Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 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 interview, the facility failed to ensure the building was maintained in a sanitary and homelike environment. This had the potential to affect all residents residing in the facility. The facility census was 93. Findings include: On [DATE] at 10:16 A.M. thru 10:41 A.M., a tour of the facility was conducted of all areas of the nursing home. The facility had four separate units (Home B, Unit 1, Unit 2, and Speret Hall, which was the facility's secured memory care unit). Home B had a short hall and a long hall and the other units were just one hallway. The hallway that led from the facility's independent living section of the building to Home B Short hall was noted to have a musty/ mildew odor on it. There were no signs of mildew, mold, or evidence of any recent water damage, but the odor was quite noticeable. The hall between the two included some offices, as well as the facility's therapy room and chapel that were accessible to residents. Home B unit (short and long halls) had FRP boarding on the bottom half of the walls in the hallways just below the handrails that went down the halls. The upper half of the walls above the handrails were all painted drywall. The FRP boarding was a tan color and the upper half of the walls were painted a beige/ yellow color giving it a two tone look. The building presented as an older building, as it was not of newer construction, and was outdated overall. The flooring was of a vinyl material that had the look of wood. A darker brown was around the edges of the flooring providing it with a border. There was some dust/ debris built up along the edge of the wall on Home B Long near room [ROOM NUMBER]. The walls on Home B long were noted to have chipped paint outside of Rooms #14, #17, #18, #19, #20, and #21. The chipped paint was where adhesive tape had been applied, and when removed, had peeled the paint off along with it leaving a white area that did not match the paint of the rest of the wall. Some of the areas had been painted over without patching first, and had a different color of paint applied that did not match the color of the rest of the walls. Multiple door jams and doors were scuffed/ scraped and in need of being painted. There was some debris (wrappers, paper, disposable gloves etc.) noted on the floors in some of the resident rooms that were in need of being swept. Unit 1, which was located between Home B and the front lobby area and the facility's assisted living unit, was noted to have chipped paint outside of room [ROOM NUMBER]. There were only minor scuffs on the doors and door jams on Unit 1. Unit 2 was noted to have peeled paint on the walls outside of room [ROOM NUMBER], #204, #205, #206, #208, and #210. The secured memory care unit was noted to have paint that had been peeled off the wall by the removal of adhesive tape outside of room [ROOM NUMBER]. There was also paint peeled off the wall near the computer that was hanging on the wall at the end of the hall on the right, as you enter into the dining room/ lounge area. On [DATE] at 10:20 A.M., an interview with Housekeeper #100 revealed the facility typically had two housekeepers working at a time and they worked five days a week. She worked 6:00 A.M. to 2:00 P.M. and the other housekeeper that was there was working 8:00 A.M. to 4:00 P.M. They both worked five days a week rotating every other weekend, so there were two days through the week that they only had one housekeeper working. She denied they had housekeeping staff on the afternoon or night shifts. She felt the facility was adequately staffed with housekeepers to be able to keep up with the cleaning that was needed. She (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was responsible for cleaning every resident room in her assigned area daily. Cleaning of the resident rooms involved emptying out the trash, dusting, cleaning the bathroom, checking supplies, and sweeping/ mopping floors. They only deep cleaned resident rooms when a resident was out to the hospital, discharged home, or was deceased . On [DATE] at 1:38 P.M., an interview with Resident #43 revealed housekeeping staff only came in her room to sweep and mop about once a week. She felt that was probably enough to keep things tidy and commented it was fine. An observation of Resident #43's shared bathroom revealed her trash was overly filled and someone had left an incontinent brief in the trash that was over the top edge of the trash can. A wrapper to a toilet paper roll was noted lying on the floor next to the trash can. There was a folded towel that was on the floor in front of the toilet. The towel was under the front right leg of the raised toilet seat that was in place over the toilet. It was not clear what the purpose of the towel was, if it was to stabilize the raised toilet seat, or if it was there to address any leaks. No active water leaks were noted, but there was what appeared to be a dried white sediment on the floor in front of and to the right of the toilet. The raised toilet seat and the inside of the commode was noted with feces splatter all around it. Follow up observations of the resident's bathroom on [DATE] at 8:39 A.M. revealed no concerns with the cleanliness of the bathroom. The trash had been emptied and the the feces splatter that was noted inside the commode and the raised toilet seat had been cleaned. On [DATE] at 8:41 A.M., a walk through