

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interviews, and facility policy review, the facility failed to assess and treat Resident #10's pain prior to or during wound care to her sacrum. Actual Harm occurred on 07/09/26 when Resident #10 was observed to verbalize pain every four seconds during a 23-minute continuous observation of care and her pain was not assessed or treated until care was complete, at which time her pain was rated as a 10 out of 10 (on a scale of 1 to 10 with 10 being the greatest amount of pain one could experience). This affected one (Resident #10) of two residents observed for wound care. The facility census was 64. Findings include: Review of the medical record for Resident #10 revealed an admission date of 06/09/23 with diagnoses including peripheral vascular disease, diabetes mellitus, anxiety, chronic kidney disease, cognitive communication deficit, heart failure and polyosteoarthritis. Review of the care plan dated 06/12/23 for Resident #10 revealed she had altered comfort as evidence by arthritis, complaints of back pain, history of fracture and peripheral vascular disease. Interventions included monitoring for pain and administering pain medications as ordered. Resident #10 had a care plan identifying the resident as at risk for impaired skin integrity dated 06/12/23 with interventions including medicating for pain as ordered and monitoring for signs and symptoms of pain. Resident #10 also had a care plan dated 10/21/25 indicating she had a wound to her sacrum. Interventions included to complete treatments as ordered. Review of the wound progress notes for Resident #10 revealed she had a new stage III pressure ulcer (full thickness skin wound extending into the subcutaneous tissue) to her sacrum on 05/26/26. On 06/02/26, Wound Nurse Practitioner (NP) #598 changed the classification of the pressure ulcer to an abscess. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 had intact cognition. Resident #10 had no noted behaviors. Resident #10 was identified to be always incontinent of bowel and bladder. Resident #10 had frequent pain which occasionally interfered with day-to-day activities. She had rated her pain as 7 out of 10 on this assessment. Resident #10 was noted to have one stage III pressure ulcer that was not present on admission. Review of the physician's orders for Resident #10 revealed she had an order for Oxycodone (an opioid analgesic) 5 milligrams (mg) every six hours as needed for pain and before dressing changes dated 06/29/26. Resident #10 also had an order dated 06/30/26 for her sacrum to cleanse with normal saline or wound cleanser, pat dry, lightly pack with calcium alginate, and cover with foam or super absorbent bordered dressing twice daily. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for July 2026 revealed on 07/09/26 at 3:59 A.M., Resident #10 received Oxycodone 5 mg for a pain rating of 10 out of 10. The medication was noted to be effective for pain. An observation on 07/09/26 at 10:37 A.M. of incontinence care and wound care to Resident #10's sacral area abscess/stage III pressure ulcer with Registered Nurse (RN) #504 and Certified Nursing Assistant (CNA) #576 was conducted. CNA #576 placed a towel and her supplies to perform (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 0686 Level of Harm - Actual harm Residents Affected - Few	multidisciplinary care process that included assessing the potential for pain, effectively recognizing the presence of pain and addressing the underlying causes of pain.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and policy review the facility failed to ensure a sanitary kitchen and resident refrigerators were maintained to prevent food spoilage. This had the potential to affect all 59 residents receiving meals from the kitchen, as five residents (Residents #4, #27, #31, #63, and #64) received nothing by mouth. The facility census was 64. Findings include: 1. Observation on 07/08/26 at 11:08 A.M. during lunch meal service revealed Dietary #514 had a hair net on but hair on the back of her neck was not restrained and the line of the hair net was approximately an inch above the exposed hair. At the time of the observation Dietary Manager #510 confirmed the observation. Observation on 07/08/26 at 12:31 P.M. revealed Dietary Manager #510's hairnet was raised off of her hairline and not all hair was contained around her ears and at the base of her neck. Dietary #518's hairnet was pushed back from the top of her hairline several inches and was not fully contained. Dietary #526's hairnet was not fully covering the hair above her ears and had hair exposed. Dietary #514's hairnet was again above the hairline at the base of her neck and had loose hair exposed at her neckline. RD # 511 confirmed the observation and stated all hair should be contained in the hairnet. Review of the undated facility policy called Hair Restraints revealed hair shall be restrained to prevent physical contamination of food. Hair restraints shall be worn by all employees while in the kitchen to cover all hair. 2. Observation on 07/09/26 at 9:01 A.M. of Resident #30's room refrigerator revealed no temperature log on the side of the refrigerator. Observation on 07/09/26 at 9:03 A.M. of Resident #32's room refrigerator revealed the temperature log was not completed after 07/06/26. Interview at the time of observation with Resident #32 revealed she was unsure if they checked the temperatures of her refrigerator. Observation on 07/09/26 at 9:06 A.M. of Resident #20's room refrigerator revealed the temperature log was not completed after 07/06/26. Interview on 07/09/26 at 9:13 A.M. with RD #511 revealed the kitchen checks resident refrigerators for dates and cleaning on the weekends and housekeeping monitors the daily temperatures of the resident refrigerators. Observation on 07/09/26 from 9:13 A.M. to 9:42 A.M. with RD #511 revealed the following concerns:-Observation on 07/09/26 at 9:13 A.M. of Resident #44's room refrigerator revealed an uncovered, unlabeled, undated four-ounce glass of unidentified juice, a 20-ounce open, undated bottle of clear Gatorade. Interview at the time of observation with Resident #44, who was noted to be cognitively intact, revealed she was unsure whose juice it was and was not sure how long it had been there, possibly from the previous resident who lived in the room.-Observation on 07/09/26 at 9:22 A.M. of Resident #2's room refrigerator revealed an approximately 20 oz plastic bottle with an unidentified liquid inside and a 20-ounce water bottle with brown unidentified liquid inside. Interview at the time with Resident #2, who was noted to have moderate cognitive impairment, revealed he had put a flavor packet in each of the bottles but was unsure of how long ago.-Observation on 07/09/26 at 9:26 A.M. of Resident #30's room refrigerator revealed the temperature log was now completed. Interview at the time of the observation with Resident #30 stated someone had come in after I spoke with him earlier and completed the temp log.-Observation on 07/09/26 at 9:32 A.M. of Resident #32's room refrigerator revealed the temperature log was not completed after 07/06/26. The refrigerator contained an apple walnut salad with a use by date of 07/07/26. Interview on 07/09/26 at 9:42 A.M. with RD #511 confirmed the above findings and stated the temperature logs should have been completed, food items should have been labeled and dated and outdated foods should have been discarded for resident safety. The facility identified 12 residents (Residents #2, #3, #6, #16, #20, #25, #30, #32, #39, #43, #44, and #47) had room refrigerators. Review of the 08/2022 facility policy called Food Brought to Residents by Family and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Visitors revealed food brought into the facility for residents will be checked by the nurse or member of the nutrition services department to perform the following steps: when food is stored in resident community refrigerator it will be labeled with the resident's name, the prepared (if known) or the opened dated and expiration date. When food is stored in resident room refrigerator it will be labeled with the prepared (if known) or the opened dated and expiration date. Expired foods will be discarded after verbally notifying the resident or responsible party. Resident refrigerators (community or resident room will have internal thermometer to monitor for safe food temperatures. Temperatures will be taken and documented daily. Resident refrigerators (community or resident room will be monitored three times a week for dating/expiration of food items.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, review of personnel records, interviews, and facility policy review, the facility administration failed to effectively administer the facility when they failed to maintain professional standards of practice by falsifying clinical documentation and instructing staff to do the same, thereby compromising the integrity of facility records and resident care. This had the potential to affect 21 residents (Residents #1, #3, #6, #9, #14, #17, #18, #22, #26, #28, #32, #33, #37, #41, #43, #47, #51, #53, #56, #58 and #64), who received blood glucose monitoring. This also had the potential to affect the clinical documentation all 64 residents residing in the facility. The facility census was 64. Findings include: Review of the employee file for the Director of Nursing (DON), hire date of 06/05/26, included her job description. The DON job description, undated, revealed she was responsible for organizing and directing activities in the nursing department to ensure proper resident care. The DON would also assist in the development of performance policies and standards for the nursing staff. The job description was initiated by the DON. Review of the original and accurate blood glucose monitoring system quality control records for July 2026 for medication carts 100-1, 100-2, 200-1, 200-2, 300-1, 300-B, 400-1 and 400-2 revealed they were not fully completed from 07/01/26 through 07/08/26. The following was documented on the logs: a. Review of the 100-1 cart's log revealed the log was blank and contained no documentation from 07/01/26 through 07/07/26. On 07/08/26, Licensed Practical Nurse (LPN) #524's initials were listed. b. Review of the 100-2 cart's log revealed the log was blank and contained no documentation from 07/01/26 through 07/07/26. On 07/08/26, LPN #524's initials were listed. c. Review of the 200-1 cart's log revealed on 07/01/26, 07/02/26, 07/04/26, and 07/06/26, nursing staff documented there was no control fluid to perform the glucometer checks. On 07/03/26, 07/05/26, and 07/07/26 the log was blank and contained no documentation. On 07/08/26, the log was initiated by LPN #577. d. Review of the 200-2 cart's log revealed on 07/01/26, 07/02/26, 07/04/26, and 07/06/26, nursing staff documented there was no control fluid to perform the glucometer checks. On 07/03/26, 07/05/26, and 07/07/26 the log was blank and contained no documentation. On 07/08/26, the log was initiated by LPN #577. e. Review of the 300-1 cart's log revealed on 07/02/26, 07/04/26, and 07/06/26, nursing staff documented there was no control fluid to perform the glucometer checks. On 07/03/26, 07/05/26, and 07/07/26 the log was blank and contained no documentation. The logs were initiated as completed on 07/01/26 and 07/08/26 by LPN #517. f. Review of the 300-B cart's log revealed on 07/01/26, 07/03/26, 07/05/26, and 07/07/26 the log was blank and contained no documentation. On 07/02/26, 07/04/26, and 07/06/26 nursing staff documented there was no control fluid to perform the glucometer checks. On 07/08/26, the log was initiated by LPN #517. g. Review of the 400-1 cart's log revealed the log was blank and contained no documentation from 07/01/26 through 07/07/26. On 07/08/26, LPN #567's initials were listed. h. Review of the 400-2 cart's log revealed the log was blank and contained no documentation from 07/01/26 through 07/07/26. On 07/08/26, LPN #567's initials were listed. Review of the falsified blood glucose monitoring system quality control records for July 2026 for medication carts 100-1, 100-2, 200-1, 200-2, 300-1 A, 300-B, 400-1 and 400-2 revealed they were completed from 07/01/26 through 07/07/26. These logs had the same handwriting on each day for nine different nurses including LPN #513, LPN #517, LPN #521, LPN #524, LPN #528, Registered Nurse (RN) #537, LPN #567, LPN #571 and LPN #577. Review of staffing schedules for 07/01/25 through 07/07/26 revealed RN #537 and LPN #513 were not on the schedule those days. Interview on 07/08/26 at 7:40 A.M. with LPN #577 revealed on 07/07/26, herself and another nurse were looking at the blood (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	glucose monitoring system quality control record and were going to document they did not have control test solution available. However, when LPN #577 went to document, she noted the record had been completely filled in and someone had forged her initials. She stated whoever had falsified the record had placed her initials on days she did not work. LPN #577 stated the days that were falsified were 07/01/26 through 07/07/26 as there was no solution to test the glucometers available at the facility. When she questioned the DON about the falsified document, the DON stated it was not acceptable to write that the solution was not available. The DON had stated to her that it was not against the law for her to [NAME] their signatures on something the nurses had not completed. Interview on 07/09/26 at 8:24 A.M. with LPN #567 revealed she was one of the nurses on night shift who had their signature forged between the dates of 07/01/26 to 07/07/26 on the blood glucose monitoring system quality control record. She stated the facility did not have the glucometer solution that was used for those audits, so she had documented the solution was not available and the testing was not completed. She provided a written statement to the state surveyor. Review of the written witness statement by LPN #567 dated 07/09/26 revealed while she was attempting to perform quality control checks on the glucometers on the night shift of 07/08/26, she noted the log had been removed and it had been replaced with a log that had been falsified. LPN #567 stated her initials were on the log in someone else's handwriting, on days she did not work, and on medication carts she had not been responsible for. She stated she then phoned LPN #515 who placed the call on speakerphone as the DON was in the office. The DON admonished LPN #567 for her attitude when she questioned why the quality control logs were falsified and someone else had placed her signature on the page. The DON then stated she had falsified the logs to avoid getting penalized during the annual survey. The statement then stated LPN #515 apologized and the DON offered to place the original quality control logs back on the medication carts. LPN #567 stated the actions were insufficient and that the DON and committed fraud in her name. On 07/09/26 at 6:24 A.M., LPN #567 stated she spoke to the Administrator on a recorded conversation. She stated the Administrator informed her the DON had been suspended and an investigation was initiated. Interview on 07/09/26 at 8:31 A.M. with the Administrator verified she had been updated by the nursing staff of a potential concern related to falsified documentation for the quality control checks on the glucometers. She stated she ensured the original and accurate records were placed back on the medication carts, the DON was suspended, nursing had audited the glucometers to ensure they were working properly, and she would be interviewing all the nursing staff. Interview on 07/09/26 at 9:30 A.M. with LPN #585 revealed she had witnessed the DON asking the Certified Nursing Assistants (CNA) to falsify shower sheets. She denied being personally asked to falsify records. Interview on 07/09/26 at 9:35 A.M. with RN #504 verified there was one time the DON wanted her to write a progress note on a resident about receiving orders when she had not been working on that specified day. She stated she had refused to falsify documentation. Interview on 07/09/26 at 9:38 A.M. with LPN #563 revealed the DON had asked her to complete skilled nurse charting on days she had not worked. She stated she had refused to falsify documentation. Interview on 07/09/26 at 9:40 A.M. with LPN #521 verified her initials were falsified on the blood glucose monitoring system quality control records and she had not completed those audits. Interview on 07/09/26 at 10:15 A.M. with CNA #559 revealed the DON had asked her to falsify shower sheets on 07/08/26. She stated it was for Resident #2, and she admitted to signing the sheets even though she did not perform the showers. She stated she did not want to tell the DON no, as she was her supervisor. Review of the facility investigation dated 07/10/26 revealed on 07/08/26, the Administrator was informed by the DON that a nurse had called her about the blood glucose quality control record log being completed with her initials on days she did not do the audits. The DON (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe environment related to potholes in the parking lot. This affected five residents (#23, #25, #28, #44, and #68) of five residents present at the resident council meeting. Additionally, the facility failed to maintain water temperature of sinks and showers at a level a reasonable person would find comfortable. This had the potential to affect the 33 residents (#1, #3, #4, #5, #6, #8, #11, #15, #16, #19, #21, #23, #29, #30, #32, #37, #39, #41, #43, #46, #48, #55, #58, #61, #63, #64, #68, #69, #76, #77, #78, #79, and #80) residing on the 200-unit and 400-unit within the facility. The facility census was 64. Findings include: 1. Review of the quotes to repair the parking lot revealed quotes were received on 09/16/24, 02/25/26, and 03/26/26. On 07/07/26 at 7:53 A.M., an observation of the parking lot in front of the building revealed 10 large potholes. On 07/08/26 at 9:52 A.M., during the resident council meeting during the annual survey, an interview with Resident #25 revealed the potholes in the parking lot were a concern that had never been addressed by the facility. Resident #25 stated the potholes had been there for a while and they were unable to enjoy outdoor activities like carnivals as a result. Residents #23, #28, #44, and #68, who were also attending the resident council meeting, were in agreeance with Resident #25. On 07/08/26 at 10:36 A.M., an interview with Activities Director #508 confirmed the parking lot needed fixed so they could hold large outdoor activities. On 07/08/26 at 10:48 A.M., an interview with the Administrator confirmed the first quote the facility got to repair the parking lot was dated 09/16/24. The Administrator stated she had a meeting with the owner of the facility at the end of June [2026] to discuss the parking lot and they were waiting on him to review the quotes and select one. On 07/08/26 at 11:31 A.M., an interview with Maintenance Director #575 confirmed the initial quote to repair the parking lot was dated 09/16/24. Maintenance Director #575 said he had not been at the facility very long, but the parking lot had definitely had the potholes for quite a while. On 07/08/26 at 11:41 A.M., an interview with Minimum Data Set (MDS) Nurse #515 stated the parking lot started getting bad about three or four years ago after they held a large carnival outside for the residents. MDS Nurse #515 stated the potholes were huge. MDS Nurse #515 stated multiple staff had complained and there was a joke amongst staff that they should turn the potholes into duck ponds. On 07/08/26 at 11:48 A.M., an interview with Resident #82 and Resident #82's family member revealed both expressed concerns with the state of the parking lot, with Resident #82's family member referring to the potholes in the parking lot as craters. On 07/08/26 at 2:07 P.M., an interview with the Administrator stated the parking lot had been patched in the past but she was unsure when that occurred. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/26 at 3:15 P.M., an interview with the Administrator stated the parking lot was patched in November 2023. The Administrator confirmed nothing had been done to the parking lot since the first quote for repairs was received on 09/16/24. The Administrator stated there was back and forth conversation between the owner of the facility and the owner of the building they lease about who would be responsible for paying for the repair. On 07/09/26 at 8:40 A.M., an interview with the Administrator stated they hired someone to come to the facility on [DATE] to fill the holes with stones until the full job could be completed. On 07/09/26 at 3:30 P.M., an observation of the parking lot revealed the large potholes remained and there was no evidence they had been filled with stones or gravel or were otherwise addressed. 2. Observation on 07/08/26 at 1:43 P.M. with Maintenance Director #575 revealed environmental rounds were completed to evaluate water temperatures using the facility thermometer. The following concerns were identified: At 1:48 P.M., the sink in (unoccupied) room [ROOM NUMBER] on the 100-hallway's hot water temped at 68 degrees Fahrenheit (F). At 2:00 P.M., the shower in the 400-hallway shower room temped at 100.2 degrees F. At 2:06 P.M., the shower in the 200-hallway shower room temped at 97 degrees F. Interview on 07/08/26 at 2:07 P.M. with Licensed Practical Nurse (LPN) #585 revealed stated concerns with resident rooms. LPN #585 reported there was a former resident who resided in room [ROOM NUMBER] and utilized the sink where the water was too cold. LPN #484 additionally stated showers are not hot at times, reporting the water gets hot, then cold, and changes quickly while residents are in the shower. Interview on 07/08/26 at 2:09 P.M. with Registered Nurse (RN) #563 revealed concerns with the temperature of showers. RN #563 reported water either gets too hot or is too cold and stated there was a concern for water temperatures on the 200-hallway. Interview on 07/08/26 at 2:09 P.M. with Maintenance Director #575 verified the water temperatures in (unoccupied) room [ROOM NUMBER], the 400-hallway shower room, and the 200-hallway shower room were not reaching sufficient temperatures. This deficiency represents non-compliance investigated under Complaint Number 3073399.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to maintain resident records in a complete and accurate manner. This affected three residents (#2, #9 and #70) out of 22 residents reviewed for complete and accurate medical records. The facility census was 64. Findings include: 1. Review of the medical record for Resident #2 revealed an admission date of 08/08/20. Diagnoses included but were not limited to hemiplegia and hemiparesis, venous insufficiency and non-pressure chronic ulcer of part of right fit and part of right lower leg. Review of the 06/18/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #2 revealed a Brief Interview of Mental Status (BIMS) of 11 which indicated moderate cognitive impairment. Resident #2 was noted to required moderate assistance with bathing. Review of Resident #2' care plan revealed it was last reviewed on 05/12/26 and indicated an activity of daily living self-care performance deficit related to hemiplegia. Interventions included shower two times a week and as needed and indicated Resident #2 was a one-person assist with showers. Review of the facility shower schedule revealed showers for Resident #2 were to be provided on Tuesday and Friday during day shift between 7:00 A.M. to 3:00 P.M. Review of the shower opportunities for Resident #2 for June 2026 revealed bathing was to be provided on 06/02/26, 06/05/26, 06/09/26, 06/12/26, 06/16/26, 06/19/26, 06/23/26, 06/26/26, and 06/30/26 for a total of 9 opportunities. Review of the shower sheets provided by the facility for Resident #2 for the month of June 2026 revealed: -a shower provided on 06/02/26 by Certified Nurse Aide (CNA) #559 -a shower provided on 06/09/26 by CNA # 559 -a shower provided on 06/12/26 by CNA #542 -a shower provided on 06/16/26 by CNA #559 -a shower provided on 06/19/26 by CNA #542 -a shower provided on 06/26/26 by CNA #542 -a shower provided on 06/30/26 by CNA #542 No shower sheets were provided for 06/05/26 and 06/23/26. