STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hills Nursing Center	3650 Beavercrest Drive Lorain, OH 44053

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 - 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, staff and resident interview, review of the water temperature logs, and policy review, the facility failed to ensure water temperatures were within an acceptable range to promote resident comfort. This had the potential to affect 10 Residents (#05, #06, #14, #19, #21, #22, #42, #46, #54, and #64) identified as residing on the 100 hallway. The facility census was 63. Findings Included:Observation on [DATE] at 9:50 A.M., with the Regional Director of Asset Management #895 revealed Resident #05's water temperature was taken using the facility's digital thermometer in the resident's bathroom measuring at 104 degrees Fahrenheit (F). Interview on [DATE] at the time of observation with Regional Director of Asset Management #895 verified Resident #5's water temperature was not within desired range of 110-120 degrees F.Interview on [DATE] at 10:14 A.M. with the [NAME] President of Asset Management #896 revealed their maintenance director had quit about one week prior. The [NAME] President of Assessment Management #896 indicated the mixing valve had been adjusted on morning of [DATE] to adjust the temperature of water after he had reviewed the water temperature logs from [DATE] to February 2026. The [NAME] President of Asset Management #896 verified the water temperatures recorded for the 100 hall by the former maintenance director were not within an acceptable range. The [NAME] President of Asset Management #896 reported the low water temperatures could have easily been remedied by adjusting the mixing valve. He indicated he would have expected the former maintenance director to take action immediately if his monthly water temperature checks were out of range.Interview on [DATE] at 11:16 A.M. with Resident #14 stated water had been cold for at least a month in her sink in the bathroom. Resident #14 stated she just checked the water and it was a little warm.Review of water temperature logs from [DATE] and February 2026 revealed water temperatures in room [ROOM NUMBER] were checked on [DATE] at 92 degrees F, on [DATE] at 95 degrees F, on [DATE] at 97 degrees F, on [DATE] at 101 degrees F, and on [DATE] at 97 degrees F. Water temperatures in room [ROOM NUMBER] were checked on [DATE] at 85 degrees F, on [DATE] at 90 degrees F, on [DATE] at 91 degrees F, on [DATE] at 100 degrees F, and on [DATE] at 95 degrees F. Water temperatures in room [ROOM NUMBER] were checked on [DATE] at 91 degrees F, on [DATE] at 92 degrees F, on [DATE] at 90 degrees F, and on [DATE] at 100 degrees F. Water temperatures in room [ROOM NUMBER] were checked on [DATE] at 85 degrees F, on [DATE] at 90 degrees F, on [DATE] at 95 degrees F, and on [DATE] at 99 degrees F. There was no evidence of any adjustments to water temperature or follow up water temperature checks.Review of the facility policy titled Safe Water Temperatures, dated [DATE] revealed staff should report abnormal findings of water too cold or too hot to the supervisor and maintenance staff. The policy stated water temperatures would not exceed 120 degrees F however did not define a lower limit to water temperatures. Water temperatures would be checked by maintenance staff on a weekly basis.This deficiency represents non-compliance investigated under Complaint Number 2719863.

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	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, review of the hospital records, staff and resident interview, and policy review, the facility failed to ensure resident safety regarding the use of marijuana products. This affected two Residents (#27 and #60) out of three reviewed. The facility census was 63.Findings Included:1. Review of medical record for Resident #27 revealed an admission date of 02/09/17 and diagnoses including schizophrenia, vascular dementia with behavioral disturbance, aphasia following cerebral infarction, and diabetes mellitus.Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #27 had moderately impaired cognition. Resident #27 required set up or clean up assistance for activities of daily living (ADLs).Review of nursing progress note dated 01/31/26 at 5:49 A.M. revealed Resident #27 was observed in his room standing in a puddle of urine. Resident #27 was assisted to the bathroom. Resident #27 stated he felt fine but was unable to make it to the toilet in time. A urinalysis was requested to rule out urinary tract infection (UTI).Review of nursing progress note dated 01/31/26 at 10:11 A.M. revealed Resident #27 had a change in mental status, difficulty with ambulating, and had been found on his hands and knees urinating on the floor. Resident #27's bed was also saturated in urine. Three staff members were needed to assist Resident #27 off the floor and to get cleaned up. Resident #27 needed much prompting to get dressed. The director of nursing (DON) and Resident #27's power of attorney (POA) were notified. Resident #27 was sent to the emergency department.Review of Emergency Department (ED) Encounter note from 01/31/26 revealed Resident #27 presented to the ED for confusion. It was noted Resident #27 was normally alert and oriented however last night mental status became altered. In the morning the nurse came to check on Resident #27 and found him on his hands and knees urinating on the floor and his bed was saturated with urine. Resident #27 was hemodynamically stable. Resident #27 received intravenous (IV) fluids and was monitored. Resident #27 became more alert and was asking for food. Lab testing had no acute findings however a urine drug screen was found to be positive for marijuana. Resident #27 was stable and was sent back to the facility.Review of nursing progress note dated 01/31/26 at 4:17 P.M. revealed Resident #27 had tested positive for tetrahydrocannabinol (THC) (the psychoactive compound in cannabis/marijuana) and would be returning to the facility.Review of nursing progress note dated 01/31/26 at 6:15 P.M. revealed Resident #27 was sitting on his bed and had removed his pants stating they were wet. Resident #27 refused to don clean pants. Resident #27 was noted to be unsteady on his feet and smiling or laughing at inappropriate times. Resident #27 was encouraged to rest and use call light if he needed assistance.Review of nursing progress note dated 03/01/26 at 3:12 P.M. revealed Resident #27 had obtained a vape pen from another resident. The interaction by the two residents was observed by the nurse. The Director of Nursing (DON) and the physician were notified. New order to monitor Resident #27's behavior closely and report any abnormal behaviors to the physician. 