STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365433	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Omni Manor Nursing Home	3245 Vestal Road Youngstown, OH 44509

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 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** 45441 Based on record review, interview and facility policy review, the facility failed to ensure a thorough investigation of Resident #120 who claimed he hit his head on the ceiling of the van when the transport driver drove over speed bumps while on an appointment on 01/28/25. This affected one resident (#120) of three residents reviewed for accidents. The facility census was 119. Findings include: Review of the medical record for Resident #120 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included malnutrition, osteomyelitis (infection of the bone), muscle weakness, arthritis, kidney disease, and diabetes. Review of the comprehensive Minimum Dat Set (MDS) assessment dated [DATE] revealed Resident #120 was cognitively intact. He was independent with eating, oral hygiene, toileting and showering. Review of the health progress noted dated 01/28/15 revealed Resident #120 had an appointment with the Blood and Cancer Center. Review of the social services progress note dated 01/29/25 revealed Resident #120 reported he hit his head on the ceiling of the van while driving over speed bumps at the prior days' appointment. He also reported he had to bend far to the side, so his head did not hit the ceiling. Interview on 04/14/25 at 2:34 P.M. with Licensed Social Worker (LSW) #404 confirmed she was told by Transport Aide #393 that Resident #120 did not have much space in the facility van between his head and the ceiling, and Resident #120 hit his head during transportation to his appointment on 01/28/25. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/14/25 at 2:38 P.M. with the Director of Nursing (DON) confirmed there was no documented evidence in the medical record that Resident #120 was assessed for injury upon hearing him hitting his head on the ceiling of the van on 01/28/25, and no investigation had been completed. He provided two witness statements, not part of the medical record, dated 01/29/25 from LSW #404 and Licensed Practical Nurse (LPN) #414 referencing the incident. LSW #404's witness statement stated, Transport Aide #393 reported that Resident #120 bumped his head while going over speed bumps. Transport Aide #393 and LSW #404 reported this to the nurse on the [NAME] Wing. LPN #414's statement stated, Resident #120 complained of pain to the right hip which is not new. Resident #120 complained of a bumpy ride to and from his appointment the prior day. No visible injuries noted per head-to-toe assessment. Neuro checks were within normal limits. (There was no documented evidence of neurological checks in the medical record. There was also no nursing progress note related to this assessment). Interview on 04/14/25 at 3:59 P.M. with Transport Aide #393 revealed she had no knowledge of Resident #120 hitting his head during transportation to his appointment on 01/28/25 until LSW #404 asked her about it on 01/29/25. Review of the facility policy titled Incident, Accident and Unusual Occurrence/Risk Management Report dated November 2024 revealed the facility would document any accidents including date, time and place of the incident, a description of the accident or incident and assess the resident. Investigation summaries would include the facts of the incident, the resident assessment, intervention by staff to reduce the chance of reoccurrence and additional interventions as necessary. This deficiency represents noncompliance investigated under Master Complaint Number OH00162169.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review, observation, interview and facility policy review, the facility failed to honor residents' preferences for meals. This affected nine Residents (#41, #71, #73, #75, #77, #78, #91, #92 and #104) of ten reviewed for meal preferences. The facility census 119. Findings include: Review of the medical record for Resident #41 revealed an admitted [DATE]. Diagnoses included obsessive compulsive disorder, hypertension, mild intellectual disabilities and epilepsy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 was severely cognitively impaired. He required partial to moderate assistance with eating. Review of the medical record for Resident #71 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, and depression. Review of the quarterly MDS assessment dated [DATE] revealed resident #71 was severely cognitively impaired. She required supervision or touching assistance with eating. Review of the medical record for Resident #73 revealed an admitted [DATE]. Diagnoses included dementia, depression, glaucoma and anemia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #73 was severely cognitively impaired. He required set up assistance for eating. Review of the medical record for Resident #75 revealed an admitted [DATE]. Diagnoses included dementia, muscle wasting, high cholesterol and diabetes. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #75 was severely cognitively impaired. He was independent in eating. Review of the medical record for Resident #77 revealed an admitted [DATE]. Diagnoses included schizophrenia, history of stroke, depression and urinary incontinence. Review of the quarterly MDS assessment dated [DATE] revealed Resident #77 was severely cognitively impaired. She required set up assistance for eating. Review of the medical record for Resident #78 revealed an admitted [DATE]. Diagnoses included muscle weakness, dementia and kidney disease. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #78 was cognitively intact. Her functional abilities had not yet been fully assessed. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for Resident #91 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, diabetes, kidney failure, malnutrition and depression. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #91 was severely cognitively impaired. He was totally dependent on staff for eating. Review of the medical record for Resident #92 revealed an admitted [DATE]. Diagnoses included depression, dysphagia, constipation and muscle weakness. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #92 was cognitively intact. He required set up assistance for eating. Review of the medical record for Resident #104 revealed an admitted [DATE]. Diagnoses included breast cancer, muscle wasting, kidney disease and dysphagia (difficulty swallowing). Review of the quarterly MDS assessment dated [DATE] revealed Resident #104 was cognitively intact. She required set-up help for eating. Review of the tray tickets for the lunch meal on 04/14/25 revealed Resident #41 was not to receive bread, Resident #71 was to receive extra gravy, Resident #73 wanted extra gravy with meats, Resident #77 did not want gravy, Resident #91 wanted gravy on the side, and Resident #104 did not want rolls. Interviews on 04/14/25 at 10:51 A.M. with Residents #75, #78 and #92 revealed they did not always get what they ordered for meals, and meal preferences were not always honored. Observation on 04/14/25 at 11:25 A.M. revealed lunch was being served which consisted of country fried steak, gravy, potatoes with onions, creamed corn, a roll and chilled cinnamon apples. Preparation of meal service revealed, Resident #41 received a roll with his lunch, Resident #71 did not receive extra gravy with her lunch, Resident #73 did not receive extra gravy with his lunch, Resident #77 received gravy with his lunch, Resident #91 had gravy served top of her country fried steak, and Resident #104 received a roll with her lunch. Interviews at the time of the observations with [NAME] #356 confirmed the above resident preferences were not honored during the lunch service. Review of the facility policy titled Accommodating Religious, Ethnic, Cultural and Personal Preferences dated February 2023 revealed the facility would provide dietary preferences if requested. This deficiency is an incidental finding identified during the complaint investigation.