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility shower task for Resident #2 for the month of June 2026 revealed: -06/01/26 a shower was indicated as being given at 3:16 A.M. by CNA #561 -06/01/26 a shower was indicated as being given at 12:07 P.M. by Certified Nurse Aide (CNA) #535 -06/09/26 a shower was indicated as being given at 12:48 P.M. by CNA #572 (Shower sheet was also provided for 06/09/26 provided by CNA #559) -06/10/26 a shower was indicated as being given at 10:03 A.M. by CNA #503 -06/12/26 a shower was indicated as being given at 1:10 A.M. by CNA #561 (shower sheet was also provided for 06/12/26 by CNA #542) -06/13/26 a shower was indicated as being given at 8:35 A.M. by CNA #503 -06/14/26 a shower was indicated as being given at 9:11 A.M. by CNA #522 -06/15/26 a shower was indicated as being given at 3:44 A.M. by CNA #561 -06/16/26 a shower was indicated as being given at 2:21 A.M. by CNA #561 (shower sheet was provided given by CNA #559) -06/17/26 a shower was indicated as being given at 12:37 P.M. by CNA #522 -06/18/26 a shower was indicated as being given at 9:03 A.M. by CNA #522 -06/19/26 a shower was indicated as being given at 2:57 A.M. by CNA #561 (shower sheet was also completed by CNA #542 who was not working that day) -06/22/26 a shower was indicated as being given at 2:26 P.M. by CNA #522 -06/23/26 a shower was indicated as being given at 11:20 A.M. by CNA #503 -06/26/26 a shower was indicated as being given at 4:06 A.M. by CNA #581 -06/27/26 a shower was indicated as being given at 11:53 A.M. by CNA #522 -06/28/26 a shower was indicated as being given at 10:40 A.M. by CNA #522 -06/29/26 a shower was indicated as being given at 12:25 P.M. by CNA #533 -06/29/26 a shower was indicated as being given at 2:01 A.M. by CNA #561 -06/30/26 s shower was indicated as being given at 11:14 A.M. by CNA #503 (shower sheet was also (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed by CNA #542) Review of the facility staff schedule and time punches revealed on 06/12/26, 06/19/26 and 06/26/26 CNA # 542 was not listed as working but was indicated as providing showers on those three dates. Interview on 07/06/26 at 2:10 P.M. with Resident #2 revealed he was not being offered his showers consistently. Interview on 07/09/26 at 8:36 A.M. with Minimum Data Set (MDS) Nurse #515 confirmed showers during the middle of the night should not have been documented and confirmed CNA #542 did not work 06/12/26, 06/19/26, 06/26/26 and 06/30/26 but signed shower sheets for each of those dates. MDS Nurse #515 confirmed shower sheets were not provided for 06/05/26. Interview on 07/09/26 at 10:17 A.M. with CNA #559 confirmed the Director of Nursing (DON) asked her to falsify shower sheets for Resident #2. The DON gave her and CNA #542 dates on paper and told them to fill out the shower sheets. CNA #559 stated she only filled out shower sheets for dates she worked but was unsure if she gave Resident #2 showers those days. CNA #559 stated she knew it was wrong but felt she had to since her supervisor told her to do it. Interview on 07/13/26 at 11:03 A.M. with Resident #2 confirmed he does not always get his showers and had not received showers during the middle of the night. Interview on 07/14/26 at 2:56 P.M. with CNA #542 confirmed she was not working 06/12/26, 06/19/26 and 06/26/26. CNA #542 also confirmed she was working on 06/30/26. CNA #542 stated on 06/30/26, she did not provide a shower for Resident #2 but completed a shower sheet for him. CNA #542 confirmed the DON asked her to fill out the shower sheets for Resident #2 and she was afraid not to so she falsified them. 2. Review of the medical record for Resident #9 revealed an admission date of 05/22/26 with diagnoses including end stage renal disease, hypertension, type two diabetes mellitus, and dependence on renal dialysis. Review of the census information for Resident #9 revealed the resident was admitted to the hospital from [DATE] through 07/01/26. Review of the Medication Administration Record (MAR) revealed on 06/27/26, while Resident #9 was in the hospital, Licensed Practical Nurse (LPN) #524 documented vital signs including a temperature of 97.6 degrees Fahrenheit (F) and an oxygen saturation of 98%. Review of the Treatment Administration Record (TAR) revealed on 06/27/26, while Resident #9 was in the hospital, LPN #524 documented that the following were completed: assess arteriovenous fistula site for thrill and bruit, assess behaviors every shift, offloading boot to right foot when in bed, encourage non-skid footwear when up out of bed, head of bed elevated 30 degrees for ease of respirations, monitor dialysis site for signs and symptoms of infection, pressure redistributing cushion to chair while up, and stomahesive protective powder to buttocks and sacrum for wound care. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Treatment Administration Record (TAR) revealed on 06/27/26, while Resident #9 was in the hospital, LPN #586 documented completion of pressure redistributing cushion to chair while up. On 07/09/26 at 12:15 P.M., an interview with the Administrator and Minimum Data Set (MDS) Nurse #515 verified Resident #9 was in the hospital from [DATE] through 07/01/26 and LPNs #524 and #586 had documented orders as completed on the MAR and TAR on 06/27/26 while the resident was in the hospital. 4. Review of Resident #70's medical record revealed the resident was admitted to the facility on [DATE] with a diagnosis of muscle wasting and atrophy, difficulty in walking, need for assistance with personal care, osteoarthritis, cognitive communication deficit, dependence on wheelchair, and polyneuropathy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/07/26, revealed the resident was cognitively impaired, was dependent in toileting and always incontinent of bowel and bladder. Review of the care plans revealed the resident had a care plan that indicated she was at risk for a urinary tract infection as she has a history of chronic urinary tract infections. Staff were to check on the resident every two hours and provide incontinence care as needed, encourage fluids, monitor for signs and symptoms of urinary tract infection and provide physician with laboratory testing as ordered by physician. The resident also has a care plan for incontinence of bowel and bladder that indicated staff were to toilet resident every two hours while awake. Review of bladder and bowel task sheets revealed Resident #70 on 07/01/26 was not checked on night shift. On 07/02/26, 07/03/26, 07/04/26, and 07/05/26 was not checked on second shift in eight hours. On 07/04/26 and 07/05/26 Resident #70 was not checked in eight hours on third shift. On 07/07/26 Resident #70 was not checked on day shift or second shift. On 07/10/26 Resident #70 was not checked for eight hours on second shift. On 07/11/26 and 07/12/26 Resident #70 was not checked on any shift. Interview on 07/13/26 at 12:05 P.M. with MDS Nurse #515 verified Resident #70's bladder continence task sheets was not completed every two hours per facility policy. Review of facility incontinence policy dated, 06/01/26 the facility will provide individualized, dignified, and evidence- based continence and incontinence care to promote resident comfort, protect skin integrity, reduce infection risk, maintain dignity, and ,maximize continence whenever possible.		

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on record review, interview, and facility policy review, the facility failed to ensure resident medical records were available upon request. This affected one (Resident #72) of one resident reviewed for medical records requests. The facility census was 64. Findings include: Review of the closed medical record for Resident #72 revealed an admission date of 05/07/26 with diagnoses including chronic respiratory failure, heart failure, anxiety and depression. Resident #72 was discharged from the facility on 05/25/26. Interview on 07/08/26 at 11:47 A.M. with Clinical Manager #533 revealed she started in the medical records office on 05/18/26. She stated the previous medical records clerk never provided her information that Resident #72 would like a copy of her medical records. Interview on 07/08/26 at 11:58 A.M. with Licensed Practical Nurse (LPN) #515 revealed she had corresponded with Resident #72's family via email. However, she was unable to provide an email related to the resident or her representative requesting medical records. LPN #515 stated the medical records request could have come in to the previous medical records clerk who had not been good with updating other staff of record requests prior to her leaving the facility. Interview on 07/08/26 at 12:10 P.M. with Social Services Designee (SSD) #527 revealed Resident #72's family member had asked for medical records on 05/19/26. SSD #527 instructed Resident #72's family member to speak to the previous medical records clerk to request those records. SSD #527 stated the previous medical records clerk was not forthcoming and did not relay information to Clinical Manager #533 upon her exit from the facility. LPN #515 was present during the interview and verified the facility had not provided the records as requested. Review of the facility policy titled, Skilled Nursing Facility Medical Records Request Policy, revised 01/08/26, revealed the facility would ensure timely, compliant access to residents' clinical records while protecting confidentiality and record integrity. This deficiency represents non-compliance investigated under Complaint Number 3025681.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interview, the facility failed to ensure resident's advance directives were accurately reflected in the medical record. This affected one (Resident #80) of 18 residents reviewed for advance directives. The facility census was 64. Findings include: Review of the medical record for Resident #80 revealed an admission date of 07/03/26 with diagnoses including cellulitis (bacterial infection of the skin layers and underlying tissue) and malignant neoplasm of the prostate (cancer). Review of Resident #80's face sheet revealed he was a Do Not Resuscitate Comfort Care Arrest (DNRCCA) which means healthcare staff would provide all life-saving measures until a person's heart or breathing stops. Review of the physician's orders for Resident #80 revealed he had an order for an advance directive of DNRCCA dated 07/04/26. Continued review of Resident #80's medical record revealed no DNRCCA form signed by a physician was present in the electronic medical record or paper chart. Interview on 07/08/26 at 10:18 A.M. with the Director of Nursing (DON) verified there was not a signed DNRCCA form in his electronic medical record or in his paper chart. She stated he should be documented as a full code until the DNRCCA form was signed by the physician.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility incident log, interviews, and policy review, the facility failed to ensure an injury of unknown origin was timely reported to the State Agency as required. This affected one resident (Resident #20) of one resident reviewed for self-reported incidents. The facility census was 64. Findings include: Review of the medical record for Resident #20 revealed an admission date of 05/11/22. Diagnoses included but were not limited to encephalopathy, obstructive hydrocephalus, chronic respiratory therapy, moderate protein-calorie malnutrition, hypokalemia and anemia. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #20 revealed a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. Resident #20 was noted to use a wheelchair and required maximum assist for upper dressing and rolling left to right. Resident #20 was noted to be dependent for toileting, bathing, lower body dressing, and transfers. Review of the physician orders for Resident #20 revealed an order dated 12/01/25 for a mechanical (Hoyer) lift for all transfers and an order dated 06/12/26 for Warfarin Sodium (an oral blood thinning medication). Review of Resident #20's care plan revised on 05/05/26 revealed Resident #20 was noted to be at risk for bleeding/bruising due to anti-coagulation therapy. Interventions listed revealed assess skin for any bruising/bleeding during activities of daily living (ADLs) and report any unusual bruising/bleeding to the physician. Resident #20 was also noted to have impaired transfer ability and required a mechanical lift for transfers. Review of the nursing progress note for Resident #20 dated 06/26/26 timed at 10:38 A.M. authored by Registered Nurse (RN) #547 revealed RN #547 walked into Resident #20's room to give meds and apply lotion to his legs. RN #547 noticed Resident #20 had a skin tear to left lower leg. Resident #20 was unsure how the wound occurred. RN #547 notified the Assistant Director of Nursing (ADON) and the (unspecified) Nurse Practitioner (NP). A new order for a non-adherent oil emulsion dressing and foam dressing was received. Review of the June 2026 facility incident log revealed Resident #20 was noted to have an injury to his skin on 06/26/26 at 10:31 A.M. Review of the skin assessment notes for June 2026 for Resident #20 indicated the resident was noted to have a skin tear to the left leg on 06/26/26 and 06/30/26. The skin tear measured one inch in length by one inch in width with no depth and had a dry scab over it. The skin injury was indicated to be healed on 07/07/26. Interview on 07/09/26 at 2:55 P.M. with MDS Nurse #515 confirmed Resident #20 had a skin injury occur on 06/26/26 and no staff witness statements were obtained and no investigation was completed. MDS Nurse #515 confirmed if there is a skin injury or fall staff are supposed to do a risk management assessment and an investigation and then the Director of Nursing (DON) is supposed to review it and put a note in as to what the investigation found. Interview on 07/09/26 at 3:14 P.M. with the Administrator confirmed she was not aware of any injuries for Resident #20 and therefore did not report the injury of unknown origin as a self-reported incident to the State Agency. Interview on 07/13/26 at 9:01 A.M. with RN #547 confirmed on 06/26/26 she went into Resident #20's room to give him lotion for his legs and noticed a skin tear on his left leg shin area and stated it looked like it was scabbed over and was unsure how long it had been there. Following her observation, she went to the Assistant Director of Nursing (ADON)/Wound Nurse #516 and got orders to care for the skin tear. RN #547 confirmed she completed a risk management assessment. RN #547 was not aware she needed to ask staff to write witness statements and therefore did not ask any other staff to write statements. Interview on 07/13/26 at 9:31 A.M. with the ADON/Wound Nurse #516 stated on 06/26/26, RN #547 made her (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware of the skin tear on Resident #20's leg and when she went to observe it, she did not observe any bruising, and it appeared to be scabbed over. ADON/Wound Nurse #516 notified the wound nurse practitioner and obtained treatment orders. ADON/Wound Nurse #516 confirmed she did not ask any other staff if they knew how it occurred. Resident #20 thought he may have bumped it on the overhead table but was unsure how it happened and was unsure how long the injury had been there. ADON/Wound Nurse #516 confirmed she did not follow up on the risk management assessment or notify anyone further besides the wound nurse practitioner. Interview on 07/15/26 at 4:29 P.M. with Resident #20 revealed he did not recall how he got the skin tear to his leg. Resident #20 reported the nurse mentioned the skin tear to him but he could not recall how or when it occurred. Review of the undated facility policy called Incident and Accident Reporting revealed all incidents, accidents and injuries must be reported immediately. Every incident will be documented, investigated and reviewed by management. Staff will not delay reporting while investigating. An incident is an unexpected event that could have caused harm but did not. An accident is an unplanned event resulting in injury, illness or property damage. The procedure was to ensure the safety of all residents, assess the resident or injured person immediately, notify the charge nurse, contact the attending physician, responsible party, and emergency services if necessary. Notify the Director of Nursing or supervisor immediately. Complete the incident report before the end of shift whenever possible and include the date and time, location, persons involved, description of the event, witness statements, injuries sustained, immediate actions taken, notifications made and staffing completing the form. Management will review medical records, inspect the environment, identify contributing factors, determine root cause when appropriate and recommend corrective actions. Corrective actions include revising the resident's care plan. Under the notification section, it stated report events requiring regulatory notification according to applicable federal and state requirements.		

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NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility incident log, interviews, and policy review, the facility failed to ensure an injury of unknown origin was timely and thoroughly investigated as required. This affected one resident (Resident #20) of one resident reviewed for self-reported incidents. The facility census was 64. Findings include: Review of the medical record for Resident #20 revealed an admission date of 05/11/22. Diagnoses included but were not limited to encephalopathy, obstructive hydrocephalus, chronic respiratory therapy, moderate protein-calorie malnutrition, hypokalemia and anemia. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #20 revealed a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. Resident #20 was noted to use a wheelchair and required maximum assist for upper dressing and rolling left to right. Resident #20 was noted to be dependent for toileting, bathing, lower body dressing, and transfers. Review of the physician orders for Resident #20 revealed an order dated 12/01/25 for a mechanical (Hoyer) lift for all transfers and an order dated 06/12/26 for Warfarin Sodium (an oral blood thinning medication). Review of Resident #20's care plan revised on 05/05/26 revealed Resident #20 was noted to be at risk for bleeding/bruising due to anti-coagulation therapy. Interventions listed revealed assess skin for any bruising/bleeding during activities of daily living (ADLs) and report any unusual bruising/bleeding to the physician. Resident #20 was also noted to have impaired transfer ability and required a mechanical lift for transfers. Review of the nursing progress note for Resident #20 dated 06/26/26 timed at 10:38 A.M. authored by Registered Nurse (RN) #547 revealed RN #547 walked into Resident #20's room to give meds and apply lotion to his legs. RN #547 noticed Resident #20 had a skin tear to left lower leg. Resident #20 was unsure how the wound occurred. RN #547 notified the Assistant Director of Nursing (ADON) and the (unspecified) Nurse Practitioner (NP). A new order for a non-adherent oil emulsion dressing and foam dressing was received. Review of the June 2026 facility incident log revealed Resident #20 was noted to have an injury to his skin on 06/26/26 at 10:31 A.M. Review of the skin assessment notes for June 2026 for Resident #20 also indicated a skin tear on the left leg on 06/26/26 and 06/30/26 on the left leg and was indicated to measure one inch long by one inch wide with no depth and had a dry scab over it. The skin injury was indicated to be healed on 07/07/26. Interview on 07/09/26 at 2:55 P.M. with MDS Nurse #515 confirmed Resident #20 had a skin injury occur on 06/26/26 and no staff witness statements were obtained and no investigation was completed. MDS Nurse #515 confirmed if there is a skin injury or fall staff are supposed to do a risk management assessment and an investigation and then the Director of Nursing (DON) is supposed to review it and put a note in as to what the investigation found. Interview on 07/09/26 at 3:14 P.M. with the Administrator confirmed she was not aware of any injuries for Resident #20 and therefore did not report the injury of unknown origin as a self-reported incident to the State Agency, nor did she initiate an investigation. Interview on 07/13/26 at 9:01 A.M. with RN #547 confirmed on 06/26/26 she went into Resident #20's room to give him lotion for his legs and noticed a skin tear on his left leg shin area and stated it looked like it was scabbed over and was unsure how long it had been there. Following her observation, she went to the Assistant Director of Nursing (ADON)/Wound Nurse #516 and got orders to care for the skin tear. RN #547 confirmed she completed a risk management assessment. RN #547 was not aware she needed to ask staff to write witness statements and therefore did not ask any other staff to write statements. Interview on 07/13/26 at 9:31 A.M. with the ADON/Wound Nurse #516 stated on 06/26/26, RN #547 made her aware of the skin tear on Resident #20's leg and when she went to (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observe it, she did not observe any bruising, and it appeared to be scabbed over. ADON/Wound Nurse #516 notified the wound nurse practitioner and obtained treatment orders. ADON/Wound Nurse #516 confirmed she did not ask any other staff if they knew how it occurred. Resident #20 thought he may have bumped it on the overhead table but was unsure how it happened and was unsure how long the injury had been there. ADON/Wound Nurse #516 confirmed she did not follow up on the risk management assessment or notify anyone further besides the wound nurse practitioner. Interview on 07/15/26 at 4:29 P.M. with Resident #20 revealed he did not recall how he got the skin tear to his leg. Resident #20 reported the nurse mentioned the skin tear to him but he could not recall how or when it occurred. Review of the undated facility policy called Incident and Accident Reporting revealed all incidents, accidents and injuries must be reported immediately. Every incident will be documented, investigated and reviewed by management. Staff will not delay reporting while investigating. An incident is an unexpected event that could have caused harm but did not. An accident is an unplanned event resulting in injury, illness or property damage. The procedure was to ensure the safety of all residents, assess the resident or injured person immediately, notify the charge nurse, contact the attending physician, responsible party, and emergency services if necessary. Notify the Director of Nursing or supervisor immediately. Complete the incident report before the end of shift whenever possible and include the date and time, location, persons involved, description of the event, witness statements, injuries sustained, immediate actions taken, notifications made and staffing completing the form. Management will review medical records, inspect the environment, identify contributing factors, determine root cause when appropriate and recommend corrective actions. Corrective actions include revising the resident's care plan. Under the notification section, it stated report events requiring regulatory notification according to applicable federal and state requirements.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review and interview, the facility failed to complete the resident Minimum Data Set (MDS) assessments accurately. This affected one resident (#74) out of three residents reviewed for resident assessments. The facility census was 64. Findings include: Review of the closed medical record for Resident #74 revealed an admission date of 05/06/26 with diagnoses including congestive heart failure, atrial fibrillation, spinal stenosis, anemia, hypertension, and hyperlipidemia. Resident #74 discharged from the facility on 05/28/26. Review of the discharge planning review assessment dated [DATE] indicated Resident #74 had met her skilled goals and would be discharging to home or community. Review of the Notice of Medicare Non-Coverage (NOMNC) dated 05/21/26 indicated Resident #74's last covered day was 05/27/26. Review of the discharge Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #74 had an unplanned discharge to home or community. Review of the progress note dated 05/28/26 at 1:15 P.M. revealed Resident #74 had a planned discharge to home on [DATE] at 1:15 P.M. and left in a private vehicle with a friend. On 07/07/26 at 2:40 P.M., an interview with MDS Nurse #515 confirmed the MDS assessment dated [DATE] indicated Resident #74 had an unplanned discharge and the progress note indicated it was a planned discharge. On 07/08/26 at 10:30 A.M., an interview with MDS Nurse #515 confirmed Resident #74's MDS assessment should have indicated it was a planned discharge and she had opened up a revision for it.