STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365663	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Genoa Retirement Village	300 Cherry St Genoa, OH 43430

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of the Centers for Medicare and Medicaid Services (CMS) Provider History Profile document, the facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) program to address repeated infection control deficiencies identified during five consecutive comprehensive surveys. This had the potential to affect all residents in the facility. The facility census was 66.Findings include:Review of the CMS Provider History Profile document, with Certification and Survey Provider Enhanced Reporting (CASPER) system data, last updated 01/07/26, revealed the facility was issued a deficiency for infection prevention and control on the four previous comprehensive surveys in February 2018, March 2019, April 2021, and January 2024. During the current comprehensive survey, with an exit date of 01/27/26, the facility was cited for infection control for the fifth consecutive comprehensive survey.1. Review of Resident #8's medical record revealed an admission date of 03/14/25 with diagnoses including, but not limited to, Parkinson's disease, unspecified head injury, pulmonary embolism, hypertensive heart and chronic kidney disease (CKD), type two diabetes mellitus (DM2), methicillin resistant staphylococcus aureus (MRSA), unspecified open wound of scalp, depression, heart failure, anxiety, and urinary tract infection (UTI). Review of the most recent Minimum Data Set (MDS) assessment, dated 12/30/25, revealed Resident #8 had a Brief Interview of Mental Status (BIMS) score of 15, indicating she was cognitively intact. Review of the physician orders revealed Resident #8 had an order dated 08/12/25 for contact precautions for MRSA head wound. Observation on 01/21/26 at 6:30 A.M. revealed signage by the door to Resident #8's room which stated she was in contact precautions. Further observation of the signage revealed PPE, including a gown and gloves, were to be donned prior to room entry.Observation on 01/21/26 at 6:33 A.M. revealed Certified Nursing Assistant (CNA) #568 entered Resident #8's room without donning gloves or a gown prior to entry.Interview on 01/21/26 at 6:55 A.M. with CNA #568 revealed she provided incontinence care to Resident #8 when she was observed to enter the resident's room at 6:33 A.M. CNA #568 verified she did not don the appropriate PPE prior to entering Resident #8's room and providing care.Review of the facility policy titled, Guidelines for Contact Precautions, dated 11/28/16, revealed contact precautions was a method designed to reduce the risk of transmission of microorganisms by direct or indirect methods. Further review revealed to wear gloves before contact with the resident or environmental objects. Additionally, a clean non-sterile, fluid resistant gown should be worn when entering the room if it was anticipated clothing could have substantial contact with the resident or environmental surface or when there was likelihood that organisms from blood, urine, stool, or wound drainage may be on surfaces or items in the resident's room. Substantial contact was defined as when the worker could anticipate that his/her clothing would be directly in contact with the resident, resident's linens, or bed.2. Review of the medical record for Resident #1 revealed she was admitted on [DATE]. Her diagnoses included aspiration pneumonia, low back pain, lymphedema, chronic obstructive pulmonary disease (COPD), stage three CKD, white matter disease, history of falls, and cardiomegaly.Review of the most recent MDS assessment, dated 12/23/25, revealed Resident #1 was (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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cognitively impaired and did not display any behaviors at the time of the assessment. She was incontinent of bowel and had an indwelling urinary catheter. Resident #1 required substantial assistance with activities of daily living (ADLs).Review of the physician orders dated 12/18/25 revealed Resident #1 had an order to utilize enhanced barrier precautions (EBP), wearing a gown and gloves, during high-contact care activities, including care of her indwelling urinary catheter.Review of the care plan dated 01/03/26 revealed EBP were to be utilized during care provided to Resident #1's indwelling urinary catheter to reduce the risk of infection transmission.Observation on 01/21/26 at 10:40 A.M. of Resident #1's doorway revealed a sign indicating EBP. Further