2. Review of the medical record for Resident #60 revealed an admission date of 09/13/24 and diagnoses including diabetes mellitus, bipolar disorder, obsessive compulsive disorder, traumatic subdural hemorrhage, and personal history of transient ischemic attack (TIA) and cerebral infarction.Review of physician order dated 08/11/25 revealed Resident #60 was permitted to take independent leaves of absence (LOA) for up to four hours per day. This order was discontinued on 03/04/26.Review of Behavior Contract dated 10/06/25 revealed Resident #60 agreed to follow all rules and policies of the facility. Rules included were residents were not permitted to use or possess illegal or unauthorized substances, all medications would be administered by staff, residents must follow physician's medication regimen, LOAs would be determined by the physician, residents agree to allow room searches at discretion of the facility to ensure safety of self and others, all visitors should sign in, the physician may order toxicology screening, and residents would adhere to facility smoking policies. Failure to follow the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rules in the behavior contract could result in immediate or 30-day discharge.Review of the MDS quarterly assessment dated [DATE] revealed Resident #60 had intact cognition and was dependent on staff assistance for ADLs including bathing, dressing, and transfers.Review of nursing progress note dated 01/29/26 revealed Resident #60 went on LOA with her nephew.Review of nursing progress note dated 01/31/26 revealed Resident #60 left on LOA with her nephew.Review of nursing progress note dated 02/15/26 revealed Resident #60 left on LOA with her nephew at 8:30 P.M. and returned at 1:46 A.M.Review of nursing progress note dated 03/01/26 entered as a late entry on 03/04/26 revealed Regional Director of Clinical Services (RDCS) #894 was notified by the DON that Resident #60 had attempted to give another resident a vape pen and nursing had intervened. The vape pen was removed. Resident #60's physician was notified and gave an order to discontinue Resident #60's LOA. Any departures from the facility would be considered against medical advice (AMA) discharge.Interview on 03/02/26 at 10:29 A.M. with Resident #27 revealed no concerns with care or treatment. Resident #27 was unable or unwilling to provide any information related to drug use or the hospitalization.Interview on 03/02/26 at 10:39 A.M. with Resident #60 revealed no concerns with care or treatment. Resident #60 denied use or distribution of any drugs or substances.Interview on 03/03/26 at 3:22 P.M. with the Social Service Designee (SSD) #813 revealed he knew of rumors there was an issue with drug use in the facility. The SSD #813 stated he was unable to verify but had heard it was Resident #60. The SSD #813 stated Resident #60 had gone out on LOAs or had visitors. SSD #813 stated allegedly Resident #27 had received a drug substance from Resident #60. Resident #27 began acting differently so he was sent to the hospital. The SSD #813 stated he did not know more than that and was not helping to investigate the situation. He said he had been assisting Resident #60 with sending referrals to different nursing homes.Interview on 03/04/26 at 9:02 A.M. with Assistant Director of Nursing (ADON) #838 revealed Resident #60 had been issued a behavior contract due to possessing marijuana vape pens. ADON #838 stated this had been an ongoing issue since around October 2025 when the behavior contract was issued. ADON #838 reported there had been some recent issues with Resident #60 possessing marijuana vape pens, but she could not recall the exact dates. ADON #838 reported Resident #27 had a marijuana vape pen that belonged to Resident #60 on or around 01/31/26. ADON #838 was unsure if Resident #27 had taken the vape pen or was given it by Resident #60. ADON #838 stated Resident #27 began acting outside of his normal and was having incontinence, so he was sent to the hospital. ADON #838 stated marijuana or other drug/substance use was not permitted in the facility.Interview on 03/04/26 at 9:26 A.M. with Regional Director of Clinical Services (RDCS) #894 revealed in the past they have had to revoke Resident #60's LOA privileges due to issues with drug use. RDCS #894 stated she was notified over the weekend Resident #60 had again attempted to give Resident #27 a marijuana vape pen. RDCS #894 indicated they were unsure of where Resident #60 was obtaining the vape pens.Review of the facility's policy titled Non-Prescribed or Illegal Drug Use, dated June 2018 revealed residents may not posses or distribute illegal substances in the building or on the premises. The facility reserved the right to give a resident a discharge notice if they consume, possess, sell or distribute illegal drugs in the building or on the premises due to the potential risk to themselves or others. The policy did not define illegal drugsThis deficiency represents non-compliance investigated under Complaint Number 2719863.

