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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, review of the pharmacy refrigerated medication list, review of manufacturer guidelines, and review of facility policy, the facility failed to ensure safe medication handling and proper labeling of multi-use vials. Additionally, the facility failed to ensure medications were not left unattended, affecting one (#71) resident with the potential to affect the direct safety risk of 14 residents (#09, #10, #15, #16, #25, #28, #29, #39, #41, #70, #77, #81, #89, #91) who were identified by the facility as being cognitively impaired, independently ambulatory, and residing on the 200 hall. The facility census was 91. Findings include: 1.Observation on 03/03/26 at 7:30 A.M. of the medication storage room located behind the east nursing station revealed a 1 milliliter (mL) vial of Tubersol PPD (Mantoux) 10 multi-use vial, lot number 4CA12C1, with a manufacturer expiration date of 02/2028, was opened and not labeled with the date it was first used. Interview on 03/03/26 at 7:32 A.M. with Licensed Practical Nurse (LPN) #245 verified that the 1 mL vial of Tubersol PPD, lot number 4CA12C1, with manufacturer expiration date 02/2028, had been opened and was not labeled with the date it was first used. Review of the pharmacy refrigerated items list indicated Tubersol PPD must be stored in the refrigerator and discarded 30 days after first use. Review of the manufacturer's packaging insert for Tubersol PPD revealed vials entered for use must be discarded 30 days after initial entry, with instruction to not use the product beyond the expiration date or 30 days after opening. 2. Review of Resident #71's medical record revealed an admission date of 01/13/16. Diagnoses included dementia, diabetes mellitus type II, peripheral vascular disease, psychosis, seizures, and depression. Review of Resident #71's quarterly Minimum Data Set (MDS) dated [DATE] revealed he had an intact cognition, was independent with eating. Review of Resident #71's most recent care plan revealed he suffered from behavior problems related to diagnosis of bipolar. Resident #71 was attention seeking and manipulative with caregivers. Interventions were to administer medications as ordered. Resident #71 was also care planned for choking and mouth issues due to dysphagia. Intervention was to encourage alternation of bites/sips, hard throat clearing followed by swallowing again when taking liquids. Observation on 03/02/26 at 9:39 A.M. revealed Resident #71 way lying in bed awake. Resident #71 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	had a medication cup on the bedside table with a large assortment of pills. Interview with Registered Nurse (RN) #334 on 03/02/26 at 9:43 A.M. verified Resident #71's medications were left at bedside. RN #334 stated Resident #71 is to be observed ingestion of medications by the nurse. RN #334 stated Resident #71's medications should not have been left at bedside. RN #334 verified the medications in the cup at bedside were aspirin 81 milligrams (mg), Colace (stool softener) 100 mg, Claritin (antihistamine) 10 mg, Depakote (anticonvulsant) 250 mg, vitamin D 2,000 units, Omeprazole (stomach acid reducer) 20 mg, Prozac (antidepressant) 60 mg, Gabapentin (anticonvulsant) 600 mg, Vesicare (overactive bladder treatment)10 mg, and Tylenol 650 mg. Review of the Employee Disciplinary form dated 03/02/26 revealed Licensed Practical Nurse #375 was disciplined on defective or improper work for leaving medications unsupervised. Review of the undated facility policy titled Medication Administration, revealed the medication will be administered to the resident with dignity and privacy in mind with direct observation of the resident taking all medications administered.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure an advance directive was in the medical record for Resident #80 and further failed to ensure the advance directive forms for Residents #28 and #97 were signed by the physician. This affected three (#28, #80, and #97) of 91 residents reviewed for advance directive. The facility census was 91.Findings include:1. Review of the medical record for Resident #28 revealed an admission date of [DATE]. Diagnoses included unspecified dementia, unspecified atrial fibrillation, and sleep apnea.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had impaired cognition. Further review of the MDS revealed Resident #28 required supervision for bathing and was independent for toileting.Review of the care plan dated [DATE] revealed Resident #28 had chosen to be a Do Not Resuscitate Comfort Care - Arrest (DNRCC - A). Interventions included for the advance directive to be in the medical chart, provide appropriate testing and treatment in the facility for acute medical conditions as indicated and as ordered, and if found not breathing or without a pulse, do not initiate cardiopulmonary resuscitation (CPR). Notify the physician and the responsible party.Review of the physician order dated [DATE] revealed Resident #28 had DNRCC - A order in the medical record.Review of Resident #28's advance directive form in the medical record revealed the advance directive form noted Resident #28 was Do Not Resuscitate Comfort Care - Arrest (DNRCC-A) but the form was not signed and completed by a physician.2. Review of the medical record for Resident #97 revealed an admission date of [DATE]. Diagnoses included chronic kidney disease, atrial fibrillation, and intestinal obstruction.Review of the entry MDS assessment dated [DATE] revealed Resident #97 was cognitively intact. Further review of the MDS revealed Resident #97 was dependent on staff for toileting, and activities of daily living (ADLs).Review of the care plan dated [DATE] revealed Resident #97 had chosen a DNRCC - A status. Interventions included for the advance directive will be in the medical