observation revealed providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy) and any skin opening requiring a dressing. Observation on 01/21/26 at 10:50 A.M. of indwelling urinary catheter care, provided by CNA #501, revealed CNA #501 did not don a gown when she provided care for Resident #1's urinary catheter. Interview on 01/21/26 at 11:00 A.M. with CNA #501 confirmed she did not don a gown when she provided catheter care for Resident #1, and she should have. Review of the facility policy titled, Enhanced Barrier Precautions (EBP) Standard Operating Procedure, reviewed 12/03/25, revealed EBP would be in place during high-contact activities for residents with the following conditions: residents at an increased risk of multidrug-resistant (MDRO) status, which included residents with wounds and all residents with indwelling medical devices (urinary catheters, central lines, feeding tubes, and tracheostomy tubes). PPE should be used even if blood and body fluid exposure was not anticipated. At a minimum, staff should wear gloves and a gown during high-contact care activities.3. Review of the medical record for Resident #43 revealed he was admitted on [DATE]. His diagnoses included spinal stenosis, peripheral vascular disease, type two diabetes mellitus, heart disease, infection and inflammatory reaction to left hip prosthesis, and cutaneous abscess.Review of the MDS assessment, dated 01/13/26, revealed Resident #43 was cognitively intact and did not display any behaviors at the time of the assessment. He required set-up to substantial assistance with ADLs and partial assistance with transfers.Review of the physician orders for Resident #43 revealed an order for two grams (gm) of cefepime (antibiotic) to be administered every eight hours via IV.Review of the Medication Administration Record (MAR) for January 2026 revealed Resident #43 was administered two gm of cefepime via IV, as ordered, every eight hours beginning at 7:00 A.M. on 01/08/26.Observation on 01/22/26 at 2:55 P.M. of Registered Nurse (RN) #531 administering an IV medication to Resident #43 revealed the end of the IV tubing was looped into a port on the IV tubing. RN #531 prepared the medication, attached the IV tubing to the medication bag, disconnected the end of the IV tubing from the port on the tubing, then attached the end of the IV tubing to Resident #43's disinfected peripherally inserted central catheter (PICC) line, located in his upper left arm. RN #531 did not disinfect the end of the IV tubing prior to attaching it to Resident #43's PICC line.Observation on 01/22/26 at 3:00 P.M. of Resident #43's IV tubing revealed it was disconnected from his PICC line, and the end of the IV tubing was looped into a port on the IV tubing hanging from the IV pole.Interview on 01/22/26 at 3:00 P.M. with RN #531 revealed IV tubing was safe to use for 24 hours and their practice, between medication administrations, was to loop the end of the IV tubing in a port on the tubing. RN #531 verified she did not disinfect the IV tubing port nor the end of the IV tubing between the IV medication administrations for Resident #43.Interview on 01/22/26 at 3:45 P.M. with Licensed Practical Nurse (LPN) #560 revealed they utilized a sterile plastic cap, specifically designed to cover the end of IV tubing, between uses and would manually disinfect the end of the IV tubing with an alcohol swab prior to re-connecting IV tubing to a resident's PICC line port.Interview on 01/22/26 at 4:45 P.M. with RN #574 revealed they used a sterile plastic cap, specifically designed to cover the end of IV tubing, between uses and would manually disinfect the end of the IV tubing with an alcohol swab prior to re-connecting IV tubing to a resident's PICC line port. RN #574 stated they did not loop IV tubing ends into ports on the IV tubing due to the risk for (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	infection and they should replace the IV tubing if they found it looped.Review of the facility policy titled, Catheter Insertion and Care - Administration Set/Tubing Changes, revised December 2015, revealed a sterile cap would be placed on the end of the IV tubing, between uses, when it was disconnected from the patient access point such as a PICC.4. Review of the medical record for Resident #41 revealed an admission date of 08/20/25 with diagnoses of osteomyelitis, dementia, and multiple sclerosis (MS).Review of the quarterly MDS assessment, dated 11/25/25, revealed Resident #41 had intact cognition and ambulated with a wheelchair and was dependent on staff for lower body dressing and putting on