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 04/17/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, review of an Emergency Medical Services (EMS) Run Report, review of the American Heart Association (AHA) 2025 guidance for adult Cardiopulmonary Resuscitation (CPR), review of the facility CPR policy and interview, the facility failed to promptly and correctly provide basic life support (BLS) including Cardio-Pulmonary Resuscitation (CPR) to Resident #92, (a resident with advance directives for a Full Code status), when the resident was found unresponsive and absent of vital signs. This resulted in Immediate Jeopardy and actual serious life-threatening harm and subsequent death of Resident #92 on 03/07/26 at approximately 9:00 A.M. when Transportation Aide (TA) #873 identified Resident #92 was unresponsive. TA #873 alerted Licensed Practical Nurse (LPN) #915 Resident #92 was not responding/needed help and LPN #915 refused to help stating that's not my resident and told TA #873 to go get Registered Nurse (RN) #815. Instead of providing immediate care, RN #815 stated to TA #873 I'll get to it when I can. TA #873 then utilized the facility overhead paging system to summon assistance. LPN #824 responded from another unit and initiated CPR (chest compressions) after a five to 10 minutes delay; however, at no time were artificial respirations provided to Resident #92. When Emergency Medical Services (EMS) arrived at 9:24 A.M., Resident #92 was absent from pulse/respiration and was transported to the hospital emergency room with unchanged presentation arriving at 9:48 A.M. and declared deceased in the hospital emergency room on [DATE] at 9:50 A.M. This affected one resident (#92) of two residents reviewed for death. The facility census was 83.On 04/09/26 at 3:58 P.M. the Administrator, the [NAME] President of Nursing (VPN) #802, Director of Nursing (DON) #801, and the Assistant Director of Nursing (ADON) #803 were notified Immediate Jeopardy began on 03/07/26 at approximately 9:00 A.M. when facility staff failed to respond to and provide timely and adequate basic life saving measures/CPR to Resident #92 per the resident's advance directive. EMTs arrived and took over CPR and transported the resident to the hospital where he was pronounced deceased on [DATE]. The Immediate Jeopardy was removed on 04/10/26 when the facility implemented the following corrective actions:On 04/09/26 the facility (Administrator, Director of Nursing (DON) #801, and [NAME] President of Nursing (VPN) #802) initiated an internal investigation. As a result of the investigation corrective actions were put into place to ensure resident safety and prevent further risk related to delayed emergency response and CPR. On 04/09/26 at 5:30 P.M. DON #801 and VPN #802 completed a review of all CPR events within the past six (6) months were reviewed. On 04/09/26 a full house audit of 81/81 residents (to include 80 in house residents and one on a leave of absence) code status to include validation of code status, code status order, and signed documents, and advance directive care plans was initiated. All were validated by DON #801, and Assistant Director of Nursing (ADON) #803, to ensure accuracy and accessibility of code status. On 04/09/26 ADON #803 placed laminated signage on all crash carts identifying the location of the automatic external defibrillator (AED). The facility has three (3) crash carts located on unit one, unit three, and unit four. On 04/09/26 VPN #802 developed a Medical Emergency Response Policy addressing timely response and notification of licensed nursing staff during a change of condition or unresponsive episode. On 04/09/26 at 7:15 P.M. (continued on next page)

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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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a root cause analysis was completed by DON #801, VPN #802, ADON #803 and the Administrator. On 04/09/26 from 7:15 A.M. until 7:32 P.M. an Ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review the root cause analysis (RCA) and the abatement plan. The meeting included DON #801, VPN #802, ADON #803, the Administrator, and the Medial Director via phone. The Ad Hoc QAPI reviewed the abatement plan to remove immediacy of jeopardy to include an implementation of a new policy to specify unlicensed staff role in alerting licensed personnel and timely response, review of prior CPR events in the past six months, education on high quality and CPR response with all licensed nursing staff, and implementation of mock code drills, The medical director was informed and updated on the facility plan. The QAPI committee accepted the plan and would continue oversight monitoring Beginning on 04/09/26 at 4:30 P.M. and continuing through 04/10/26 at 3:20 P.M. DON #801 provided education (verbally in person) to licensed nursing staff (20/21 LPNs, 5/6 RNs, 2/2 nurse practitioners), including the nurses who were involved in the CPR care on 03/07/2. Education topics included immediate CPR response, Code Blue activation, high-quality CPR (30:2 ratio), Ambu bag use and the new Medical Emergency Response policy. 