STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365608	A. Building B. Wing	08/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristocrat Berea Healthcare and Rehabilitation	255 Front Street Berea, OH 44017

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on medical record review, staff interview, and facility policy review, the facility failed to report an allegation of misappropriation to the State Agency as required. This affected two residents (#13 and #22) of three residents reviewed for misappropriation. The facility census was 137.Findings Include:1.Review of Resident #13's medical record revealed an admission date of 10/20/23. Her diagnoses included cerebral infarction, congestive heart failure, type II diabetes, COPD, multiple sclerosis, dementia, hypertension, factitious disorder, hypertensive heart disorder, anxiety disorder, chronic pain syndrome, psychosis disorder, osteoarthritis, personality disorder, hyperlipidemia, and glaucoma. Review of Resident #13 physician orders, dated 12/12/24 to 06/23/25, revealed an order for oxycodone five (5) milligrams (mg) every six hours as needed for pain.Review of Resident #13 physician orders, dated 06/23/25 to current, revealed an order for oxycodone five (5) mg every 12 hours as needed for pain.Review of Resident #13's Minimum Data Set (MDS) assessment, dated 07/30/25, revealed she was cognitively intact.2. Review of Resident #22's medical record revealed an admission date of 01/24/25. Her diagnoses were antiphospholipid syndrome, insomnia, anxiety disorder, major depressive disorder, diverticulitis, endocarditis, adjustment disorder, lupus anticoagulant syndrome, cognitive communication deficit, hypotension, fibromyalgia, osteoarthritis, anemia, depression, hyperlipidemia, sleep apnea, and convulsions. Review of Resident #22 physician orders, dated 01/25/25 to current, revealed an order for oxycodone five mg every eight hours as needed for pain.Review of Resident #22's MDS assessment, dated 07/14/25, revealed she was cognitively intact.Interview with Licensed Practical Nurse (LPN) #104 on 08/29/25 at 12:45 P.M. confirmed he reported to nursing management that there were reported concerns to him from other nurses, that there were things that didn't look right when it came to Resident #13 and Resident #22's narcotic logs. When asked to explain, he stated it was reported to him by LPN #110 that he felt his signature/initials were being forged by another nurse, when it came to administering oxycodone. He confirmed he reported this to nursing management. He does not know what happened with the rest of the investigation, but he stated all nurses were sent a message from the Director of Nursing (DON) that they were part of a narcotic investigation and would need to report to the facility for a drug test.Interview with DON on 08/29/25 at 1:20 P.M. confirmed they completed an investigation regarding a nurse and the administration of narcotics. DON stated they did not consider this to be an allegation of misappropriation, even though she confirmed the investigation was due to an allegation of this nurse potentially forging LPN #110 signature during administration of oxycodone. When asked why they required all the nurses who worked that area of the facility to take a drug test, if it wasn't an allegation of misappropriation or misuse of narcotics, she stated they were simply trying to collect information to see if they could prove wrongdoing.Review of the facility Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property policy, dated May 2025, revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. It is the facility's policy to investigate all alleged violations involving abuse, neglect, misappropriation of resident property, exploitation or mistreatment in accordance with this policy and to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. All incidents and allegations of abuse, neglect, exploitation, mistreatment and misappropriation of resident property must be reported immediately to the administrator or designee. If any form of of abuse is alleged, or serious bodily injury is identified related to any other reportable incident, the administrator or his/her designee will notify the state department of health immediately, but no later than two hours after the allegation is made.This deficiency represents non-compliance investigated under Complaint Number 2590074.