and taking off footwear, and required partial/moderate assistance for bed mobility and chair to bed transfers. Further review revealed Resident #41 had unhealed pressure ulcers. Review of the physician orders revealed Resident #41 had an order initiated 12/04/25 for as-needed (PRN) changes to the dressing on her left heel wound. Further review revealed the order stated Do not remove anything below the steri-strips on the left heel. Okay to change the outer alginate and ABD (absorbent bandage) and roll gauze every three days and as needed for drainage. Observation on 01/21/26 at 4:00 P.M. revealed LPN #502 prepared to change the ABD pad and gauze bandage to Resident #41's left heel. Resident #41 was seated in a wheelchair at bedside with both feet resting on the hard plastic footrests. LPN #502 donned a gown, washed her hands and put on disposable gloves and bent to provide wound care to Resident #41. LPN #502 removed the outer gauze, peeled off the ABD pad, then supported Resident #41's left heel with one hand while she opened the packaging of the clean ABD pad. LPN #502 used both hands, while one continued to support Resident #41's heel, to apply the clean ABD pad. After applying the clean ABD pad, LPN #502 continued to support Resident #41's heel, switching from her right hand to her left hand, and picked up the package of new gauze. LPN #502 continued to support Resident #41's heel while she used both hands to wrap the ABD paid and left foot with fresh gauze. LPN #502 then allowed Resident #41's left foot to rest on the wheelchair footrest while LPN #502 applied a piece of tape to the gauze to hold it in place. Interview on 01/21/26 at 4:09 P.M. with LPN #502 confirmed she did not change her gloves and perform hand hygiene between removing Resident #41's soiled bandage and applying the clean dressing. Review of the CDC titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 02/27/24 and located at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, revealed to change gloves and clean hands when moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurred.Review of the facility policy titled, Guideline for Handwashing/Hand Hygiene, reviewed 11/18/25, revealed Health Care Workers (HCW) shall use hand hygiene at times such as: before and after having direct physical contact with residents and after removing gloves for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled line, et cetera (etc).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, review of the Centers for Disease Control and Prevention (CDC) guidelines and review of facility policy, the facility failed to ensure appropriate personal protective equipment (PPE) was utilized while providing care for residents on transmission-based precautions (TBP). This affected two (#8 and #1) of two residents reviewed for TBP. Additionally, the facility failed to ensure intravenous (IV) medication administration tubing was maintained in a sanitary manner. This affected one (#43) of one resident reviewed for IV medication administration. Lastly, the facility failed to ensure appropriate hand hygiene during wound dressing changes. This affected one (#48) of one resident reviewed for pressure ulcers. The facility census was 66. Findings include: 1. Review of Resident #8's medical record revealed an admission date of 03/14/25 with diagnoses including, but not limited to, Parkinson's disease, unspecified head injury, pulmonary embolism, hypertensive heart and chronic kidney disease (CKD), type two diabetes mellitus (DM2), methicillin resistant staphylococcus aureus (MRSA), unspecified open wound of scalp, depression, heart failure, anxiety, and urinary tract infection (UTI). Review of the most recent Minimum Data Set (MDS) assessment, dated 12/30/25, revealed Resident #8 had a Brief Interview of Mental Status (BIMS) score of 15, indicating she was cognitively intact. Review of the physician orders revealed Resident #8 had an order dated 08/12/25 for contact precautions for MRSA head wound. Observation on 01/21/26 at 6:30 A.M. revealed signage by the door to Resident #8's room which stated she was in contact precautions. Further observation of the signage revealed PPE, including a gown and gloves, were to be donned prior to room entry. Observation on 01/21/26 at 6:33 A.M. revealed Certified Nursing Assistant (CNA) #568 entered Resident #8's room without donning gloves or a gown prior to entry. Interview on 01/21/26 at 6:55 A.M. with CNA #568 revealed she provided incontinence care to Resident #8 when she was observed to enter the resident's room at 6:33 A.M. CNA #568 verified