STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365508	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Welcome Nursing Home	417 South Main Street Oberlin, OH 44074

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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, medical record review, resident interview, staff interview, and review of facility policy, the facility failed to ensure a homelike environment. This affected two (#64 and #66) of two residents reviewed for a homelike environment. The facility census was 91.Findings include:Review of the medical record for Resident #64 revealed an admission date of 12/12/25 with diagnoses including bilateral osteoarthritis of the knees, weakness, generalized muscle weakness, abnormalities of gait and mobility, cognitive communication deficit, pneumonia, hypertension, pain in the right and left knee, shortness of breath, hyperlipidemia, hypothyroidism, personal history of malignant neoplasm of the thyroid, lymphedema, neuralgia and neuritis, alcohol dependence, and stage three chronic kidney disease (CKD3).Review of Resident #64's Medicare 5-Day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Further review of the MDS indicated Resident #64 required assistance or was dependent for activities of daily living, including eating, hygiene, toileting, dressing, rolling, sitting, repositioning, and transferring.Observation on 03/02/26 at 12:16 P.M. revealed the window in Resident #64's room was covered in plastic. Interview with Resident #64 at the time of the observation revealed Resident #64 did not like the plastic over the window and the resident found it bothersome.Interview on 03/02/26 at 12:21 P.M. with Director #348 verified there is plastic covering the window in Resident #64's room.2. Review of the medical record for Resident #66 revealed an admission date of 08/18/25 with diagnoses including chronic osteomyelitis of the ankle and foot, pressure ulcer of the left heel, type II diabetes mellitus, congestive heart failure, atrial fibrillation, peripheral vascular disease, chronic obstructive pulmonary disease, obesity, generalized muscle weakness, and dependence on a wheelchair.Review of Resident #66's most recent MDS assessment, dated 12/30/25, revealed a BIMS score of 15, indicating the resident was relatively cognitively intact. Further review of the MDS assessment revealed Resident #66 required assistance with eating, but was dependent for all other functional abilities including, but not limited to, hygiene bathing, dressing, rolling, turning, and repositioning, transferring, and propelling in her wheelchair.Observation on 03/02/26 at 10:31 A.M. of Resident #66's room revealed plastic on the window along with duct tape across the plastic on the window. Resident #66 stated at the time of the observation that the duct tape was being used to keep the upper window from sliding down. Interview on 03/05/26 at 9:25 A.M. with Certified Nursing Assistant (CNA) #428 verified there was plastic covering on Resident #66's window and the upper window was being held closed with duct tape to prevent the window from sliding open.Additional observation on 03/04/26 at 9:05 A.M. of Resident #66's room revealed a strong odor of cigarettes.Interview on 03/04/26 at 9:05 A.M. with Resident #66 verified the strong cigarette odor. Resident #66 stated she does not like the odor, adding the odor, from the smokers outside, is coming through the plastic and taped window.Review of the undated facility policy titled, Homelike Environment Policy revealed the facility will consistently design, maintain, and operate the environment to promote choice and autonomy. In resident rooms window coverings should support comfort and individual preference. Rooms will be kept clean, odor-free, and arranged to promote both (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	privacy and mobility. This deficiency represents non-compliance investigated under Complaint Number 2646853.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of a facility self-reported incident, and review of facility policy the facility failed to protect residents from abuse. This affected two (#100 and #41) of two residents reviewed for abuse with the ability to affect all residents. The facility census was 91.Findings include: 1.Review of Former Resident (FR) #100's medical record revealed an admission date of 03/20/21 and a discharge date of 09/04/25. Diagnoses included osteoarthritis, pelvis fracture, protein malnutrition, obsessive compulsive disorder, scoliosis, and kyphosis. Review of FR #100's quarterly Minimum Data Set (MDS) dated [DATE] revealed she had an intact cognition and was dependent on staff for all activities of daily living except eating. Review of Self-Reported