1/21 LPNs and 1/6 RNs were educated verbally via phone and would sign in person prior to their next working shift. Beginning on 04/09/26 at 4:30 P.M. and continuing through 04/10/25 at 3:20 P.M. ADON #803, LPN #805 LPN #806 and Physical Therapy Assistant (PTA) #807 provided (verbally in person) education to non-licensed staff (29/37 Certified Nursing Assistants), 2/2 transportation Aides, 1/3 activities staff, 7/7 administrative staff, 13/13 food service staff, 15/15 environmental/maintenance staff, 4/7 therapy staff) on recognition of an unresponsive resident and the requirement to immediately notify nursing staff, clearly stating this is an emergency and the resident's location , to include the new Medical Emergency Response policy. 8/37 CNAs, 2/3 activity staff, 3/7 therapy staff were educated verbally via phone and would sign in-person prior to their next working shift. Beginning on 04/09/26 the facility implemented a plan for general orientation to include education on the facility Medical Emergency Response Policy and CPR policy. All newly hired staff would be educated by DON #801 or ADON #803 prior to assuming independent resident care responsibilities. On 04/10/26 at 2:00 P.M. Human Resources (HR) #804 completed an audit of licensed nurses (21 LPNs, six RNs, and two NPs) for current CPR certifications. Beginning on 04/13/26 the facility implemented a plan to host CPR mock code drills for licensed nurses led by certified CPR instructors Respiratory Therapist (RT) #808 and RT #809. These drills would be conducted on first, second, and third shift on 04/13/26 and on first and second shift on 04/14/26. Any licensed nursing staff who had not participated in a mock code drill by 04/14/26, would complete a drill with DON #801, RT #809 or ADON #803 prior to their next scheduled shift. The facility implemented a plan for the DON/designee to conduct mock code drills twice weekly for four (4) weeks, then monthly for two (2) months with emphasis on timely response and high-quality CPR. The facility implemented a plan for the DON/designee to complete an audit of all crash carts to validate inventory and CPR readiness; additionally, an audit would be conducted on all new admission/readmission to validate code status order, accuracy, and care plan weekly for four weeks, then monthly for two months. The facility implemented a plan for all CPR/emergency events to require DON lead investigations, reviewed by Regional VPN #810 evaluating timeliness of response and adherence to CPR standards. This review would be expected to be completed within 24 to 48 hours following any CPR event. All findings would be reviewed by the QAPI Committee. The QAPI committee would meet monthly and as needed. Although the Immediate Jeopardy was removed on 04/10/26 the deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.Review of the closed medical record for Resident #92 revealed an admission date of 02/07/26 with diagnoses including atrial fibrillation, type two diabetes, congestive heart failure (CHF), end stage renal disease (ESRD), anxiety, dementia, left kidney cancer, anal fistula, hypertension and dependency on renal dialysis. Resident #92 was discharged from the facility on (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	03/07/26 and expired at the hospital on [DATE].Review of Resident #92's physician order dated 02/08/26 revealed the resident was a full code (all life-saving measures/interventions including but not limited to cardiopulmonary resuscitation (CPR)). The resident also had a physician order for oxygen (O2) at two liters per minute via nasal cannula as needed for shortness of breath and an order for (hemo)dialysis treatments at 10:15 A.M. at an outside dialysis center every Tuesday, Thursday, Saturday.Review of the care plan initiated 02/13/26 revealed Resident #92 was at risk for ineffective breathing related to diagnoses of CHF and ESRD. Interventions included check breath sounds and monitor/document for labored breathing, monitor/document for the use of accessory muscles while breathing, oxygen therapy as needed, vital signs as needed, give cardiac medications as ordered and monitor lab work.Review of Resident #92's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had slight cognitive impairment, was independent with eating, dependent on staff for toileting, required partial to moderate assistance from staff with showers and substantial to maximum staff assistance with bed mobility. Resident #92 used intermittent oxygen therapy per the assessment.Review of Emergency Medical Services (EMS) (Run Number 26-22237) report, dated 03/07/26, revealed a call was received (on 03/07/26) at 9:18 A.M. with arrival to the facility at 9:24 A.M. Resident #92 was found unresponsive with facility staff performing CPR. Staff reported witnessing resident arrest. Staff instructed to pause. Resident was pulseless and apneic (not breathing). The resident was in pulseless electrical activity (PEA) and administered three doses of epinephrine (a drug administered to help restart effective circulation and improve chances of getting a pulse back) and given calcium. The resident was intubated and transport initiated. A fourth and fifth dose of epinephrine were given with no change in presentation. Care was transferred to the hospital staff at the emergency room (ER). Arrival at ER 9:48 P.M.Review of