she did not don the appropriate PPE prior to entering Resident #8's room and providing care. Review of the facility policy titled, Guidelines for Contact Precautions, dated 11/28/16, revealed contact precautions was a method designed to reduce the risk of transmission of microorganisms by direct or indirect methods. Further review revealed to wear gloves before contact with the resident or environmental objects. Additionally, a clean non-sterile, fluid resistant gown should be worn when entering the room if it was anticipated clothing could have substantial contact with the resident or environmental surface or when there was likelihood that organisms from blood, urine, stool, or wound drainage may be on surfaces or items in the resident's room. Substantial contact was defined as when the worker could anticipate that his/her clothing would be directly in contact with the resident, resident's linens, or bed. 2. Review of the medical record for Resident #1 revealed she was admitted on [DATE]. Her diagnoses included aspiration pneumonia, low back pain, lymphedema, chronic obstructive pulmonary disease (COPD), stage three CKD, white matter disease, history of falls, and cardiomegaly. Review of the most recent MDS assessment, dated 12/23/25, revealed Resident #1 was cognitively (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impaired and did not display any behaviors at the time of the assessment. She was incontinent of bowel and had an indwelling urinary catheter. Resident #1 required substantial assistance with activities of daily living (ADLs). Review of the physician orders dated 12/18/25 revealed Resident #1 had an order to utilize enhanced barrier precautions (EBP), wearing a gown and gloves, during high-contact care activities, including care of her indwelling urinary catheter. Review of the care plan dated 01/03/26 revealed EBP were to be utilized during care provided to Resident #1's indwelling urinary catheter to reduce the risk of infection transmission. Observation on 01/21/26 at 10:40 A.M. of Resident #1's doorway revealed a sign indicating EBP. Further observation revealed providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy) and any skin opening requiring a dressing. Observation on 01/21/26 at 10:50 A.M. of indwelling urinary catheter care, provided by CNA #501, revealed CNA #501 did not don a gown when she provided care for Resident #1's urinary catheter. Interview on 01/21/26 at 11:00 A.M. with CNA #501 confirmed she did not don a gown when she provided catheter care for Resident #1, and she should have. Review of the facility policy titled, Enhanced Barrier Precautions (EBP) Standard Operating Procedure, reviewed 12/03/25, revealed EBP would be in place during high-contact activities for residents with the following conditions: residents at an increased risk of multidrug-resistant (MDRO) status, which included residents with wounds and all residents with indwelling medical devices (urinary catheters, central lines, feeding tubes, and tracheostomy tubes). PPE should be used even if blood and body fluid exposure was not anticipated. At a minimum, staff should wear gloves and a gown during high-contact care activities. 3. Review of the medical record for Resident #43 revealed he was admitted on [DATE]. His diagnoses included spinal stenosis, peripheral vascular disease, type two diabetes mellitus, heart disease, infection and inflammatory reaction to left hip prosthesis, and cutaneous abscess. Review of the MDS assessment, dated 01/13/26, revealed Resident #43 was cognitively intact and did not display any behaviors at the time of the assessment. He required set-up to substantial assistance with ADLs and partial assistance with transfers. Review of the physician orders for Resident #43 revealed an order for two grams (gm) of cefepime (antibiotic) to be administered every eight hours via IV. Review of the Medication Administration Record (MAR) for January 2026 revealed Resident #43 was administered two gm of cefepime via IV, as ordered, every eight hours beginning at 7:00 A.M. on 01/08/26. Observation on 01/22/26 at 2:55 P.M. of Registered Nurse (RN) #531 administering an IV medication to Resident #43 revealed the end of the IV tubing was looped into a port on the IV tubing. RN #531 prepared the medication, attached the IV tubing to the medication bag, disconnected the end of the IV (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tubing from the port on the tubing, then attached the end of the IV tubing to Resident #43's disinfected peripherally inserted central catheter (PICC) line, located in his