, and Exploitation last reviewed on 01/10/26, revealed Misappropriation refers to the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident consent. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation. This deficiency represents non-compliance investigated under Complaint Number 2676302.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, review of facility Self-Reported Incidents (SRI), and review of facility policy, the facility failed to implement policies related to misappropriation. This affected one Resident (Resident #26) out of three residents reviewed for misappropriation. The facility census was 91. Findings include: Review of Resident #26's medical record revealed an admission date of 12/24/25. Diagnoses included attention deficit hyperactivity disorder (ADHA), drug induced secondary parkinsonism, lower back pain, bipolar disorder, cervicothoracic fusion of spine, gender identity disorder, borderline personality disorder, seizures, and Tourette's Disorder. Review of Resident #26's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and was independent with all Activities of Daily Living (ADLs). Review of Resident #26's Physician orders dated March 2025 revealed the resident was ordered Amphetamine-Dextroamphetamine (Adderall) 20 milligrams (mg) twice daily at 8:00 A.M. and 3:00 P.M. for ADHD. Review of Resident #26's Adderall narcotic count sheets revealed on 10/17/25 at 3:00 P.M. the count of Adderall pills was 33. When Licensed Practical Nurse (LPN) #219 signed out medication on 10/18/25 the count decreased from 33 to 31, at 2:12 P.M. On 10/18/25 the count decreased from 31 to 30 by LPN #219. On 10/19/25 at 8:00 A.M. LPN #219 signed the count at 29, then at 3:00 P.M. the count went from 29 to 27 indicating on these dates and times the resident received two pills instead of the one pill as ordered. Review of the facility SRI #266258 revealed on 10/20/25 it was brought to the attention of the DON that Resident #26's count for their Adderall 20 mg capsules was not accurate. The DON informed the Administrator and the nurse in question (LPN #219) was called and suspended, the local police were notified, the pharmacy was notified, and the Medical Director was notified there were missing doses of Adderall. It was identified that LPN #219 signed out medication on 10/18/25 and the count went from 33 to 31, at 2:12 P.M. on 10/18/25 the count went from 31 to 30 by LPN #219, then on 10/19/25 at 8:00 A.M. LPN #219 signed the count at 29, then at 3:00 P.M. the count went from 29 to 27 indicating on these dates and times the resident received two pills instead of the one pill as ordered. Interview on 03/03/26 at 11:30 A.M. with the DON revealed LPN #219 was present in the facility for an interview related to the investigation for SRI #266258 and explained she did not know why the count for the Adderall for Resident #26 was not correct and explained there was one day she punched two capsules out and wasted one but could not find another nurse to witness the waste. She additionally was asked to complete a urine drug screen at the facility and LPN #219 refused to complete it and left the facility. The DON stated she called LPN #219 and spoke with her and LPN #219 asked for the drug screen to be completed at an independent drug testing center. This accommodation was provided and to be completed on 10/21/25, however, LPN #219 did not show for drug screen until 10/22/25. The results of the drug screen were negative. The DON stated it only takes two days for Adderall to clear your system so if LPN #219 took Resident #26's Adderall on 10/18/25 or 10/19/25 it would not show. The DON stated LPN #219 was allowed to return to work on 10/27/25, 10/29/25, 11/01/25, and 11/02/25 then called to the facility and informed the DON she was going to Rehab and was quitting her job. The DON confirmed LPN #219 worked in Resident #26's section and administered her medications. The DON stated there were no narcotic discrepancies on these dates. When asked why LPN #219 was permitted to return to work after refusing the in-facility drug test and not showing up to the independent drug testing center on 10/21/25 she stated because her drug test was negative and she was needed to work in the facility. The DON stated it was facility policy that if a drug test was refused or missed it is automatic termination. Review of the undated facility policy titled Drug Free Safety Policy, revealed under the section titled Testing Frequency and Patterns it stated Refusal to comply with the testing requirements, failure to provide the required valid specimens, adulteration, or substitution of specimen will be considered a refusal to test and any such refusal shall be subject to immediate termination of employment. Additionally, under the section titled Discipline bullet point #2 it (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>was the policy of the facility that No employee shall refuse to submit to a pre-employment, post-accident, reasonable suspicion, and/or follow up test. Refusal will result in termination. This deficiency represents non-compliance investigated under Complaint Number 2676302.