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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 medical record review, observation, staff interview and policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed during a wound treatment. This affected one (Resident #16) out of three reviewed for pressure ulcer treatment. The facility census was 63.Findings Included:Review of the medical record for Resident #16 revealed an admission date 09/24/25. Diagnosis included muscle weakness, pressure ulcer of right buttock, infrarenal abdominal aortic aneurysm and restless legs syndrome.Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #16 had memory impairment. He was dependent on staff for all activities of daily living (ADL's). He was always incontinent of bowel and bladder.Review of the physician orders revealed on 02/24/26 gloves and a gown were to be worn when providing treatment to Resident #16's sacral wound. The treatment was to cleanse the sacrum with normal saline, pat dry with gauze, apply calcium alginate (a debridement treatment), cover with super absorbent dressing every-day shift and as needed dated 02/11/26.Observation on 03/03/26 at 2:15 P.M. of Resident #16's wound care with Licensed Practical Nurse (LPN) #838 and LPN #833 revealed there was a sign posted outside of Resident #16's room stating Resident #16 was on enhanced barrier precautions (EBP). LPN #838 and LPN #833 gathered treatment supplies and walked into Resident #16 room. Both nurses put gloves on but had not put on a gown and completed the wound treatment.Interview on 03/03/26 at 2:35 P.M., LPN #838 verified Resident #16 was on EBP's and she should have put an isolation gown on while completing Resident #16's treatment.Interview on 03/03/26 at 2:36 P.M., LPN #833 verified she had not put on a gown when they were doing a treatment on Resident #16. LPN #833 was unable to state why she should have had a gown on. She stated all she thought she had to wear was gloves. Review of the facility policy titled Transmission-Based (Isolation) Precautions, dated 09/01/22 revealed EBP are to be worn when completing a dressing change on a wound/pressure ulcer. This deficiency represents non-compliance investigated under Complaint Number 2790510 and 2719863.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to maintain a building in good repair. This had the potential to affect all residents residing in the facility. The facility census was 63.Findings Include:During an environment tour on 03/03/26 from 8:02 A.M. to 8:22 A.M. revealed physical damage to resident rooms and the hallways throughout the facility. Damage included general dents and chipped paint on walls throughout the building in the hallways. Observation in the hallway outside of Resident #05's room revealed a hole in the wall near the floor behind a carpeted wall. Inside Resident #05's room revealed holes on both sides of the bathroom door. Observation of room [ROOM NUMBER], which was empty, revealed significant wall damage on the wall with the window and missing baseboards. Observation by the nursing station revealed the wall adjacent to the station had been patched however it was unpainted, the base board on the side of the nursing station was missing, and the wall surrounding the thermostat was patched however it was unpainted. Observation in the hallway by the therapy gym and smoking area revealed the ceiling had been patched however remained unpainted. Observation revealed the rubber baseboard was missing between the bathroom and the entrance to Resident #38 and #44's and Resident #11 and #32's room. Observation revealed the wall was unpainted between the bathroom and the entrance to Resident #36's room. Observation revealed a missing transition strip in the doorway of Resident #35 and #41's room. There was a large hole in the wall between the bathroom and the entrance to Resident #25 and #60's room. Resident #25 and #60's bathroom door had large holes on both sides of the door.During a follow-up tour and interview on 03/04/26 from 9:50 A.M. to 10:05 A.M. with the Director of Asset Management #895 verified the above findings. The Director of Asset Management #895 reported the maintenance director had quit.Interview on 03/04/26 at 10:14 A.M with the [NAME] President (VP) of Asset Management #896 revealed the former maintenance director had quit and they were aware of the concerns with the physical damage of the building. He reported the facility maintenance team took care of all repairs in house.This deficiency represents non-compliance investigated under Complaint Number 2719863.