upper left arm. RN #531 did not disinfect the end of the IV tubing prior to attaching it to Resident #43's PICC line. Observation on 01/22/26 at 3:00 P.M. of Resident #43's IV tubing revealed it was disconnected from his PICC line, and the end of the IV tubing was looped into a port on the IV tubing hanging from the IV pole. Interview on 01/22/26 at 3:00 P.M. with RN #531 revealed IV tubing was safe to use for 24 hours and their practice, between medication administrations, was to loop the end of the IV tubing in a port on the tubing. RN #531 verified she did not disinfect the IV tubing port nor the end of the IV tubing between the IV medication administrations for Resident #43. Interview on 01/22/26 at 3:45 P.M. with Licensed Practical Nurse (LPN) #560 revealed they utilized a sterile plastic cap, specifically designed to cover the end of IV tubing, between uses and would manually disinfect the end of the IV tubing with an alcohol swab prior to re-connecting IV tubing to a resident's PICC line port. Interview on 01/22/26 at 4:45 P.M. with RN #574 revealed they used a sterile plastic cap, specifically designed to cover the end of IV tubing, between uses and would manually disinfect the end of the IV tubing with an alcohol swab prior to re-connecting IV tubing to a resident's PICC line port. RN #574 stated they did not loop IV tubing ends into ports on the IV tubing due to the risk for infection and they should replace the IV tubing if they found it looped. Review of the facility policy titled, Catheter Insertion and Care – Administration Set/Tubing Changes, revised December 2015, revealed a sterile cap would be placed on the end of the IV tubing, between uses, when it was disconnected from the patient access point such as a PICC. 4. Review of the medical record for Resident #41 revealed an admission date of 08/20/25 with diagnoses of osteomyelitis, dementia, and multiple sclerosis (MS). Review of the quarterly MDS assessment, dated 11/25/25, revealed Resident #41 had intact cognition and ambulated with a wheelchair and was dependent on staff for lower body dressing and putting on and taking off footwear, and required partial/moderate assistance for bed mobility and chair to bed transfers. Further review revealed Resident #41 had unhealed pressure ulcers. Review of the physician orders revealed Resident #41 had an order initiated 12/04/25 for as-needed (PRN) changes to the dressing on her left heel wound. Further review revealed the order stated Do not remove anything below the steri-strips on the left heel. Okay to change the outer alginate and ABD (absorbent bandage) and roll gauze every three days and as needed for drainage. Observation on 01/21/26 at 4:00 P.M. revealed LPN #502 prepared to change the ABD pad and gauze bandage to Resident #41's left heel. Resident #41 was seated in a wheelchair at bedside with both feet resting on the hard plastic footrests. LPN #502 donned a gown, washed her hands and put on disposable gloves and bent to provide wound care to Resident #41. LPN #502 removed the outer gauze, peeled off the ABD pad, then supported Resident #41's left heel with one hand while she opened the packaging of the clean ABD pad. LPN #502 used both hands, while one continued to support Resident #41's heel, to apply the clean ABD pad. After applying the clean ABD pad, LPN #502 continued to support Resident #41's heel, switching from her right hand to her left hand, and picked up (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the package of new gauze. LPN #502 continued to support Resident #41's heel while she used both hands to wrap the ABD paid and left foot with fresh gauze. LPN #502 then allowed Resident #41's left foot to rest on the wheelchair footrest while LPN #502 applied a piece of tape to the gauze to hold it in place. Interview on 01/21/26 at 4:09 P.M. with LPN #502 confirmed she did not change her gloves and perform hand hygiene between removing Resident #41's soiled bandage and applying the clean dressing. Review of the CDC titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 02/27/24 and located at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, revealed to change gloves and clean hands when moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurred. Review of the facility policy titled, Guideline for Handwashing/Hand Hygiene, reviewed 11/18/25, revealed Health Care Workers (HCW) shall use hand hygiene at times such as: before and after having direct physical contact with residents and after removing gloves for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled line, et cetera (etc).