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interview, review of the facility self-reported incident (SRI) and investigation and review of the facility policy, the facility failed to thoroughly investigate allegations of resident-to-resident abuse. This affected two (Residents number #40 and #52) of six residents reviewed for abuse. The facility census was 91. Review of the medical record for Resident #40 revealed an admission date of 04/07/16. Diagnoses included autistic disorder, developmental disorder, anxiety, hypertension and scoliosis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was severely cognitively impaired. She required substantial assistance for eating and was dependent for oral care, toileting, showering, dressing and personal hygiene. Review of the medical record for Resident #52 revealed an admission date of 03/20/25. Diagnoses included diabetes, depression, high cholesterol, depression and respiratory disorders. Review of the quarterly MDS assessment dated [DATE] revealed Resident #52 was cognitively intact. He was independent in all ADL's. Review of the care plan dated 03/24/25 revealed Resident #52 exhibited sexually inappropriate behaviors including entering female resident's rooms. Interventions included anticipating and meeting Resident #52's needs, discussing inappropriate behavior and praising progress improvement and behavior. Review of the nursing note dated 01/11/26 at 9:32 P.M. revealed Resident #52 indecently exposed himself to another resident in the hallway. Review of the facility SRI and related investigation dated 01/12/26 revealed Resident #52 was observed standing to the left of Resident #40 in the hallway. Resident #52's pants appeared to be positioned below his waist, however, no movements, physical contact or behavior suggesting any interactions of concern had taken place. Resident #40 lacked the cognitive ability to give any statement. The facility unsubstantiated an allegation of sexual abuse citing the Certified Nursing Assistant (CNA) did not establish any reasonable indication that inappropriate conduct had occurred and there was no evidence of unintentional harm or an adverse outcome. Other Resident interviews were obtained with no findings of abuse. Resident #52 was offered relocation to a hall with male peers and increased staffing for supervision. All facility staff were re-educated on the abuse policy. Review of the witness statement provided by CNA #213 revealed she saw Resident #52 standing in front of Resident #40 exposing his genital area saying There you go, look at it. When Resident #52 saw CNA #213, he rushed back to his bedroom. CNA #213 asked Resident #40 if Resident #52 showed his genitals and the residents responded with yes. Resident #40 was taken to the nurse's station for monitoring and another CNA stayed one-to-one with Resident #52 while the nurse was notified of the incident. There was no witness statement in the investigation from a nurse. Review of the police report #26-00878 revealed police were dispatched to the facility for a report of public indecency. Resident #52 was reportedly exposing his genitals to Resident #40. Resident #52 denied doing so. CNA #213 was interviewed and stated she witnessed resident #52 standing in front of resident #40 exposing his genitals and telling Resident #40 to look. Resident #40 was not able to provide any meaningful information regarding the account. Facility staff reported resident #52 was being discharged to the hospital. Interview on 02/26/26 at 11:20 A.M. with CNA #213 confirmed she saw Resident #52 standing near resident #40; his pants were halfway down and his genitals were exposed in front of Resident #40. When Resident #52 saw CNA #213 he returned to his bedroom. CNA #213 revealed she told LPN #214 who confirmed knowledge Resident #52 had a history of inappropriate sexual behaviors. CNA #213 revealed Resident #40 was overheard telling another CNA (unidentified) after the incident that she was scared. CNA #213 stated after Resident #40's initial report of being scared, she showed no lasting signs of distress or any indication of psychosocial harm. She revealed Resident #40's statements were not always congruent with her mood and behaviors and there had been no mood or behavior changes since the incident. Interview on 02/26/26 at 11:45 A.M. with LPN #214 revealed she was told by CNA #213 Resident #52 exposed himself to Resident #40. She (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/04/2026