a facility progress note dated 03/07/26 at 9:55 A.M. and authored by Registered Nurse (RN) #815 revealed called to resident room at 09:14 per transportation aide to check resident. Resident was lying in bed on back unresponsive to verbal, tactile stimuli or to sternal rub. Resident pupils minimally responsive. Blood pressure (BP) 83/38 (hypotensive), heart rate (HR) 27 (bradycardic) with no respirations noted; unable to obtain pulse ox (oxygen saturation level). Skin warm and clammy. No palpable auscultated pulse. Bed flattened, CPR initiated at 09:15. Non-rebreather mask applied at 15 L (liters) per portable O2 (oxygen) tank. At 09:17 bed board applied CPR continue. EMS called and informed that resident in full arrest. AED called for. At 09:18 AED applied shock advised then prompts followed to continue CPR. At 09:20 EMS on site, status report given. IO (intraosseous line to deliver fluids) placed left knee per ambulance personnel. Epi and calcium given per squad who also placed their AED. 09:23 CPR continues. 09:25.Review of a facility progress note dated 03/07/26 at 10:11 A.M. authored by RN #815 revealed 09:25 continued EMS states that there is a disorganized rhythm on AED with HR of 94 but no palpable pulse. CPR continued. At 09:30 squad left facility. At 09:33 report called to hospital. At 09:36 brother notified of change in status and to call facility. At 10:00 phone call received from hospital ER stating the resident expired at 09:50 A.M.Review of a late entry progress note dated 03/07/26 at 11:27 A.M. authored by RN #815 revealed resident last known well time was when aide delivered breakfast tray at 8:45 A.M. Resident was sleeping and aide told him his tray was at the bedside and he mumbled oh, ok.An interview on 04/08/26 at 1:44 P.M. with Registered Nurse (RN) #815 revealed she was the assigned nurse for Resident #92 on 03/07/26. RN #815 stated Transportation Aide (TA) #873 was seeing if Resident #92 was going to dialysis on 03/07/26 in the morning and saw something was wrong with him. RN #815 then stated TA #873 came to her and said she needed to go see Resident #92 because there was something wrong with him. RN #815 stated she told TA #873 I'll be there when I can and proceeded to assist another resident she was working with. RN #815 stated TA #873 then stated, I don't think it can wait, and again RN #815 stated she told her OK, I'll be there when I can. RN #815 stated there was a three-to-four-minute delay from the time she was told there was an issue with Resident #92 to when she went to his room. RN #815 stated when she entered Resident #92's room he needed CPR, so she started compressions. RN #815 stated she could not remember (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	who else was in the room and could not remember who called 911. An interview on 04/08/26 at 3:00 P.M. with ADON #803 revealed LPN #915 was working at the time of the incident. LPN #915 had stated that's not my resident, to Transportation Aide (TA) #873 when TA #873 first approached LPN #915 about Resident #92 needing help the morning of 03/07/26. ADON #803 confirmed LPN #915 did not help or assess the resident. ADON #803 revealed LPN #915 was terminated due to this incident/situation.Review of LPN #915's employee file revealed a hire date of 02/11/26 and a termination date of 03/19/26 for poor performance. There were no specific details in the termination documentation to illustrate the termination was related to LPN #915 refusing to provide nursing intervention to Resident #92 during a change of condition on 03/07/26.An interview on 04/08/26 at 3:10 P.M. with LPN #824 revealed she was working on the secured unit the morning of 03/07/26 and overheard a page requesting help in Resident #92's room because there was something wrong with him and no other nurse would go and assess him. LPN #824 stated when she entered the room no one else was in there and the resident was absent of vital signs. LPN #824 stated she began chest compression and yelled for help. LPN #824 stated RN #815 then entered the room with the crash cart and was attempting to insert an intravenous (IV) line. At this time no one was supporting the resident's respiration, as no one was supplying breaths via mouth or by Ambu bag. When asked if anyone was giving Resident #92 oxygen, LPN #824 stated no she did not believe anyone did. LPN #824 stated an AED was applied and a shock was advised and given and then EMTs arrived and took over the resident's care. LPN #824 stated Resident #92 was transported to the emergency room where he then expired.An interview on 04/09/26 at 10:00 A.M. with TA #873 revealed she was working on 03/07/26 and had gone into Resident #92's room and found the resident in distress. TA #873 revealed she immediately went and got LPN #915; however, LPN #915 would not come help Resident #92 stating LPN #915 said that's not my resident. LPN #915 also did not come in to help with CPR for Resident #92. TA #873 revealed she then went to RN #815 to try to get help for the resident and the RN stated, I'll get to it when I can. TA #873 told RN #815 it cannot wait, Resident #92 was in distress and again RN #815 stated I'll be there when I can. TA #873 stated that morning on 03/07/26 she had gone into the resident's room at