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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, and staff interview, the facility failed to ensure skin assessments were completed accurately. This affected one (#24) resident reviewed for skin assessments. The facility census was 66. Findings Include: Review of the medical record for Resident #24 revealed an admission date of 01/08/26 with diagnoses of congestive heart failure, type II diabetes mellitus, and chronic kidney disease. Review of the admission Observation and Data Collection, dated 01/08/26, revealed Resident #24 was oriented to person, place, time and situation. Review of a physician order dated 01/08/26 revealed Resident #24 received weekly skin assessments. Review of the Treatments Administration History revealed Resident #24 had no skin findings identified during the skin assessment completed 01/19/26. Observation on 01/20/26 at 2:21 P.M. revealed Resident #24 sitting in his wheelchair wearing a sock on his left foot and the sock on his right foot was pushed down around the arch of his foot. A concurrent interview with Resident #24 revealed he had a wound on the outer side of his right ankle and said it had been there a couple of days and he would like some ointment for it. Observation of Resident #24's right ankle revealed a dark red area that appeared to be scabbed over and dry. Interview, and concurrent observation, on 01/20/26 at approximately 2:26 P.M. with Licensed Practical Nurse (LPN) #502 confirmed Resident #24 had a red area to his right ankle. LPN #502 stated she was not aware of the area. Observation on 01/20/26 at 2:32 P.M. with the Director of Nursing (DON) of Resident #24's right ankle revealed the area to the resident's right ankle appeared to be scabbed over. The DON confirmed, based on her observation, the wound was likely in place for more than two days (prior to the completion of the skin assessment dated [DATE]). A follow-up interview on 01/20/26 at 2:47 P.M. with the DON, and concurrent review of Resident #24's medical record revealed a skin assessment was completed 01/19/26 and the area on Resident #24's right ankle was not identified. Interview on 01/22/26 at 8:16 A.M. with LPN #595, whose tasks included weekly wound rounds to assess residents' wounds, stated she assessed Resident #24's right ankle wound on 01/21/26 and described the wound as dry, stable eschar, measuring one centimeter (cm) long x 1.5 cm wide with no depth. LPN #595 stated the wound would have been present on 01/19/26 when the weekly skin assessment was completed.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review, review of wound clinic notes, observation, and staff interview, the facility failed to ensure pressure ulcer wound treatments and pressure reducing interventions were implemented as physician ordered. This affected one (#41) of two residents reviewed for pressure ulcers. The facility census was 66. Findings include:Review of the medical record for Resident #41 revealed an admission date of 08/20/25 with diagnoses of osteomyelitis, dementia, and multiple sclerosis (MS). Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/25/25, revealed Resident #41 had intact cognition and ambulated with a wheelchair and was dependent on staff for lower body dressing and putting on and taking off footwear, and required partial/moderate assistance for bed mobility and chair to bed transfers. Further review revealed Resident #41 had unhealed pressure ulcers. Review of the outside clinic wound assessment, dated 12/30/25, revealed Resident #41 had a stage IV pressure ulcer (full-thickness wound extending through the skin into muscle, tendon, or bone) to her left heel and was seen weekly at the wound clinic for a treatment of Kerecis (intact fish skin used for tissue regeneration) weekly for ten treatments, with the final treatment of Kerecis applied 12/30/25. During the weeks Resident #41 received Kerecis treatments at the outside wound clinic, the treatment orders for the facility to complete stated Please do not remove anything except the outer ABD (an absorbent pad), rolled gauze, and alginate if drainage seeps through. The Versatel (a silicone coated dressing) and everything underneath needs to remain in place until next visit. Do not remove anything below the steri-strips on the left heel. Additional orders were to change the outer alginate, ABD and roll gauze every three days and as needed for drainage. Then pad and protect the top of the left foot with foam or ABD pad. Measurements of the left heel wound on 12/30/25 were 2.8 centimeters (cm) in length by (x) 0.9 cm in width x 0.1 cm in depth. Review of the outside clinic wound assessment, dated 01/08/26, revealed the left heel pressure ulcer measured 3.6 cm long x 0.8 cm wide x 0.1 cm deep. The clinic initiated a new treatment on 01/08/26 of collagen, moisten with normal saline, covered with copper alginate, secured with ABD and roll gauze, change daily. Additionally, the recommendations were to wear heel boots to offload the heels even in a chair. Review of the physician orders dated 