of the facility was conducted again with focus on the environment. No changes were noted with the condition of the walls where tape had been used and removed peeling the paint off with it. The musty/ mildew odor that was noted on the hall between Home B Short and the independent living side continued to be present. The floor in the hall on Home B Long continued to have dust/ dirt/ grime along the edge of the wall where it had been seen the day before. On [DATE] at 8:57 A.M., an interview with Maintenance Director #125 revealed he had been the facility's maintenance director for a year now. He was asked how the facility identified environmental issues within the facility that needed to be addressed. He indicated the nurses and aides had access to work orders at the nurses' stations they could fill out anytime they noticed something that needed addressed. He also did daily checks, weekly checks, monthly checks, semi-annual checks, and annual checks that were required through the facility's TELS system. He also took care of the day to day stuff that broke. He walked the halls all day long, so if he seen something that needed to be addressed, he would take care of it. He commented that he could not always see the forest through the trees and did not always notice things others may, since he was in it daily. He was asked about the odor on the hall between Home B short hall and the facility's independent living section. He reported he had an employee, who had an office on that hall, mention something to him about it last week. That employee reported a musty smell. He was not able to smell odors well, so he had three other employees see if they smelled anything. All three denied that they did. He was informed there was a distinct musty/ mildew smell on that hall. He denied any recent flooding or water damage to the floors/walls that may have been the source of that kind of odor. He stated he was dealing with a leak in the roof around that area of the building. He had worked on sealing the roof last year, but had not made it to the roof over that section yet. He was hoping that he would be able to do that, but had to wait until the weather permitted him to pressure wash it before putting down the sealant. He was then asked what his opinion was of the overall cleanliness of the facility. He indicated the housekeeping staff seemed to run short handed to him and thought it was a battle for them to keep up with the cleaning they had to do. He described the overall cleanliness of the facility as not being terrible, but it was not top notch either. He was asked about peeled paint off the walls in the hallways in different areas of the building. He indicated his boss from the corporate office was in last week for a walk through and noted the same concern. He indicated those areas were caused by new activity staff that had been hanging birthday signs up outside a resident's room for the resident's birthday and when the signs were taken down and the tape was removed it was peeling the paint off with it. He questioned if there was some kind of tape that they may be able to use that did not pull the paint off with it. He denied he was the one that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER: Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 44565 Sunset Road Caldwell, OH 43724	

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	painted over some of those areas using a different color of paint. He was not sure who had done that but acknowledged that the damaged area needed some type of filler put over it so the wall was a smooth surface and the spots where the paint had been pulled off would not still be visible. He acknowledged there were multiple doorways (jams and doors) that were in need of being touched up with paint, due to scuff and scrape marks. He also acknowledged the FRP boarding that was on the lower half of the wall on Home B Long and Short hall needed to be cleaned to remove scuff marks from that. He verified the floor on the front end of Home B Long near room [ROOM NUMBER] was still dirty (as seen the previous day) and was in need of being swept and mopped. He reported the building had been built in 1965 and was in need of some updates. He was not aware of any plans for further remodeling and he had been trying to get them (corporate office) to replace the roof. On [DATE] at 10:40 A.M., an interview with Certified Nursing Assistant (CNA) #150 revealed she did not feel the facility had enough housekeepers. The housekeeping staff struggled a lot with keeping up and they only had two available. She felt they did do a good job with what they were able to clean, but did not feel they had enough to keep up with everything that needed to be cleaned. Some of the residents would say that it had been a couple of weeks since someone had been in their room to clean. She stated she would try to clean it if she noticed it was dirty, as she did not feel anyone would want to use a bathroom that was not clean. On [DATE] at 10:52 A.M., an interview with RN #175 revealed she did not feel the facility had enough housekeeping staff to keep up with the cleaning. She reported there had been times she has noticed the floors in the halls were dirty and looked like they needed to be swept and mopped. She recalled one male resident's sister calling into the facility and complained about his room being a mess. This deficiency represents non-compliance investigated under Complaint Number 2796085 and 2793565.