chart, provide appropriate testing and treatment in facility for acute medical conditions as indicated and as ordered, and if found not breathing or without a pulse, do not initiate CPR. Notify the physician and responsible party.Review of the physician order dated [DATE] revealed Resident #97 had DNRCC - A order in the medical record.Review of Resident #97's advance directive form in the medical record revealed the advance directive form noted Resident #97 was Do Not Resuscitate Comfort Care - Arrest (DNRCC-A) but the form was not signed and completed by a physician.3. Review of the medical record for Resident #80 revealed an admission date of [DATE]. Diagnoses included acute respiratory failure with hypoxia, essential hypertension, and chronic kidney disease.Review of the quarterly MDS assessment dated [DATE] revealed Resident #80 had moderately impaired cognition. Further review of the MDS revealed Resident #80 required supervision for toileting and was dependent on staff for ADLs.Review of the care plan dated [DATE] revealed Resident #80 had chosen a DNRCC - A status. Interventions included for the advance directive to be in the medical chart, provide appropriate testing and treatment in facility for acute medical conditions as indicated and as ordered, and if found not breathing or without a pulse, do not initiate CPR. Notify the physician and responsible party.Review of the physician order dated [DATE] revealed Resident #80 had DNRCC - A order in the medical record.Further review of Resident #80's medical record revealed the resident did not have an advance directive in the medical record.Interview on [DATE] at 8:49 A.M. with Licensed Practical Nurse (LPN) #301 revealed if a resident were to require CPR, he would first determine what the code status of the resident. LPN #301 stated the code status should be in the electronic medical record (EMR) or in the resident's paper charts. LPN #301 stated he would use whatever chart was closest at the time of an emergency situation to determine code status of a resident. LPN #301 verified Resident #28 and Resident #97's had advance directives that were not signed by a physician. Furthermore, LPN #301 verified Resident #80 did not have an advance directive (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	present in the medical record or paper chart.Review of the facility policy titled Code Status and Advance Directives with a last updated date of [DATE] revealed copies of all advance directives will be obtained from the resident and/or family and placed in the medical record and the facility would follow the code status and advance directive of residents as directed by law.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, medical record review, staff interview, and review of facility policy, the facility failed to ensure physician notification when a significant change in condition occurred for one resident (#66) when a lumen of the resident's peripherally inserted central catheter (PICC) line (a central venous catheter that provides access to the large veins near the heart through a peripheral vein in the arm) was occluded, preventing administration of a physician-ordered intravenous antibiotic (Meropenem). This affected one (#66) of three residents (#14, #53, and #66) receiving intravenous therapy. The facility census was 91. Findings include: 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 2 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 quarterly Minimum Data Set (MDS) assessment, dated 12/30/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was relatively cognitively intact. Further review of this 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. Review of the medical record revealed a physician order dated 12/11/25 for Meropenem intravenous solution reconstituted, one gram, to be administered intravenously (IV) three times daily for osteomyelitis. Observation on 03/03/26 at 8:35 A.M. revealed a one-gram bag of Meropenem hanging in Resident #66's room that had not been administered. Concurrent observation revealed Resident #66's PICC-line dressing was loose and partially detached. During interview on 03/03/26 at 8:35 A.M., Licensed Practical Nurse (LPN) #245 confirmed the one-gram bag of Meropenem had not been administered and the PICC-line dressing was loose. Observation on 03/03/26 at 8:37 A.M. revealed LPN #245 attempted to flush the purple lumen of the PICC line and was unable to flush the lumen and there was no blood return. During interview on 03/03/26 at 8:37 A.M., LPN #245 confirmed she was unable to flush the purple lumen of the PICC line and there was no blood return. Review of the electronic Medication Administration Record (eMAR) revealed the physician-ordered Meropenem dose scheduled for 03/03/26 at 6:00 A.M. was not administered and was documented in the eMAR as Other/See Progress Notes. Review of the progress notes revealed no documentation regarding the occluded PICC lumen, inability to administer the physician-ordered Meropenem dose, or physician notification. During interview on 03/03/26 at 8:50 A.M., Registered Nurse (RN) #326 confirmed the Meropenem dose scheduled for 03/03/26 at 6:00 A.M. was not administered and confirmed there were no progress notes documenting the occluded PICC lumen, inability to administer the medication, or physician notification. During interview on 03/03/26 at 8:58 A.M., Director of Nursing (DON) #356 confirmed there were no progress notes documenting the occluded PICC lumen, inability to administer the medication, or physician notification. The DON stated the physician should have been notified immediately when the PICC lumen was found to be occluded and the antibiotic could not be administered. Review of the facility's undated Medication Administration Policy revealed any medication not administered must be documented in the eMAR with a corresponding progress note explaining the reason.