Incident #259280 dated 04/12/25 revealed a confused male resident with dementia entered FR #100's room and refused to leave when asked. The male resident became agitated after FR #100 continued to tell him to leave. The male resident lifted FR #100's shirt up, grabbed her arm, and slapped her on the forehead. Interview following the incident revealed that FR #100 yelled out to beckon the staff to intervene. Review of the witness statement by CNA #290 revealed she was walking past the nurse's station and heard FR #100 yell get out. CNA #290 stated she ran down to the room and found Resident #70 was standing over FR #100 at which time she assisted Resident #70 from the room and led the resident back to his room. CNA #290 stated she then went back to FR #100's room to check on FR #100. CNA #290 stated FR #100 reported that she was fine and that when Resident #70 walked into her room, he pulled the front of her shirt up, hit her in the forehead and squeezed her arm. Review of a statement from the Administrator dated 04/12/25 revealed at 2:18 P.M. she received a text message from Charge Nurse #304 that there was a resident-to-resident contact that they needed to discuss. At 2:25 P.M. the Administrator called the Charge Nurse #304. Charge Nurse #304, with the Administrator on the phone went to FR #100's room to speak with the resident. FR #100 explained to both the Administrator and Unit Manger #304 that Resident #70 had come into her room and stood over to her bed. FR #100 stated she told Resident #70 that he needed to leave the room at which time Resident #70 reached out and pulled up her shirt. FR #100 stated the whole time she is telling Resident #70 that he needs to leave but Resident #70, mumbling, seemed to get frustrated with her asking him to leave and he swatted FR #100 on the forehead and grabbed her arm. After the interview, Charge Nurse #304 assessed FR #100 and said there was no redness or apparent injury. FR #100 was not complaining of pain but stated at the time of the smack to the forehead, it hurt. Review of the incident revealed the incident was reported to the State Agency, staff interviews and written statements of the incident were obtained, and the interview conducted with FR #100 by the Administrator and Unit Manager #304 revealed FR #100 was unsure of what Resident #70 was doing and was fearful at the time of the incident. Further review of Self-Reported Incident #259280 revealed the facility failed to thoroughly investigate the incident as there were no interviews or assessments of like residents to ensure the residents had not experienced abuse or were fearful of abuse. Interview with the Administrator on 03/04/26 at 8:16 A.M. confirmed Resident #70 entered FR #100's (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room, lifted FR #100's shirt, grabbed her arm, and slapped her forehead. 2. Review of Resident #41's medical record revealed an admission date of 03/27/24. Diagnoses included Alzheimer's disease, cognitive communication deficit, major depressive disorder, and hyperlipidemia. Review of Resident #41's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 03. Furthermore, Resident #41 was dependent for showers/bathing and required substantial or maximal assistance for toilet hygiene. Review of Resident #41's care plan dated 02/11/26 revealed Resident #41 had a behavior problem and would become physically aggressive during care. Interventions included to administer medications as ordered, anticipate and meet Resident #41's needs, and to provide opportunity for positive interaction and attention by stopping and talking with her when passing by. Review of SRI #267182 revealed on 11/04/25 at 6:40 P.M. Resident #41 was being assisted in the bathroom by Certified Nursing Assistant (CNA) #304. Resident #41 was yelling while being assisted so CNA #426 came into Resident #41's bathroom to assist CNA #304. Resident #41 was yelling at the two CNA's and became combative with them. Resident #41 went to bite CNA #426 and CNA #426 pushed Resident #41's head back while yelling at her to stop. CNA #426 was aggressively grabbing Resident #41's arms. CNA #426 than grabbed Resident #41 by her chin and yelled into her face to stop that. CNA #304 reported the abuse at approximately 7:45 P.M. on 11/04/25. Review of the witness statement dated 11/04/25 written by CNA #304 revealed she was providing care for Resident #41, and the resident was yelling help and being combative. CNA #426 came into the bathroom to assist and when the resident was resisting care and screaming, CNA #426 started grabbing Resident #41's arms very aggressively. Resident #41 ripped off CNA #426's glasses after which CNA #426 grabbed Resident #41's face and told her to stop. CNA #304 stated CNA #426 then stated, it is the adrenaline that just makes me want to do something and walked out of the room. CNA #304 completed care and left Resident #41 in her room. Review of the facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property with a last reviewed date of 03/11/25 revealed the facility would not tolerate abuse, neglect, exploitation, or misappropriation. Abuse is the willful infliction of injury, intimidation, or punishment resulting physical harm, pain, or mental anguish. This deficiency represents non-compliance investigated under Complaint Number 2703061.