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews the facility failed to ensure resident care plans were revised to reflect current resident medical changes and preferences. This affected three residents (Residents #20, #45 and #68) of 18 residents reviewed for care plans. The facility census was 64. Findings include: 1. Review of the medical record for Resident #20 revealed an admission date of 05/11/22. Diagnoses included but were not limited to encephalopathy, obstructive hydrocephalus, chronic respiratory therapy, moderate protein-calorie malnutrition, hypokalemia and anemia. Review of the 04/08/26 annual Minimum Data Set (MDS) 3.0 for Resident #20 revealed a Brief Interview of Mental Status (BIMS) of 14 which indicated intact cognition. Resident #20 was noted to use a wheelchair and required maximum assist for upper dressing and rolling left to right. Resident #20 was also noted to be dependent for toileting, bathing, lower dressing and transfers. Review of physician orders for Resident #20 revealed a 12/01/25 order for a mechanical lift (Hoyer) for all transfers and an order dated 06/12/26 for warfarin sodium (blood thinner). Review of Resident #20's care plan which was last reviewed on 05/05/26 revealed Resident #20 was noted to be at risk for bleeding/bruising due to anti-coagulation therapy. Interventions listed revealed assess skin for any bruising/bleeding during activities of daily living (ADLs) and report any unusual bruising/bleeding to the physician. Resident #20 was also noted to have impaired transfer ability and require a mechanical lift for transfers. The care plan was not revised to reflect intervention to treat and prevent skin tears. Review of the nursing progress note dated 06/12/26 timed at 10:37 A.M. written by Registered Nurse (RN) #547 revealed the aide came and reported a skin tear to right hand during transfer with the Hoyer (mechanical) lift. RN #547 observed a wound to right hand and notified the nurse practitioner and received new orders to cleanse with normal saline, pat dry and apply steri strip one time until they fall off naturally. Check for signs and symptoms of infection each shift. Review of the nursing progress note dated 06/26/26 timed at 10:38 A.M. written by RN #547 revealed RN #547 walked into Resident #20's room to give meds and apply lotion to his legs. RN #547 noticed a skin tear to left lower leg. Resident #20 was unsure how the wound occurred. RN #547 notified the Assistant Director of Nursing (ADON) and the nurse practitioner. A new order for non-adherent oil emulsion dressing and foam dressing was received. Review of the June facility incident log revealed an injury to skin for Resident #20 on 06/12/26 at 10:15 A.M. and on 06/26/26 at 10:31 A.M. Review of the skin assessment notes for June 2026 for Resident #20 revealed a skin tear on the right hand dated 06/12/26. Measurements on 06/16/26 were noted to be one inch in length by two inches wide with zero depth. The measurement on 06/23/26 was noted to be one inch long by two inches wide and zero depth. The measurement on 06/30/26 and 07/07/26 indicated the wound was scabbed over and the treatment indicated was steri- strips. Review of the skin assessment notes for June 2026 for Resident #20 also indicated a skin tear on the left leg on 06/26/26 and 06/30/26 on the left leg and was indicated to measure one inch long by one inch wide with no depth and had a dry scab over it. The skin injury was indicated to be healed on 07/07/26. Interview on 06/12/26 at 10:37 A.M. with Resident #20 revealed he had an injury to his hand that occurred during transfer and his skin was pulled back on his left hand. Observation at the time of the interview revealed two steri-strips on the top of his hand. Resident #68's hand appeared to be dry and no drainage was noted. Interview on 07/13/26 at 9:01 A.M. with RN #547 confirmed on 06/12/26 she was notified by Certified Nurse Aide (CNA) #579 Resident #20 was injured during a Hoyer transfer and confirmed she wrote a witness statement for herself but did not (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get a witness statement from the two aides involved. RN #547 also confirmed on 06/26/26 she went into Resident #20's room to give him lotion for his legs and noticed a skin tear on his left leg shin area and stated it looked like it was scabbed over and was unsure how long it had been there. Following her observation she went to the Assistant Director of Nursing (ADON)/Wound Nurse and got orders to care for the skin tear. RN #547 confirmed she was told to put an intervention into place to prevent it from happening again but was unable to recall if an intervention was put into place following the incident or whether the care plan was updated. Interview on 07/14/26 at 9:43 A.M. with MDS Nurse #515 confirmed due to not being made aware of the injury, an investigation was not completed and therefore the care plan was not updated and no interventions were added. 2. Review of the medical record for Resident #45 revealed an admission date of 11/17/23. Diagnoses included but were not limited to progressive multiple sclerosis, myalgia encephalomyelitis, chronic fatigue syndrome and depression. Review of the 05/08/26 quarterly MDS 3.0 for Resident #45 revealed a Brief Interview of Mental Status (BIMS) of 12 which moderate cognitive impairment. Resident #45 was noted to require set up for meals, and moderate assist for personal hygiene and wheeling 150 feet. Resident #45 was also noted to require maximum staff assistance for bathing and was dependent for toileting and lower dressing. Review of the 06/15/26 smoking and safety assessment for Resident #45 revealed resident was noted to have balance problems with sitting or standing, insufficient fine motor skills need to securely hold tobacco or other smoking items. Resident #45 was noted to be unable to hold tobacco or other smoking products safely and unable to extinguish tobacco or other smoking products. Clinical suggestions listed were to apply smoking apron and staff to extinguish cigarette. Review of Resident #45's care plan which was last updated on 06/15/26 revealed resident was a smoker and resident was to wear an apron when smoking and staff were to supervise resident when smoking. The care plan did not reflect the resident was vaping. Observation on 07/07/26 at 1:14 P.M. with Certified Nursing Aide (CNA) #595 revealed Resident #45 outside using a disposable vape (electronic device used to heat a liquid into an aerosol that is inhaled into the lungs) with no apron on. Interview on 07/08/26 at 3:30 P.M. with Resident #45 revealed staff do not usually put on the smoking apron when he vapes but will put it on when he smokes cigarettes. Interview on 07/08/26 at 3:52 P.M. with the Director of Nursing (DON) and MDS Nurse #515 revealed smoking assessments are completed upon admission and every six months. DON confirmed whether they are smoking or vaping residents are to wear a smoking apron if indicated and also confirmed she was aware Resident #45 smoked but was not aware he vaped. The DON confirmed the care plan did not reflect that Resident #45 used a vaping device. 3. Review of the medical record for Resident #68 revealed an admission date of 08/21/25. Diagnoses included but were not limited to congestive heart failure, unspecified severe protein-calorie malnutrition and dysphagia. Review of the 05/20/26 quarterly MDS 3.0 for Resident #68 revealed a Brief Interview of Mental Status (BIMS) of 10 which indicated moderate cognitive impairment. Resident #68 was noted to be independent for eating. Review of the physician orders for Resident #68 revealed an order dated 03/02/26 for a No Salt Packet (NSP) pureed diet with thin liquids. Review of the physical therapy Discharge summary dated [DATE] for Resident #68 revealed resident required maximum staff assistance for roll left and right, sit to lying, lying to sitting, sit to stand, chair and toilet transfer. Resident #68 was noted to have a mobility score of 2 out of 12 which indicated severely impaired movement and requires significant physical assistance or specialized equipment to ambulate. Review of the speech therapy Discharge summary dated [DATE] for Resident #68 revealed he was provided skilled treatment interventions including instruction and training for safe swallow strategies to determine least restrictive diet to ensure adequate intake with limited difficulty. Review of Resident #68's care plan which was last reviewed on 05/12/26 revealed resident has impaired (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	balance and limited mobility. Resident #68 was noted to be at nutritional risk related to congestive heart failure, anemia, severe malnutrition, hypophosphatemia, and a low body mass index (BMI). Interventions included were to honor food preferences as available. Monitor labs, monitor skin status, monitor weights, offer substitutes if intake is less than 50% and provide NSP pureed diet and supplements as ordered. Observation on 07/08/26 at 11:49 A.M. revealed Resident #68 in the dining room eating his lunch. Resident #68 was observed reclining in his wheelchair at about a 30-to-40-degree angle while trying to eat his lunch. Resident had consumed 100% of his pureed muffin, about 50% of his mashed potatoes and had not eaten any of the pureed quiche. Interview at the time of the above listed observation with Registered Dietitian (RD) #511 confirmed Resident #68 was reclined in his chair while eating his lunch. RD #511 also confirmed he received a pureed diet for safety and his positioning was a potential choking hazard. Interview on 07/08/26 at 12:51 P.M. with Resident #68 revealed he prefers to sit reclined in his wheelchair while eating as it is more comfortable because it does not put as much pressure on his left leg which is turned out (over rotated) to the right. Interview on 07/08/26 at 1:47 P.M. with Registered Nurse (RN) #563 confirmed Resident #68 received a pureed diet and received his medications crushed in applesauce for swallowing safety. RN #563 confirmed Resident #68 prefers to recline somewhat in his chair. RN #563 also confirmed Resident #68's care plan did not show a resident preference to recline while eating nor specify interventions for safe swallowing related to dysphagia. Observation at the time of the interview with RN #563 confirmed Resident #68 was sitting in his wheelchair in his room reclined at about a 30-40-degree angle. Interview on 07/15/26 at 7:09 A.M. with Rehab Director #599 revealed upon admission Resident #68 had almost fixed hip joints and therapy was very painful for him and he declined to continue therapy. Speech therapy last worked with Resident #68 on 03/23/26 with a recommendation to continued with a pureed diet with thin liquids. Rehab Director #599 confirmed safe swallowing strategies would be chin tuck, alternation liquids and an upright position about 90 degrees. Review of the undated facility policy called Care Plan Policy revealed the care plan will reflect the resident's goals and preferences, be reviewed and revised whenever the resident's condition changes and after each comprehensive assessment. Review of the undated facility policy called Incident and Accident Reporting revealed all incidents, accidents and injuries must be reported immediately. Every incident will be documented, investigated and reviewed by management. Staff will not delay reporting while investigating. An incident is an unexpected event that could have caused harm but did not. An accident is an unplanned event resulting in injury, illness or property damage. The procedure was to ensure the safety of all residents, assess the resident or injured person immediately, notify the charge nurse, contact the attending physician, responsible party, and emergency services if necessary. Notify the Director of Nursing or supervisor immediately. Complete the incident report before the end of shift whenever possible and include the date and time, location, persons involved, description of the event, witness statements, injuries sustained, immediate actions taken, notifications made and staffing completing the form. Management will review medical records, inspect the environment, identify contributing factors, determine root cause when appropriate and recommend corrective actions. Corrective actions include revise the resident's care plan. Under the notification section, it stated report events requiring regulatory notification according to applicable federal and state requirements.		