approximately 9:00 A.M. to see if he was ready for dialysis and the resident was still in bed, he did not respond to her and just took a deep breath in and let it out and then was absent of respiratory effort. She stated she went over to the resident and tapped his leg and shouted his name with no response. She then went to the first nurse she saw who was LPN #915 who stated to her that is not my resident and told her to go get RN #815. She then went to RN #815 who also did not come to the resident's room. TA #873 stated she made an announcement over the PA system to get someone to come in and help. TA #873 stated LPN #824 came down from the secured unit to assist. TA #873 stated she was waiting outside Resident #92's room for approximately five to 10 minutes before anyone came to help Resident #92. RN #815 entered the room with the pulse oximeter and stated there was no heart rate and then said she needed to find out if the resident was full code or a Do Not Resuscitate (DNR). LPN #824 had entered and started chest compressions, but at no point did anyone provide artificial breaths to the resident with the use of an Ambu bag. TA #873 stated she was the one who called 911 and when they arrived, they stated to provide the resident with artificial respirations and took over CPR and transported the resident to the hospital.An interview on 04/09/26 at 10:48 A.M. with RN #815 verified no artificial respirations were provided to Resident #92 even though he was not breathing. She confirmed there was an Ambu bag available on the side of the crash cart. An interview on 04/09/26 at 11:15 A.M. with CNA #866 revealed on 03/07/26 she had taken Resident #92's breakfast tray to him between 8:15 A.M. and 8:30 A.M. and he was still in bed. CNA #866 revealed the resident replied Oh Ok when told his breakfast tray was there. CNA #866 stated the resident's breakfast tray remained untouched.An interview conducted on 04/09/26 at 1:30 P.M. with DON #801 revealed the facility did not do an internal investigation related to the CPR performed for Resident #92 at the time of the incident. The DON revealed it wasn't until the state surveyors started to question the quality and timeliness of the CPR (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	provided during the annual survey that the facility initiated an investigation.An interview on 04/09/26 at 1:52 P.M. with the Administrator revealed Resident #92 and one other resident (Resident #98) had required CPR in the past 6 months. The Administrator confirmed there had been no investigation completed into the incident and subsequent death of Resident #92, and Resident #98 had also not been reviewed until after the concerns were brought forth by the state surveyors for Resident #92 during the annual survey.An interview on 04/09/26 at 3:00 P.M. with LPN #833 revealed (on 03/07/26) she entered Resident #92's room and jumped in to help with chest compressions. She was alerted to a situation going on by over hearing TA #873 yelling for RN #815 and went down to see what was going on. She also stated she called 911 as well and instructed the CNAs to go get the AED. She stated she was not aware of LPN #915 initially refusing to go and help and of the statement made by him that that was not his resident. She also confirmed at no time were artificial respirations given to the resident while she was in the room.Review of the American Heart Association (AHA) 2025 guidance for adult CPR included the following: Check for breathing, if the person is not breathing or only gasping, begin CPR; Chest compressions included to push down hard and fast at a rate of 100 to 120 compressions per minute; After every 30 compressions, give two rescue breaths; and make sure the person is on a firm surface. In 2008, after the publication of several studies looking at the rates of bystander CPR and public attitudes toward it, the AHA updated their guidance and decided to take out rescue breathing (mouth to mouth) for untrained or lay responders as a way to encourage and focus on hands only CPR. This updated guidance did not apply to trained healthcare professionals. Review of the facility policy titled Cardiopulmonary Resuscitation (CPR) last revised 10/25/25 revealed it was the facility policy to adhere to residents' rights to formulate advanced directives. In accordance with these rights, this facility would implement guidelines regarding cardiopulmonary resuscitation (CPR).The facility would follow current American Heart Association (AHA) guidelines regarding CPR.If a resident experienced a cardiac arrest, facility staff would provide basic life support, including CPR, prior to the arrival of emergency medical services and:In accordance with the resident's advanced directives, [NAME] the absence of advanced directives or a Do Not Resuscitate order: andIf the resident does not show obvious signs of clinical death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition).CPR certified staff would be available at all times.Staff would maintain current CPR certification for healthcare providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor-led setting I accordance with accepted national standards.This deficiency represents noncompliance investigated under Complaint Numbers 2977495.