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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.	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 privacy and mobility. This deficiency represents non-compliance investigated under Complaint Number 2646853.

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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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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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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 self-reported incident (SRI), staff interview, and policy review, the facility failed to timely report an allegation of abuse to the state agency. This affected one (#41) of two residents reviewed for abuse. The facility census was 91. Findings include: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 the facility's Self-Reported Incident (SRI) #267182 submitted on 11/05/25 at 2:34 P.M. 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. Interview on 03/04/26 at 3:55 P.M. with the Administrator and the Director of Nursing (DON) verified the facility failed to timely report the incident to the state agency. The Administrator verified the incident was reported to the state agency the day after the incident (11/05/25) after interviewing multiple staff members regarding the situation. Review of the facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property with a last reviewed date of 03/11/25 revealed if abuse or serious bodily injury is alleged. If the event that caused the allegation involves an allegation of abuse or serious bodily injury, it should be reported to the Ohio Department of Health (ODH) immediately, but not later than two hours after the allegation is made.

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

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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 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 record review, staff interview, review of facility self-reported incidents (SRIs), and review of facility policy, the facility failed to ensure thorough investigations were conducted for allegations of abuse and injuries of unknown origin. Specifically, the facility failed to complete all required investigative steps to determine the cause of the incidents and whether abuse, neglect, or mistreatment occurred. This affected three (#41, #43, and #100) of five residents reviewed for SRI's. The facility census was 91. Findings include:1.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 Resident #41's medical record revealed no assessments were completed by nursing on 11/04/25. Review of Resident #41's skin assessments between 11/04/25 and 11/12/25 revealed a skin assessment completed on 11/12/25 revealing a right lower leg skin tear. Review of the facility investigation completed revealed no other residents were interviewed regarding the abuse allegation. Furthermore, no skin sweeps were completed for residents who were cognitively impaired due to the incident of abuse. The facility completed skin assessments on residents weekly but did not complete skin assessments on cognitively impaired residents due to the incident of abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. 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 the resident had an intact cognition, was dependent on staff for all activities of daily living except eating. Review of SRI #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 room, lifted FR #100's shirt, grabbed her arm, and slapped her forehead. Follow up interview with the Administrator on 03/05/26 at 10:22 A.M. revealed during the investigation no like residents were assessed nor interviewed related to their safety in the facility. 3. Review of the medical record for Resident #43 revealed an admission date of 10/27/22 with diagnoses including Alzheimer's disease, dementia, fracture at the lower end of the ulna, urinary tract (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection, heart disease, poly osteoarthritis, anxiety, age-related physical debility, generalized muscle weakness, difficulty walking, cognitive communication deficit, hypertension, and insomnia. Review of the most recent quarterly MDS assessment, dated 01/15/26, revealed the Brief Interview for Mental Status (BIMS) was unable to be assessed due to impaired cognition. Further review of the MDS indicated Resident #43 was dependent for all activities of daily living, including eating, hygiene, toileting, dressing, rolling, repositioning, transferring, and wheelchair mobility. Review of the facility Self-Reported Incident (SRI) #262553 dated 07/08/25 revealed documentation indicating Resident #43 routinely received Tylenol for chronic pain. Documentation indicated that during the weekend of 07/05/25 through 07/06/25 the resident complained of pain. Further documentation indicated that on 07/07/25 bruising was observed on the resident's left arm, and an x-ray was ordered on 07/08/25. The x-ray results revealed a fracture of Resident #43's left ulna. Review of the SRI documentation revealed Resident #43 was unable to provide reliable information related to the injury due to impaired cognition. Documentation indicated the resident was asked if anyone had hurt her and the resident responded no. Review of the facility's investigation revealed interviews were conducted with staff who provided care to Resident #43, and these interviews did not indicate abuse had occurred. Further review of the investigation documentation revealed the facility failed to complete resident interviews, or complete resident assessments on like residents pertaining to ensure no injuries of unknown origin. During an interview on 03/04/26 at 10:34 A.M., the Administrator verified the facility failed to complete a thorough investigation as no other residents were interviewed or assessed for injuries of unknown origin. Review of the facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, dated 03/11/25, revealed the facility's procedures include identifying suspicious bruising and other injuries, evaluating occurrences, patterns, and trends that may constitute abuse, and determining the direction of the investigation.