12/04/25 for Resident #41's left heel revealed do not remove anything below the steristrips on the left heel, okay to change the outer alginate and ABD and roll gauze every three days and as needed for drainage. An additional physician order, dated 08/21/25, revealed Resident #41 should be encouraged to float heels while in bed as tolerated. Further review revealed no wound care orders for daily dressing changes or wearing heel boots to offload the heels even in a chair were initiated as ordered by the wound clinic on 01/08/26. Observation on 01/21/26 at 3:53 P.M. revealed Resident #41 sitting in a wheelchair at bedside. Resident #41 had socks on both feet and her feet were resting on the hard plastic foot supports of the wheelchair. A pair of offloading boots were on the couch. Concurrent interview with Licensed Practical Nurse (LPN) #502 confirmed Resident #41's boots were on the couch. Further observation revealed LPN #502 removed the sock on Resident #41's left foot and confirmed the bandage was dated 01/14/26. LPN #502 further stated the order for Resident #41's left heel wound were to only change the exterior bandage and ABD if they were soiled. LPN #502 stated the staff were not cleaning or treating the actual wound per the orders from the wound clinic to leave the wound untouched. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365663	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Genoa Retirement Village	300 Cherry St Genoa, OH 43430

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/26 at approximately 10:00 A.M. with the Director of Nursing (DON) confirmed the facility did not update Resident #41's wound care orders on 01/08/26 and verified Resident #41 did not receive daily wound treatments as ordered by the wound clinic from 01/08/26 through 01/21/26. Review of the wound clinic notes dated 01/22/26 revealed Resident #41's left heel wound measured 3.6 cm long, 0.9 cm wide, and 0.5 cm deep. Further review revealed the left heel wound healing status was wound stable and the wound on the left heel was progressing as expected. Interview on 01/27/26 at 10:24 A.M. with Registered Nurse (RN) #624 confirmed the facility did not implement an order on 01/08/26 to ensure Resident #41 offloaded her heels while up in the chair. Observation on 01/27/26 at 10:30 A.M. of Resident #41's left heel wound revealed red granulation tissue in the wound bed, callous peri-wound boarder, no peri-wound redness, and no drainage. Wound measurements obtained during this observation by LPN #595 were 3.6 cm long x 1.0 cm wide x 0.2 cm deep.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365663	A. Building B. Wing	01/27/2026

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure consistent communication with the hemodialysis (HD) clinic. This affected one (#3) of one resident identified by the facility as receiving HD. The facility census was 66.Findings include:Review of the medical record for Resident #3 revealed an admission date of 12/28/25 with diagnoses of end stage renal disease with dependence on HD and type II diabetes mellitus. Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 12/31/25, revealed Resident #3 had intact cognition and received dialysis. Review of the physician order dated 12/28/25 revealed Resident #3 went to offsite HD on Tuesdays, Thursdays, and Saturdays. Further review of the physician order revealed staff should complete a Dialysis Center Communication Observation (DCCO) form and send it with the resident. Review of Resident #24's electronic medical record (EMR) revealed two DCCO, one dated 01/10/26 and the other dated 01/17/26. Review of two additional DCCOs, revealed hard copies were available for HD completed on 01/13/26 and 01/20/26. Interview on 01/21/26 at 10:49 A.M. with Registered Nurse (RN) #508 revealed all HD communication forms (DCCOs) were scanned into the EMR and no hard copies or HD notebooks were kept for Resident #24. RN #508 stated the facility completed a pre-HD assessment on Resident #24, printed the form and sent it with Resident #24 to HD. RN #508 stated Resident #24 brought the paperwork back to the facility and staff scanned the form into his EMR. Continued interview with RN #508 and concurrent review of Resident #24's EMR confirmed there were only two HD communication forms in the resident's EMR, one dated 01/10/26 and the other dated 01/17/26. RN #508 stated she scanned the one on 01/17/26 when she worked the previous weekend. Interview on 01/22/26 at approximately 11:00 A.M. with the Director of Nursing (DON) confirmed the facility only had evidence of HD communications on 01/10/26, 01/13/26, 01/17/26, and 01/20/26 (four of 10 HD treatments) for Resident #24 and further verified no additional evidence was available. Review of the facility policy titled, Guidelines for Dialysis, reviewed 05/22/18, revealed a report (may be written or verbal) shall be requested from the Dialysis Provider that will alert the campus regarding: tolerance to procedure, vital signs, medications administered, and other information deemed necessary for the ongoing provision of care.