NAME OF PROVIDER OR SUPPLIER  Community Skilled Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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F 0610  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	separated the residents, placed Resident #52 on 15-minute checks and notified the DON. After the incident, Resident #52's room was moved to a location which was further away from female residents. She could not confirm if she wrote a witness statement regarding the incident. Interview on 02/26/26 at 1:51 P.M. with the Administrator confirmed he recalled reporting resident #52's pants were down and his genitals were exposed to Resident #40 which was inconsistent with the conclusion of the submitted SRI. He could provide no explanation as to why the SRI contained information inconsistent with what he recorded. He also confirmed witness statements were not obtained from all staff involved in the incident, and sexual abuse could not be ruled inconclusive based on results of the investigation. Review of the facility policy titled Abuse, Neglect and Exploitation dated 01/10/26 revealed abuse was defined as the infliction of injury, intimidation, pain or mental anguish which could include resident to resident altercations. Sexual abuse was identified as a non-consensual type of sexual contact with any resident. The facility would establish a safe environment that supported consensual sexual relationships and a determination of the capacity of residents to consent to that sexual contact would be recorded. An immediate investigation is warranted when suspicion of abuse or reports of abuse occur. Identify and interview all involved persons, included alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations. Provide complete and thorough documentation of the investigation. This deficiency represents noncompliance investigated under complaint #2715317.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, and review of facility policy the facility failed to ensure Resident #93 received a safe and complete discharge process. This affected one resident (Resident #93) out of four residents reviewed for discharge. The facility census was 91. Review of Resident #93's medical record revealed an admission date of 10/03/25 and a discharge date to home on [DATE]. Diagnosis included Rhabdomyolysis, moderate protein-calorie malnutrition, hypertensive chronic kidney disease stage V, seizures, hypothyroidism, anemia, hyperfunction of pituitary gland, urinary retention, hyperlipidemia, diabetes insipidus, and hypopituitarism. Review of Resident #93's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had cognitive impairment and required set up or clean up assistance for Activities of Daily Living (ADLs). Review of Resident #93's progress notes dated 11/03/25 authored by Licensed Practical Nurse (LPN #222) revealed she was the nurse who discharged Resident #93 to home. Resident #93 left via private car; Family was present and gathered belongings and discharge paperwork was given. Review of Resident #93's discharge documents dated 11/03/25 completed by LPN #222 revealed the nursing section was not filled out. There was no evidence discharge medications were reviewed or offered to the resident and family. Interview on 02/24/26 at 1:07 P.M. with the Ombudsman revealed Resident #93 was discharged without his medication prescriptions and discharge paperwork was not filled out completely. The Ombudsman stated Resident #93 was able to obtain his medication from his primary care physician and did not suffer physical or psychosocial harm as a result. Interview on 03/02/26 at 12:15 P.M. with the Director of Nursing (DON) confirmed the discharge documentation was not filled out completely and there was no evidence discharge medications were reviewed or offered to the resident. Interview on 03/02/26 at 3:21 P.M. with LPN #222 revealed she confirmed she did not fill out Resident #93's discharge paperwork completely, she did not indicate on the paperwork that she went over discharge medications or offered a three-day supply of these medications to the resident or family. LPN #222 stated she should have documented the discharge completely and offered medications as this was the facility policy. Review of facility policy titled Transfer and Discharge last reviewed on 01/10/26 revealed on page four of the document under section titled Anticipated Discharge to the Community letter B a member of the interdisciplinary team will complete relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to the following: a recap of the Resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results; a final summary of resident's status; a reconciliation of all pre-discharge medications with the resident's post-discharge medications both prescribed and over the counter. This deficiency represents noncompliance investigated under Complaint Number 2743741.</p>		