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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 record review, staff interview, and policy review the facility failed to have the focus interventions in place within the care plan for one (#100) resident who was identified at risk for fractures. This affected one (#100) of two residents reviewed for care planning. The facility census was 91. Findings include: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, protein malnutrition, scoliosis, and kyphosis.Review of Resident #100's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had an intact cognition and was dependent on staff for all activities of daily living except eating. Review of FR #100's most recent care plan revealed it was absent of documentation regarding osteoarthritis and fragility of bones. Review of a FR #100's intradisciplinary team note dated 9/11/25 revealed on 09/03/25 the resident complained of right leg pain after two staff members pulled her up in bed and the resident felt a pop. Radiological examination revealed a right hip fracture. Interview with the Director of Nursing (DON) on 03/05/25 at 12:10 P.M. revealed she was unable to provide documentation that FR #100's care plan included caution with repositioning related to osteoarthritis and osteopenia. Review of the undated facility policy titled Comprehensive Care Plans - Person Centered, revealed the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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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. **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 access to hand hygiene supplies for a resident utilizing a bedside commode (BSC). This affected one (#64) of three residents reviewed for hand hygiene. 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 12:17 P.M. of Resident #64's room revealed a bedside commode present in the room with no observable hand hygiene supplies available for resident use, including no sink with soap or running water and no alcohol-based hand sanitizer (ABHS). Interview on 03/02/26 at 12:19 P.M. with Resident #64 revealed the resident was concerned that after utilizing the bedside commode for toileting the resident does not have access to a sink with soap, running water or ABHS in the room to perform hand hygiene after toileting. Resident #64 verified staff do not offer hand hygiene when being assisted back to bed after using the bedside commode. Interview on 03/02/26 at 12:21 P.M. with Director #348 verified there was no sink with soap and running water or ABHS available in the resident's room for hand hygiene after toileting. Review of the facility policy titled Hand Hygiene Policy, dated May 2022, revealed hand hygiene shall be regarded as the single most important means of preventing the spread of infection in the facility, and handwashing with soap and water is required when hands are visibly soiled.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review the facility failed to ensure a resident had skin breakdown protection in place as ordered. This affected one (#72) of two residents reviewed for non-pressure skin issues. The facility identified two (#44, #72) residents requiring skin protection related to contractures. The facility census was 91.Findings include:Review of Resident #72's medical record revealed an admission date of 03/08/19. Diagnoses included quadriplegia, neurocognitive disorder, and dementia. Review of Resident #72's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a low cognitive function. Review of Resident #72's most recent care plan revealed the resident was at risk for skin breakdown/skin injury related to decreased mobility. Intervention included to ensure lamb's wool hand rolls were in bilateral hands. The resident was also at risk for impaired functional range of motion related to age, arthritis, dementia, weakness, pain, and contractures with an identified intervention to keep washcloths in bilateral hands to protect the skin. Review of Resident #72's physician orders revealed an order dated 08/27/25 to ensure lamb's wool hand rolls were in bilateral hands. Observations on 03/03/26 at 2:29 P.M. revealed Resident #72 was sitting in his geriatric chair in the lounge, both of Resident #72's hands were contracted and tightly folded. Neither hand had either the lamb's wool hand rolls or rolled wash clothes. Observation on 03/04/26 at 1:44 P.M. revealed Resident #72 was lying in bed with eyes closed, both of the resident's hands were tightly contracted and free of lamb's wool hand rolls or rolled wash clothes. Interview with the Director of Nursing on 03/04/26 at 1:45 P.M. verified Resident #72 failed to have the physician ordered interventions in place to protect Resident #72's contracted hands. Review of the policy titled Splint Application, dated July 2024 revealed residents are to be provided the appropriate splint/appliance to ensure that a resident with a limited range of motion received appropriate treatments and services to increase range of motion and or to prevent further decrease of range of motion and to protect skin integrity. If a resident is ordered a split, the order will be reflected on the physician orders and will be communicated in several other places to notify the staff of the specific application requirements. The splint is to be worn per the physician order and documented in the medical record. Staff are to notify the charge nurse and rehabilitation team if the splint is not fitting properly, causing red areas, or if the resident is refusing to wear the splint.