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interview, product label review, and facility policy review, the facility failed to ensure the resident environment was free from improperly stored hazardous chemicals. This had the potential to affect 14 residents (#9, #10, #15, #16, #25, #28, #29, #39, #41, #70, #71, #81, #89, and #91) identified by the facility as cognitively impaired and independently mobile. The facility census was 91. Findings include: Observation on 03/02/26 at 2:29 P.M. revealed a 10.1-ounce tube of 3M Fire Barrier Sealant Caulk in a caulk gun, approximately three-quarters used, sitting on a handrail in the common area of hall 200. The chemical was within reach of residents and in an area where residents frequently mobilize. Review of the product label for 3M Fire Barrier Sealant Caulk indicated: May irritate eyes, nose, and throat. Avoid eye contact. Do not swallow. Wash thoroughly after handling. Keep out of reach of children. Interview on 03/02/26 at 2:30 P.M. with Licensed Practical Nurse (LPN) #375 verified the chemical caulk tube was unsecured on the handrail in the 200 hall and confirmed the warnings on the product label. LPN #375 acknowledged the caulk was accessible to residents who are cognitively impaired and independently mobile. Interview on 03/04/26 at 2:05 P.M. with Maintenance Supervisor #214 verified the same tube of caulk had been observed on the handrail on hall 200 on 03/02/26 at 2:29 P.M. and confirmed the product warning label indicates the chemical may cause irritation or harm if handled or ingested. Review of the facility policy titled Chemical/Biological Storage, dated 08/11/09, revealed the facility will provide residents with an environment as free of accident hazards as possible. All chemicals/biologicals not in use must be stored in a locked location. This deficiency represents non-compliance investigated under Complaint Number 2646853.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure incontinence care was completed in a timely manner. This affected one (#11) resident reviewed for incontinence care. The facility census was 91. Review of the medical record for Resident #11 revealed this resident was admitted to the facility on [DATE]. Diagnoses included unspecified dementia, with psychotic disturbance, Neuromuscular dysfunction of bladder, and pneumonitis due to inhalation of food and vomit. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had impaired cognition. This resident was dependent on staff for activities of daily living (ADLs), and incontinence care. Review of the care plan dated 01/29/26 revealed Resident #11 was always incontinent of bowel and had a foley catheter in place. Interventions included monitoring and documenting for signs and symptoms of urinary tract infection (UTI). Further review of the care plan revealed Resident #11 was at risk for self-care deficit related to impaired cognition. Interventions included staff intervention for incontinent episodes. Staff were to reposition the resident every two hours and as needed. Resident #11 was at risk for skin breakdown. Interventions included repositioning every two hours as needed. Observation on 03/02/26 at 9:59 A.M. revealed Resident #11 lying in bed. Resident #11 had a strong odor of stool. Interview on 03/02/26 at 10:30 A.M. with CNA #247 revealed Resident #11 had not been checked since 6:00 A.M. CNA #247 further stated that Resident #11 should have been checked every two to three hours and confirmed she was not checked and had an odor of stool. Observation on 03/03/26 at 8:42 A.M. revealed Resident #11 lying in bed. Resident #11 had a strong odor of stool. Interview on 03/03/36 at 8:46 A.M. with CNA #247 confirmed Resident #11 had a strong odor of stool. CNA #247 further stated that she would change Resident #11 after feeding her breakfast. Review of the undated facility policy titled Incontinence Care Policy and Procedure, revealed proper incontinence care was to be provided to all incontinent residents to help prevent skin breakdown, the spread of infection, and to promote dignity. This deficiency represents non-compliance investigated under Complaint Numbers 2597065 and 2703061.