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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. Based on medical record review, shower sheets reviews, interviews and facility policy the facility failed to ensure bathing was provided as required. This affected one resident (Resident #2) of two reviewed for bathing. The facility census was 64. Findings include: Review of the medical record for Resident #2 revealed an admission date of 08/08/20. Diagnoses included but were not limited to hemiplegia and hemiparesis, venous insufficiency and non-pressure chronic ulcer of part of right fit and part of right lower leg. Review of the 06/18/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #2 revealed a Brief Interview of Mental Status (BIMS) of 11 which indicated moderate cognitive impairment. Resident #2 was noted to required moderate assistance with bathing. Review of Resident #2's care plan revealed it was last reviewed on 05/12/26 and indicated an activity of daily living self-care performance deficit related to hemiplegia. Interventions included shower two times a week and as needed and indicated Resident #2 was a one-person assist with showers. Review of the facility shower schedule revealed showers for Resident #2 were to be provided on Tuesday and Friday during day shift between 7:00 A.M. to 3:00 P.M. Review of the shower opportunities for Resident #2 for June 2026 revealed bathing was to be provided on 06/02/26, 06/05/26, 06/09/26, 06/12/26, 06/16/26, 06/19/26, 06/23/26, 06/26/26, and 06/30/26 for a total of 9 opportunities. Review of the shower sheets provided by the facility for Resident #2 for the month of June 2026 revealed: a shower provided on 06/02/26 by Certified Nurse Aide (CNA) #559-a shower provided on 06/09/26 by CNA #559-a shower provided on 06/12/26 by CNA #542-a shower provided on 06/16/26 by CNA #559-a shower provided on 06/19/26 by CNA #542-a shower provided on 06/26/26 by CNA #542-a shower provided on 06/30/26 by CNA #542. No shower sheets were provided for 06/05/26 and 06/23/26. Review of the facility shower task for Resident #2 for the month of June 2026 revealed: 06/01/26 a shower was indicated as being given at 3:16 A.M. by CNA #561-06/01/26 a shower was indicated as being given at 12:07 P.M. by CNA #535-06/09/26 a shower was indicated as being given at 12:48 P.M. by CNA #572 (Shower sheet was also provided for 06/09/26 provided by CNA #559)-06/10/26 a shower was indicated as being given at 10:03 A.M. by CNA #503-06/12/26 a shower was indicated as being given at 1:10 A.M. by CNA #561 (shower sheet was also provided for 06/12/26 by CNA #542)-06/13/26 a shower was indicated as being given at 8:35 A.M. by CNA #503-06/14/26 a shower was indicated as being given at 9:11 A.M. by CNA #522-06/15/26 a shower was indicated as being given at 3:44 A.M. by CNA #561-06/16/26 a shower was indicated as being given at 2:21 A.M. by CNA #561 (shower sheet was provided given by CNA #559)-06/17/26 a shower was indicated as being given at 12:37 P.M. by CNA #522-06/18/26 a shower was indicated as being given at 9:03 A.M. by CNA #522-06/19/26 a shower was indicated as being given at 2:57 A.M. by CNA #561 (shower sheet was also completed by CNA #542 who was not working that day)-06/22/26 a shower was indicated as being given at 2:26 P.M. by CNA #522-06/23/26 a shower was indicated as being given at 11:20 A.M. by CNA #503-06/26/26 a shower was indicated as being given at 4:06 A.M. by CNA #581-06/27/26 a shower was indicated as being given at 11:53 A.M. by CNA #522-06/28/26 a shower was indicated as being given at 10:40 A.M. by CNA #522-06/29/26 a shower was indicated as being given at 12:25 P.M. by CNA #533-06/29/26 a shower was indicated as being given at 2:01 A.M. by CNA #561-06/30/26 a shower was indicated as being given at 11:14 A.M. by CNA #503 (shower sheet was also completed by CNA #542) Review of the facility staff schedule and time punches revealed on 06/12/26, 06/19/26 and 06/26/26 CNA #542 was not listed as working but was indicated as providing showers on those three dates. Interview on 07/06/26 at 2:10 P.M. with Resident #2 revealed he was not being offered his showers consistently. Interview on 07/09/26 at 8:36 A.M. with Minimum (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Data Set (MDS) Nurse #515 confirmed showers during the middle of the night should not have been documented and confirmed CNA #542 did not work 06/12/26, 06/19/26, 06/26/26 and 06/30/26 but signed shower sheets for each of those dates and also confirmed shower sheets were not provided for 06/05/26. Interview on 07/09/26 at 10:17 A.M. with CNA #559 confirmed the Director of Nursing (DON) asked her to falsify shower sheets for Resident #2. The DON gave her and CNA #542 dates on paper and told them to fill out the shower sheets. CNA #559 stated she only filled out shower sheets for dates she worked but was unsure if she gave Resident #2 showers those days. Interview on 07/13/26 at 11:03 A.M. with Resident #2 confirmed he does not always get his showers and had not received showers during the middle of the night. Interview on 07/14/26 at 2:56 P.M. with CNA #542 confirmed she was not working 06/12/26, 06/19/26 and 06/26/26. CNA #542 also confirmed she was working on 06/30/26 but did not provide a shower for Resident #2 but completed a shower sheet for him. CNA #542 confirmed the Director of Nursing asked her to fill out the shower sheets for Resident #2 and she was afraid not to so she falsified them. Review of the undated facility policy called Shower Policy and Procedure revealed showers will be done according to the shower schedule posted in the shower book assigned by room number. Each resident will be given two showers a week including shampoo and a partial or completed bath on other days depending on the preference and status of the resident. Showers will be charted in PCC and shower sheets will be given to the nurse to be reviewed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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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. Based on observation, record review, and interview, the facility failed to apply ted hose as ordered for Resident #28. This affected one resident (#28) out of one reviewed for edema. The facility census was 64. Findings include: Review of the medical record for Resident #28 revealed an admission date of 11/13/25 with diagnoses including atrial fibrillation, hypertension, type two diabetes mellitus, hyperlipidemia, and obesity. Review of the physician's orders for Resident #28 identified orders for ted hose on in the morning and off in the evening for edema effective 12/09/25. Review of the care plan dated 05/05/26 revealed Resident #28 experienced cardiovascular disease as evidenced by arrhythmia, hypertension, and hyperlipidemia. Interventions included administer medications and treatments as ordered and document side effects if observed initiated 05/05/26, and notify the physician of edema and changes in skin color initiated 05/05/26. Review of the treatment administration record (TAR) for Resident #28 indicated ted hose were applied on the mornings of 07/08/26 and 07/09/26. On 07/08/26 at 9:52 A.M., during the resident council meeting, Resident #28 was observed wearing pants that ended just above the ankles and her ankles were puffy and purple in color. No ted hose were observed. On 07/09/26 at 2:40 P.M., an interview with Certified Nursing Assistant (CNA) #522 stated she had not had a chance to put Resident #28's ted hose on today because they were running behind this morning. On 07/09/26 at 2:44 P.M., an observation of Resident #28 confirmed she was not wearing ted hose. Resident #28 was wearing cropped pants and both legs were visibly swollen and purple in color.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, incident investigation, falls investigation and facility policy the facility failed to ensure a safe transfer for Resident #20, failed to ensure safety was provided during incontinence care for Resident #12, and also failed to ensure a safe smoking environment for Resident #45. This affected three residents (Resident #12, Resident #20, and Resident #45) of three residents reviewed for accidents. The facility census was 64. Findings include: 1. Review of the medical record for Resident #20 revealed an admission date of 05/11/22. Diagnoses included but were not limited to encephalopathy, obstructive hydrocephalus, chronic respiratory therapy, moderate protein-calorie malnutrition, hypokalemia and anemia. Review of the 04/08/26 annual Minimum Data Set (MDS) 3.0 for Resident #20 revealed a Brief Interview of Mental Status (BIMS) of 14 which indicated intact cognition. Resident #20 was noted to use a wheelchair and required maximum assist for upper dressing and rolling left to right. Resident #20 was noted to be dependent for toileting, bathing, lower dressing and transfers. Review of physician orders for Resident #20 revealed a 12/01/25 order for a mechanical lift (Hoyer) for all transfers and an order dated 06/12/26 for warfarin sodium (blood thinner). Review of Resident #20's care plan which was last reviewed on 05/05/26 revealed Resident #20 was noted to be at risk for bleeding/bruising due to anti-coagulation therapy. Interventions listed revealed assess skin for any bruising/bleeding during activities of daily living (ADLs) and report any unusual bruising/bleeding to the physician. Resident #20 was also noted to have impaired transfer ability and require a mechanical lift for transfers. Review of the nursing progress note for Resident #20 dated 06/12/26 timed at 10:37 A.M. written by Registered Nurse (RN) #547 revealed the aide came and reported a skin tear to right hand during transfer with the Hoyer (mechanical) lift. RN #547 observed a wound to right hand and notified the nurse practitioner and received new orders to cleanse with normal saline, pat dry and apply steri strip one time until they fall off naturally. Check for signs and symptoms of infection each shift. Review of the June facility incident log revealed an injury to skin for Resident #20 on 06/12/26 at 10:15 A.M. and on 06/26/26 at 10:31 A.M. Review of the skin assessment notes for June 2026 for Resident #20 revealed a skin tear on the right hand dated 06/12/26. Measurements on 06/16/26 were noted to be one inch in length by two inches wide with zero depth. The measurement on 06/23/26 was noted to be one inch long by two inches wide and zero depth. The measurement on 06/30/26 and 07/07/26 indicated the wound was scabbed over and the treatment indicated was steri- strips. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/12/26 at 10:37 A.M. with Resident #20 revealed he had an injury to his hand that occurred during transfer and his skin was pulled back on his left hand. Observation at the time of the interview revealed two steri-strips on the top of his hand. Resident #68's hand appeared to be dry and no drainage was noted. Interview on 07/13/26 at 9:01 A.M. with RN #547 confirmed on 06/12/26 she was notified by Certified Nurse Aide (CNA) #579 Resident #20 was injured during a Hoyer transfer and confirmed she wrote a witness statement for herself but did not get a witness statement from the two aides involved. RN #547 also confirmed on 06/26/26 she went into Resident #20's room to give him lotion for his legs and noticed a skin tear on his left leg shin area and stated it looked like it was scabbed over and was unsure how long it had been there. Following her observation she went to the Assistant Director of Nursing (ADON)/Wound Nurse #516 and got orders to care for the skin tear. RN #547 confirmed she filled out a risk management assessment. Interview on 07/13/26 at 9:31 A.M. with the ADON/Wound Nurse #516 revealed she was not working on 06/12/26 and RN #547 called and then she called the Wound Nurse Practitioner to get orders. ADON stated she did not see the wound on 06/12/26. ADON confirmed she did not notify any other management about the incident. Phone interview on 07/13/26 at 4:00 P.M. with CNA #579 confirmed on 06/12/26 he and another aide, possibly CNA #550 were transferring Resident #20 with the Hoyer lift. While Resident #20 was in the air and when they went to lower him, the Hoyer started to tilt but they were able to catch it and stabilize the Hoyer and lower Resident #20 down into his wheelchair. CNA #579 stated he did not see how the injury occurred to Resident #20 and noticed it when they lowered him and went to get RN #547. CNA #579 stated the Hoyer legs were fully open during the transfer, did not think the Hoyer malfunctioned, but thought it was a weight issue. Interview on 07/14/26 at 9:43 A.M. with MDS Nurse #515 confirmed since she was not aware of the injury an investigation was not completed to determine the root cause of the mechanical lift tilting and no new interventions were put into place. Phone interview on 07/14/26 at 1:19 P.M. with CNA #550 confirmed she helped CNA #579 to transfer Resident #20 on 06/12/26. CNA #550 stated Resident #20 was up in the Hoyer above the bed and when CNA #579 went to turn Resident #20, the leg of the Hoyer that was under the bed caught on the edge of the bedside table and started to tilt as CNA #579 was lowering Resident #20. Both CNA #550 and #579 used their bodies and arms to prevent Hoyer from tipping and were able to lower Resident #20 down into his wheelchair and then noticed his right hand was cut and bleeding. Resident #20 had not indicated pain until he was lowered to the chair and then CNA #550 went to get paper towels and applied pressure while CNA #579 went to get the RN #547. Interview on 07/15/26 at 4:29 P.M. with Resident #20 revealed he did not recall what he hit his hand on during the Hoyer transfer and noticed it when they lowered him into his chair. He stated the cut was about 1-1/2 inches long. Review of the undated facility policy called Incident and Accident Reporting revealed all incidents, (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accidents and injuries must be reported immediately. Every incident will be documented, investigated and reviewed by management. Staff will not delay reporting while investigating. An incident is an unexpected event that could have caused harm but did not. An accident is an unplanned event resulting in injury, illness or property damage. The procedure was to ensure the safety of all residents, assess the resident or injured person immediately, notify the charge nurse, contact the attending physician, responsible party, and emergency services if necessary. Notify the Director of Nursing or supervisor immediately. Complete the incident report before the end of shift whenever possible and include the date and time, location, persons involved, description of the event, witness statements, injuries sustained, immediate actions taken, notifications made and staffing completing the form. Management will review medical records, inspect the environment, identify contributing factors, determine root cause when appropriate and recommend corrective actions. Corrective actions include revise the resident's care plan. Review of the undated facility policy called Mechanical Lifts revealed the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device under the post procedure steps it listed document and report any skin issues, pain with movement or any other changes noted with the resident. 2. Review of the medical record for Resident #45 revealed an admission date of 11/17/23. Diagnoses included but were not limited to progressive multiple sclerosis, myalgia encephalomyelitis, chronic fatigue syndrome and depression. Review of the 05/08/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #45 revealed a Brief Interview of Mental Status (BIMS) of 12 which moderate cognitive impairment. Resident #45 was noted to require set up for meals, and moderate assist for personal hygiene and wheeling 150 feet. Resident #45 was also noted to require maximum staff assistance for bathing and was dependent for toileting and lower dressing. Review of the 06/15/26 smoking and safety assessment for Resident #45 revealed resident was noted to have balance problems with sitting or standing, insufficient fine motor skills need to securely hold tobacco or other smoking items. Resident #45 was noted to be unable to hold tobacco or other smoking products safely and unable to extinguish tobacco or other smoking products. Clinical suggestions listed were to apply smoking apron and staff to extinguish cigarette. The care plan did not identify interventions to ensure safe vaping practices. Review of Resident #45's care plan which was last updated on 06/15/26 revealed resident was a smoker and resident was to wear an apron when smoking and staff were to supervise resident when smoking. Observation on 07/07/26 at 1:14 P.M. with Certified Nursing Aide (CNA) #595 revealed Resident #45 outside using a disposable vape (electronic device used to heat a liquid into an aerosol that is inhaled into the lungs) with no apron on. Interview on 07/08/26 at 3:30 P.M. with Resident #45 revealed staff do not usually put on the smoking apron when he vapes but will put it on when he smokes cigarettes. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone Interview on 07/08/26 at 3:49 P.M. with CNA #595 revealed staff keep the smoking supplies behind the nurses station. CNA #595 confirmed she did not put an apron on Resident #45 when he was using the vape and stated that since there is no ash, she was not aware she needed to apply the apron before vaping. Interview on 07/08/26 at 3:52 P.M. with the Director of Nursing and MDS Nurse #515 revealed smoking assessments are completed upon admission and every six months. DON confirmed whether they are smoking or vaping residents are to wear a smoking apron if indicated and also confirmed she was aware Resident #45 smoked but was not aware he vaped. MDS Nurse #515 stated she did not feel residents need to wear an apron when they vape as it did not have an open flame. Interview on 07/08/26 at 3:58 P.M. with the Administrator revealed she thought the fire hazard for vaping was only while the vape was charging. Administrator confirmed the facility policy stated electronic cigarettes were permitted but will follow smoking guidelines and also confirmed since vaping did not have an open flame, she thought it was not a fire hazard. Review of the July 2017 revised facility policy called Smoking Policy-Residents/Staff revealed electronic cigarettes may be permitted but follow smoking guidelines. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include current level of tobacco consumption, method tobacco consumption (traditional cigarettes, electronic cigarettes, pipe, etc.), ability to smoke safely with or without supervision (per a completed smoking evaluation. A resident's ability to smoke safely will be re-evaluated every six months, upon a significant change and as determined by the staff. Review of the website www.fda.gov/tobacco-products revealed While a significant majority of vape fires and explosions occur during charging&mdash;often due to using incompatible chargers or overcharging&mdash;they are a fire hazard at all times. Review of the website www.usfa.fema.gov revealed Fires with electronic cigarettes (e-cigarettes) can happen while they are being used, charged or transported. Battery failures can lead to small explosions. 3. Review of medical record for Resident #12 admission on [DATE] with a diagnosis of major depressive disorder, recurrent, abnormalities of gait and mobility, disorder of muscle, dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, need for assistance with personal care, cognitive communication deficit, difficulty in walking, and lack of coordination. Review of Resident #12's MDS 3.0 assessment dated [DATE] revealed Resident #12 was cognitively impaired, and dependent in all activities of daily living (ADLS). Review of Resident #12's care plan dated 06/15/26 revealed Resident #12 was at risk for falls and was care planned for two person assist for all care. Review of falls investigation from 07/02/26 revealed Resident #12 had a witnessed fall from bed and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was lowered to the ground during incontinence care. Falls investigation revealed one certified nurse assistant (CNA) was administering care to Resident #12 at the time of fall. Interview on 07/09/26 at 12:49 P.M. with CNA #588 confirmed she was the only CNA administering care to Resident #12 during incontinence care and linen change when Resident #12 fell. Review of facility falls policy, dated 04/26 revealed the facility is committed to providing a safe environment that minimizes the risk of resident falls.		

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NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on record review, observation and interview, the facility failed to ensure resident's enteral feedings were administered as ordered. This affected one (Resident #63) of one resident reviewed for enteral nutrition. The facility census was 64. Findings include: Review of the medical record for Resident #63 revealed an admission date of 11/19/25 with diagnoses including respiratory failure, quadriplegia, dysphagia (difficulty swallowing) and dependence on mechanical ventilator. Review of the physician's orders for Resident #63 for July 2026 revealed an order for enteral tube feeding to run at 54 milliliters (mL)/hour for 20 hours dated 06/08/26. Observation on 07/06/26 at 1:37 P.M. of Resident #63 revealed her enteral tube feeding to be running at 45 mL/hour. Observation and interview on 07/06/26 at 2:02 P.M. with Licensed Practical Nurse (LPN) #515 revealed Resident #63's enteral tube feeding was running at 45 mL/hour. LPN #515 verified it was not running at the correct rate per the physician's order. Review of the facility policy titled, Enteral Feeding Policy, dated April 2026, revealed residents requiring enteral nutrition would receive feedings according to the physician's order.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to ensure Resident #9 had physician's orders to receive dialysis treatments and failed to assess Resident #9's condition upon return from dialysis. This affected one Resident (Resident #9) out of one reviewed for dialysis. Findings include: Review of the medical record for Resident #9 revealed an admission date of 05/22/26 with diagnoses including end stage renal disease, hypertension, type two diabetes mellitus, and dependence on renal dialysis. Review of the care plan dated 05/23/26 indicated Resident #28 required hemodialysis related to end stage renal disease. Interventions included provide dialysis as ordered initiated 05/23/26, follow the in-house dialysis schedule initiated 05/23/26, complete the handoff communication form daily initiated 05/23/26, transport to dialysis initiated 05/23/26, and check for bruit and thrill every shift initiated 05/25/26. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9 received dialysis treatments. Review of the physician's orders for Resident #9 revealed there were no physician's orders for dialysis treatments as of 07/09/26 at 8:38 A.M. The most recent order for dialysis treatments was discontinued on 06/18/26 due to hospitalization. There were no orders to assess vital signs before and after dialysis. Review of the dialysis handoff communication forms for Resident #9 revealed dialysis treatments were received on 06/26/26, 07/02/26, 07/06/26, 07/07/26, and 07/08/26 and there were no physician's orders in place for dialysis treatments. The communication forms also included a post-dialysis assessment to be completed by facility staff which did not include vital signs. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #28 revealed there was no documentation of vital signs before and after dialysis on all days which dialysis was received. On 07/09/26 at 8:55 A.M., an interview with MDS Nurse #515 verified Resident #9 received dialysis treatments and there was no physician's order for dialysis treatments. On 07/09/26 at 10:15 A.M., an interview with MDS Nurse #515 stated facility staff fill out the top portion of the dialysis handoff communication form for the pre-dialysis assessment and complete the TAR for the pre- and post-dialysis assessments. MDS Nurse #515 confirmed there were no vital signs obtained by facility staff after dialysis. Review of the facility's policy titled Skilled Nursing Facility (SNF) Dialysis Policy, not dated, indicated physician's orders for dialysis treatment would be obtained and nursing responsibilities included obtaining and documenting vital signs before and after dialysis.		