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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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident interview, staff interview, and policy review, the facility failed to ensure oxygen was administered per the physician's order. This affected two (#17 and #86) of two residents reviewed for oxygen therapy. The facility census was 91. Findings include: 1. Review of Resident #86's medical record revealed an admission date of 03/21/25. Diagnoses included Alzheimer's disease with early onset, type two diabetes mellitus, muscle weakness, and hypertensive chronic kidney disease. Review of Resident #86's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #86 had moderately impaired cognition. Furthermore, Resident #86 required oxygen therapy. Review of Resident #86's physician orders revealed an order for oxygen at two liters per minute (lpm) via nasal cannula as needed for shortness of breath or to keep pulse oximetry above 92%. Review of Resident #86's care plan dated 02/11/26 revealed oxygen therapies and interventions were not included in the comprehensive care plan. Interview on 03/02/26 at 2:58 P.M. with Resident #86 revealed he wore oxygen all the time as he felt he needed it. Observation on 03/02/26 at 3:00 P.M. of Resident #86's oxygen concentrator revealed his oxygen to be running at three lpm via nasal cannula. Concurrent interview with Licensed Practical Nurse (LPN) #323 verified Resident #86's oxygen concentrator was set to three lpm. 2. Review of Resident #17s medical record revealed an initial admission date of 04/15/22 and a re-admission date of 03/01/24. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic heart failure (CHF), chronic atrial fibrillation, chronic bronchitis, type two diabetes mellitus, and dependence on supplemental oxygen. Review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14. Review of Resident #17's care plan dated 02/17/26 revealed Resident #17 was at risk for respiratory distress related to COPD and CHF with interventions that included to administer oxygen and monitor pulse oximetry per the physician's orders. Review of Resident #17's physician orders revealed an order with a start date of 02/18/26 with instructions for oxygen at two lpm via nasal cannula as needed for shortness of breath or to keep pulse oximetry above 92%. Observation on 03/02/26 at 3:02 P.M. of resident #17's oxygen concentrator revealed the oxygen to be running at three lpm. Concurrent interview with LPN #323 verified the oxygen concentrator was running at three lpm. Review of the undated facility policy titled Oxygen Delivery revealed oxygen would be used according to physician orders and monitored by nursing.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, and review of facility policy, the facility failed to ensure medications and treatments were administered as ordered. This affected one (#66) of three residents reviewed for medication and treatment administration. The facility census was 91. Findings include: 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 quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS further indicated Resident #66 required assistance with eating and was dependent for all other functional abilities, including hygiene, bathing, dressing, rolling, turning, repositioning, transferring, and wheelchair propulsion.Review of a physician order dated 11/20/25 for Resident #66 revealed per the CHF Protocol staff were to monitor lung sounds, monitor for edema, and weight changes and notify the provider if changes occur. Review of the medication administration record (MAR) revealed the protocol was not followed on 02/07/26 and 02/08/26.Review of a physician order for Resident #66 revealed an order dated 12/10/25 for a peripherally inserted central catheter (PICC) to be flushed with 10 milliliters (ml) of normal saline every shift and after each IV medication. Review of the MAR revealed the PICC line was not flushed on 01/02/26 and 01/08/26.Review of a physician order for Resident #66 revealed an order dated 12/11/25 for Meropenem intravenous (IV) antibiotic one gram IV three times a day for osteomyelitis. Review of the MAR revealed doses were not administered on 01/03/26 at 6:00 A.M., 01/09/26 at 6:00 A.M., and 03/03/26 at 6:00 A.M.Review of a physician order dated 12/15/25 revealed Resident #66 was to have Nystatin Powder applied to the groin, abdominal folds and under the breasts twice a day. Review