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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. Based on medical record review, staff interview, facility investigative document review, and facility policy review, the facility failed to fully investigate an allegation of misappropriation as required. This affected two residents (#13 and #22) of three residents reviewed for misappropriation. The facility census was 137. Findings Include:1. Review of Resident #13's medical record revealed an admission date of 10/20/23. Her diagnoses included cerebral infarction, congestive heart failure, type II diabetes, COPD, multiple sclerosis, dementia, hypertension, factitious disorder, hypertensive heart disorder, anxiety disorder, chronic pain syndrome, psychosis disorder, osteoarthritis, personality disorder, hyperlipidemia, and glaucoma. Review of Resident #13 physician orders, dated 12/12/24 to 06/23/25, revealed an order for oxycodone five (5) milligrams (mg) every six hours as needed for pain.Review of Resident #13 physician orders, dated 06/23/25 to current, revealed an order for oxycodone five (5) mg every 12 hours as needed for pain.Review of Resident #13's Minimum Data Set (MDS) assessment, dated 07/30/25, revealed she was cognitively intact.2. Review of Resident #22's medical record revealed an admission date of 01/24/25. Her diagnoses were antiphospholipid syndrome, insomnia, anxiety disorder, major depressive disorder, diverticulitis, endocarditis, adjustment disorder, lupus anticoagulant syndrome, cognitive communication deficit, hypotension, fibromyalgia, osteoarthritis, anemia, depression, hyperlipidemia, sleep apnea, and convulsions. Review of Resident #22 physician orders, dated 01/25/25 to current, revealed an order for oxycodone five mg every eight hours as needed for pain.Review of Resident #22's MDS assessment, dated 07/14/25, revealed she was cognitively intact.Interview with the DON on 08/29/25 at 1:20 P.M. confirmed they completed an investigation regarding a nurse and the administration of narcotics. DON also confirmed she had no written statements from this investigation. When asked why, she stated, we just did face to face interviews with all the nurses involved to help make the determination if wrongdoing happened. She also confirmed they have no interviews/statements completed with any potential residents involved as well.Review of facility Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property policy, dated May 2025, revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. It is the facility's policy to investigate all alleged violations involving abuse, neglect, misappropriation of resident property, exploitation or mistreatment in accordance with this policy and to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. Investigation protocol includes the person investigating the incident should generally take the following actions: interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident and employees who worked closely with the accused employees and/or alleged victim the day of the incident. Evidence of the investigation should be documented in accordance with quality assurance protocols.This deficiency represents non-compliance investigated under Complaint Number 2590074.

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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 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. Based on observations, staff interviews, and resident interviews, the facility failed to maintain a clean and sanitary living environment. This had the potential to affect all 137 residents in the facility.Findings Include:Observation on 08/29/25 at 8:20 A.M. revealed multiple items of food, dirt, and dust on the first floor dining room. Breakfast was being served at that time, but no residents were in the dining room. Observation during that time revealed an unidentified nursing staff person tell two residents in the hallway that the dining room was closed and they had to eat in their room.Observation on 08/29/25 from 9:05 A.M. to 9:15 A.M. revealed black soot on multiple ceiling tiles in the main laundry room. The black soot was caused by a dryer fire that happened in that room on approximately 05/29/25.Interview with the Housekeeping and Laundry Director #120 on 08/29/25 at 9:22 A.M. and 9:27 A.M. confirmed the black soot on the ceiling tiles. He confirmed the facility is waiting on the insurance claim to be approved prior to replacing all the affected items, including the new dryer, the windows, and the black ceiling tiles.Observation on 08/29/25 at approximately 2:35 P.M. revealed water damage from a water leak to two ceiling tiles above Resident #3 bed.Interview with Resident #3 on 08/29/25 at 2:35 P.M. confirmed she has asked for that ceiling tile to be replaced, but it hasn't been. When asked how long it had been that way, she did not know exactly, but stated, it's been a while.Interview with the Administrator (via e-mail) on 08/29/25 at 3:24 P.M. confirmed they need to replace the ceiling tiles listed above. He confirmed they were waiting for the insurance claim to be approved to replace the ceiling tiles in the laundry room, but then stated they would go ahead and replace them as of this day.Observation of Resident #123 room on 08/29/25 at 4:45 P.M. revealed his room had an strong odor in it. The odor appeared to be of an unkempt person who does not take showers. The odor was so strong the surveyor could not stay in the room for more than 30 seconds. Interview with Licensed Practical Nurse (LPN) #130 and Certified Nursing Aide (CNA) #140 on 08/29/25 at 4:50 P.M. confirmed Resident #123 is able to take showers/baths independently, but needs reminders to do so. But, he is someone that refuses baths/showers constantly, to the point that he has only accepted one shower in the last three months. They confirmed his room has a strong body odor to it, and it's because he refuses to take showers.This deficiency represents non-compliance investigated under Complaint Numbers 2602108, 2599468, 2599445, and 1343060.