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NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure the pharmacy recommendations were addressed by the physician in a timely manner. This affected one resident (Resident #2) of five residents reviewed for unnecessary medications. The facility census was 64. Findings include: Review of the medical record for Resident #2 revealed admission date of 08/08/20. Diagnoses included but were not limited to hemiplegia and hemiparesis, severe bipolar disorder with psychotic features, anxiety disorder, chronic post traumatic headaches and history of traumatic brain injury. Review of the 06/18/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #2 revealed he required moderate assistance with most activities of daily living and no noted behaviors. Medications included antipsychotic, antidepressant, diuretic, opioid, anticonvulsant and no gradual dose was noted as attempted. Review of the physician orders for Resident #2 revealed an order dated 03/17/23 for one oral capsule of 75 milligrams (mg) of Effexor extended release to be given by mouth two times a day for depression. This order was discontinued on 03/20/26. Review of the pharmacy recommendation dated 01/29/26 for Resident #2 revealed a recommendation to review the Venlafaxine (Effexor) order. Please evaluate need for BID (twice daily) administration. Recommend to adjust therapy to: Venlafaxine ER 150 milligram tablet. Give one tablet once daily in the morning for depression. The pharmacy recommendation was indicated as agreed, signed and dated on 03/19/26. Review of the pharmacy recommendation dated 02/09/26 for Resident #2 revealed a recommendation stating the last gradual dose reduction for Venlafaxine (Effexor) 75 mg po BID was greater than one year. The pharmacy recommendation was signed by a nurse practitioner on 03/19/26 as disagreed and indicated that additional attempts would likely cause increased distressed behavior. Review of the Medication Administration Record (MAR) for January and February 2026 revealed Venlafaxine (Effexor) 75 MG was given orally twice daily (BID) for depression as ordered for January, February. Review of the physician orders for Resident #2 revealed an order dated 03/21/26 for one oral capsule of 150 milligrams (mg) of Effexor extended release to be given by mouth one time a day for major depressive disorder. Review of the 03/26 Medication Administration Record (MAR) for March 2026 revealed Venlafaxine (Effexor) 75 MG was given orally twice daily BID for depression as ordered until 03/21/26 when it was changed to 150 mg to be given once daily in the morning. Interview on 07/13/26 at 1:57 P.M. with MDS Nurse #515 revealed once the pharmacist reviews the medical records, the pharmacist findings are sent to the Director of Nursing who then sends them to the nurse practitioner or physician for a response. MDS Nurse #515 confirmed pharmacy recommendations should be acknowledged in less than 30 days and confirmed the physician did not respond timely for the pharmacy recommendations for Resident #2 and also confirmed the physician signed both the 01/29/26 and 02/09/26 pharmacy recommendations and they contraindicated each other with the 01/29/26 saying they agreed and the 02/09/26 saying they disagreed for the same medication recommendation. Phone interview on 07/13/26 at 2:41 P.M. with Nurse Practitioner #600 confirmed he must have made a mistake and did intend to attempt the GDR for Resident #2 and stated he thought he had responded to the pharmacy recommendations while he was in the building but may have put the response in the wrong place. Review of the undated facility policy called Pharmacy Review/Unnecessary Medications revealed all medications will be prescribed, administered, monitored and reviewed according to the resident's clinical condition, current standards of practice and applicable federal and state regulations. Under the procedure section, it stated the attending provider will review pharmacist recommendations and document acceptance or clinical rationale for declining recommendations, response within 30 days.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and interview, the facility failed to ensure Resident #72 was free of significant medication errors. This affected one (Resident #72) of nine residents reviewed for medications. The facility census was 64. Findings include: Review of the medical record for Resident #72 revealed an admission date of 05/07/26 with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease, heart failure, anxiety and depression. She was discharged from the facility on 05/25/26. Review of the infectious disease consult dated 05/07/26, Resident #72 was ordered Cresemba 372 milligrams (mg) once daily. Cresemba is an antifungal medication prescribed to treat invasive fungal infections, specifically invasive aspergillosis which is a severe rapidly progressive form that attacks the lungs and can spread to the brain, kidneys and skin and causes symptoms of fever, chest pain, shortness of breath and coughing up blood. Review of the physician's orders for Resident #72 revealed an order for Isavuconazonium Sulfate (Cresemba) 372 mg one time a day for aspergillosis for 30 days, family to supply, dated 05/07/26. On 05/22/26 the order was discontinued and a new order for Cresemba 186 mg, give two tablets one time a day for aspergillosis for 30 days. Review of the Medication Administration Record (MAR) for May 2026 for Resident #72 revealed Cresemba 372 mg was documented as administered daily from 05/08/26 through 05/22/26 as ordered. Review of the facility investigation for Resident #72's missed medication revealed on 05/22/26 at 10:15 A.M. the facility was notified of a medication error for Resident #72. It was determined that 11 doses were given at half the strength ordered by the physician. The dates the medications were not administered as ordered were 05/08/26 through 05/21/26. Interview on 07/08/26 at 11:19 A.M. with Licensed Practical Nurse (LPN) #515 revealed Resident #72's family had brought in her Cresemba medication in pill form that were 186 mg for each capsule so she should have received two pills for each dose. The initial order had been Cresemba 372 mg one time a day, however, nursing staff had only been giving one capsule which was half of the dose prescribed. LPN #515 stated Resident #72's family had alerted nursing management that she was only being given half of the dose as there was still medication left when they brought in the weekly doses. LPN #515 stated she had updated the physician's order on 05/22/26 alerting staff to give two capsules for each dose. Review of the facility policy titled, Medication Pass Policy and Procedure, dated June 2026, revealed medications should be administered in accordance with healthcare provider orders. Nursing staff were to follow the five rights of medication administration including right resident, right medication, right dose, right route and right time. This deficiency represents non-compliance investigated under Complaint Number 3025681.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Sanctuary Wadsworth		STREET ADDRESS, CITY, STATE, ZIP CODE 365 Johnson Rd Wadsworth, OH 44281	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to ensure proper infection control standards were maintained during incontinence care and wound care for Residents #10 and #58. This affected two (Residents #10 and #58) of three residents observed for incontinence care and wound care. The facility census was 64. Findings include: 1. Review of the medical record for Resident #10 revealed an admission date of 06/09/23 with diagnoses including peripheral vascular disease, diabetes mellitus, anxiety, chronic kidney disease, cognitive communication deficit, heart failure and polyosteoarthritis. Review the care plan dated 06/12/23 for Resident #10 revealed she had bladder and bowel incontinence. Interventions included for staff to provide good pericare after each episode of incontinence. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 had intact cognition. It was documented that she had no behaviors. Resident #10 was dependent on staff for toileting. Review of the physician's orders for Resident #10 revealed she had an order for her sacrum to cleanse with normal saline or wound cleaner, pat dry, lightly pack with calcium alginate, cover with foam or super absorbent bordered dressed two times a day for wound care dated 06/30/26. Observation on 07/09/26 at 10:37 A.M. of incontinence care and wound care to Resident #10's sacral area abscess/Stage III Pressure Ulcer (full thickness skin wound extending into the subcutaneous tissue) with Registered Nurse (RN) #504 and Certified Nursing Assistant (CNA) #576. CNA #576 placed a towel on the tray table and placed her supplies to perform incontinence care. RN #504 then went to the bathroom and washed her hands for a total of ten seconds and dried her hands and placed gloves on to assist Resident #10 with rolling on her side. CNA #576 removed Resident #10's brief leaving her unclean buttocks on the cloth bed pad. During peri-care, CNA #576 cleansed both sides of the labia front to back with different sections of the washcloth and then wiped front to back without separating the labia. She then rinsed each area with a new washcloth the same way and dried with a clean towel. CNA #576 and RN #504 then rolled Resident #10 on her side and CNA #576 cleansed her buttocks. CNA #576 then placed a clean brief on the soiled cloth bed pad and rolled the resident on it and fastened. RN #504 then removed her gloves and washed her hands for a total eight seconds. She then dried her hands and placed new gloves on. CNA #576 did not change her gloves after pericare before assisting the nurse with wound care. RN #504 cleaned the tray table and placed her wound care supplies on the tray table. She then removed her gloves and went into the bathroom and washed her hands for a total of five seconds. She dried her hands and placed gloves on and removed Resident #10's old dressing to the sacral area. RN #504 removed her gloves and went to the bathroom again washing her hands for five seconds and returned and placed clean gloves on. RN #504 cleaned the sacral area per the order and placed calcium alginate on top of the sacral wound and placed a new dressing over the calcium alginate. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/09/26 at 12:11 P.M. with RN #504 revealed she did not properly perform hand hygiene during wound care and incontinence care. RN #504 also verified the soiled cloth bed pad was left under the resident after incontinence care. Review of the facility policy titled, Infection Control Policy and Procedure, dated 06/01/26, revealed staff should wash hands before and after patient care regardless of whether gloves are worn. Review of the facility policy titled, Hand Hygiene Policy and Procedure, dated 06/01/26, revealed after applying soap to wet hands, hands are to be rubbed together for at least 20 seconds. 2. Review of Resident #58's medical record revealed the resident was admitted to the facility on [DATE] with a diagnosis of necrotizing fasciitis, pressure ulcer of left buttock, stage 3, pressure ulcer of right buttock. Review of Resident #58's admission Minimum Data Set (MDS) 3.0 assessment dated , 05/06/26 revealed Resident #58 is cognitively intact. Resident #58 required setup or clean up assistance with activities of daily living (ADL) and was dependent in bathing. Resident #58 had an indwelling catheter and was always continent of bowel. Resident #58 had two stage 3 pressure ulcers upon admission. Review of Resident #58's physician orders for the left gluteal wound revealed orders to apply negative pressure wound therapy (NPWT) at 125 mmHg continuously with black foam to wound bed. Drape with clear film adhesive. Change Tuesday, Thursday, Saturday and as needed (prn) if leaking/unable to maintain seal. Ok to apply wet to dry dressing if unable to maintain a seal or after shower on Monday night due to wound rounds on Tuesday morning one time a day every Tuesday, Thursday, Saturday for wound care and as needed for Leaking/unable to maintain seal. Observation on 07/09/26 at 9:15 A.M. of wound dressing change for Resident #58 with Wound Licensed Practical Nurse (LPN) #516 and Registered Nurse (RN) #500 in the room to assist during the treatment revealed LPN #516 had all the supplies for the dressing change. Proper personal protective equipment (PPE) was donned for enhanced barrier precautions (EBP). After cleaning the resident's bedside table and laying a clean, waterproof field, LPN #516 closed the blinds with her gloved hand and did not change her gloves or perform proper hand washing prior to touching Resident #58 with same gloved hand. LPN #516 proceeded with dressing change at 9:24 A.M. At 9:34 A.M. after RN #500 took of soiled gloves and put on new gloves, RN #500 placed 4X4 gauze pad from Resident #58's drawer on sterile field over clean scissors. RN #500 did not sanitize scissors prior to cutting foam dressing for wound. At 9:44 A.M. wound packed with foam dressing, clear drape applied over foam, and tube connected per physician orders. LPN #516 didn't change gloves or use proper hand washing after dressing change prior to touching machine. Interview on 07/09/26 at 9:52 A.M with LPN #516 verified she used gloved hand used to close blind and did not use proper hand hygiene or changed soiled gloves prior to touching Resident #58 for wound care. Interview on 07/09/26 at 10:03 A.M. RN #500 verified she did not sanitize scissors after she placed unsterile 4X4 on top of scissors were not sanitized prior to cutting foam for wound dressing. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Hand Hygiene Policy and Procedure, dated 06/01/26, revealed after contact with inanimate object indicates handwashing to prevent incidence of healthcare -associated infections.		