of the treatment administration record (TAR) for January and February 2026 revealed treatments at bedtime on 01/01/26, 01/02/26, 01/03/26, 01/06/26, 01/10/26, 01/11/26, 01/15/26, 01/16/26, 01/19/26, 01/20/26, 01/24/26, 01/25/26, 01/27/26, 01/29/26, 01/30/26, 02/02/26, 02/03/26, 02/07/26, 02/08/26, 02/12/26, 02/13/26, 02/16/26, 02/17/26, 02/21/26, 02/22/26, 02/26/26, and 02/27/26 were not completed.Review of a physician order dated 12/15/25 revealed Resident #66 was to have a Triad Hydrophilic Wound Dressing applied to the buttocks and perineal area every shift. Review of the TAR revealed the treatment was not completed on 01/01/26 evening, 01/02/26 evening/night, 01/03/26 evening, 01/06/26 evening, 01/10/26 evening/night, 01/11/26 evening/night, 01/15/26 evening, 01/19/26 evening/night, 01/20/26 evening/night, 01/22/26 night, 01/24/26 evening/night, 01/25/26 evening, 01/27/26 night, 01/29/26 evening, 01/30/26 evening/night, 02/02/26 evening, 02/03/26 evening, 02/05/26 night, 02/07/26 evening, 02/08/26 evening, 02/10/26 night, 02/12/26 evening, 02/13/26 evening/night, 02/16/26 evening/night, 02/17/26 evening, 02/19/26 night, 02/21/26 evening/night, 02/22/26 evening/night, 02/26/26 evening, and 02/27/26 evening.Review of a physician order dated 12/17/25 revealed Resident #66 was to have the PICC line dressing changed weekly, including a change of the caps every Wednesday on day shift and as needed. Review of the MAR revealed neither the dressing change or the cap change for the PICC were completed on 01/06/26 and 01/21/26.Review of a physician order dated 01/06/26 revealed Resident #66 was to have the right stump to be washed every 12 hours followed by a stump shrinker to be applied to the right lower limb for 12 hours to aid limb maturation. Review of the MAR revealed the order was not completed on 01/14/26 at 6:00 A.M., 01/15/26 at 6:00 A.M., 02/09/26 at 6:00 A.M., and 02/19/26 at 6:00 A.M.Review of the progress notes for Resident #66 revealed no documentation of missed medications or treatments.Interview on 03/05/26 at 1:22 P.M. with Director of Nursing (DON) #356 verified that the (continued on next page)

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.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	above physician orders were not consistently followed and that Resident #66 did not receive multiple scheduled medications and treatments as ordered.Review of the undated facility policy titled, Medication Administration Policy, revealed, medications will be administered using an Electronic Medication Administration Record (EMAR). The administered medications/treatments will be documented in the EMAR, and any medications or treatments not administered will be documented and will have a progress note written.

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

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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 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 observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure Enhanced Barrier Precautions were followed. This affected one (#11) resident reviewed for Enhanced Barrier Precautions. The facility census was 91. FIndings include:Record review 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, was dependent on staff for activities of daily living (ADLs), and incontinence care.Review of the care plan for Resident #11 revealed Resident #11 required Enhanced Barrier Precautions (EBP) related to an indwelling medical device. Interventions included a yellow sign placed on resident's door frame, staff to wear gowns and gloves during high contact care activities.Observation on 03/02/26 at 9:45 A.M. of Resident #11's room revealed a sign for EBP precautions.Observation on 03/02/26 at 10:38 A.M. revealed Certified Nursing Assistant (CNA) #247 and CNA #233 provided incontinence care for Resident #11 without a gown on.Interview on 03/02/26 at 10:58 A.M. with CNA #247 confirmed Resident #11 was on EBP precautions and that CNA #247 and CNA #233 were not wearing gowns.Review of the facility policy titled Enhanced Barrier Precautions Policy and Procedure not dated revealed EBP will be implemented in resident who have chronic wounds or indwelling medical devices and for residents who have an infection or colonization with a CDC targeted or other epidemiologically important MDRO when contact precautions do not apply. EBP will be employed when performing changing briefs or assisting with toileting.