STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365667	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medina Center for Rehabilitation and Nursing	555 Springbrook Dr Medina, OH 44256

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, staff interview and review of facility policy, the facility failed to notify the physician of allegations of sexual abuse. This affected one resident (#42) of one resident reviewed for physician notification. The facility census was 60. Findings include: Record review for Resident #42 revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included Wernicke's Encephalopathy (presence of neurological symptoms caused by biochemical lesions of the central nervous system) and post-traumatic stress disorder. Review of the Admission Medicare Five-Day Minimum Data Set (MDS), dated [DATE], revealed Resident #42 was cognitively intact. Resident #42 had no impairment of the upper of lower extremities and used a walker/wheelchair for mobility. Review of SRI tracking number 249272, dated 07/02/24 at 2:53 P.M., revealed Resident #42 was the alleged perpetrator of a sexual abuse allegation against a female resident. Further review of Resident #42's medical record revealed no evidence the physician was notified of the allegation. Review of SRI tracking number 251540, dated 09/05/24 at 3:04 A.M., revealed Resident #42 was the alleged perpetrator of a sexual abuse allegation against a female resident. Further review of Resident #42's medical record revealed no evidence the physician was notified of the allegation. Interview on 10/03/24 at 12:24 P.M. with [NAME] President of Operations (VPO) #451 confirmed the facility had no evidence Resident #42's physician was notified of either allegation of sexual abuse. Review of the facility policy titled Abuse and Neglect - Clinical Protocol, revised March 2018, revealed the nurse will assess the individual and document related findings and report findings to the physician. The physician and staff will help identify risk factors for abuse within the facility. This deficiency was an incidental finding discovered during the complaint investigation.

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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(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	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** 42011 Based on observation, resident interview, family interview, staff interview and medical record review, the facility failed to ensure a comfortable, homelike environment free from loud noises. This affected three residents (#42, #28 and #17) of three residents reviewed for a comfortable, homelike environment. The facility census was 60. Findings include: 1. Record review for Resident #42 revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included Wernicke's Encephalopathy (presence of neurological symptoms caused by biochemical lesions of the central nervous system) and post-traumatic stress disorder. Review of the Admission Medicare Five-Day Minimum Data Set (MDS) assessment, dated 08/28/24, revealed Resident #42 was cognitively intact. Review of the care plan initiated 03/24/24 revealed Resident #42 had an alteration in mood/behavior/psychosocial well-being related to anxiety. Interventions included attempt to identify what triggers behaviors, convey acceptance of resident, encourage resident to take an active role within the facility and introduce resident to other residents. An additional intervention was added on 09/18/24 for an alarm system to the door to alert staff (the intervention did not specify what staff were to be alerted to or what action to take). Review of the physician orders for Resident #42 revealed an order dated 09/19/24 indicating the resident may have an alarm ti the door for safety. Review of a skilled evaluation note, dated 09/01/24 at 12:47 A.M. and completed by Registered Nurse (RN) #466, revealed Resident #42 slept intermittently and wandered at night. Observation on 09/24/24 at 4:40 P.M. revealed Resident #42 was sitting in his wheelchair in the foyer area located at the end of the hall where he resided. Continuous observation revealed Resident #42 propelled himself back to his room. When Resident #42 opened his room door, a loud alarm sounded. Once Resident #42 entered his room and closed the door, the alarm stopped. Further observation revealed a magnet alarm was placed near the top of the door. Coinciding interview with Resident #42 revealed the facility staff placed the alarm on the door. Resident #42 stated, I hate that thing. It's terrible. Resident #42 stated the alarm was used to monitor him so the staff were aware when he left his room. Resident #42 stated everyone could hear the alarm. Interview on 09/25/24 at 10:39 A.M. with Licensed Practical Nurse (LPN) #446 revealed Resident #42 had an alarm on his door to alert staff when his door opened and it shut off as soon as the door closed. LPN #446 revealed Resident #42 left his room frequently. Interview on 10/02/04 at 10:54 A.M. with Resident #42's daughter revealed the facility placed the alarm on the resident's door. The resident's daughter further stated the alarm was very loud. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for Resident #28 revealed an admitted [DATE]. Diagnoses included acute and chronic congestive heart failure, ischemic cardiomyopathy and muscle weakness. Review of the Admission MDS assessment, dated 08/13/24, revealed Resident #28 was cognitively intact. Resident #28 had adequate hearing. Observation on 09/25/24 at 12:52 P.M. revealed Resident #28's room was located across the hall from Resident #42, who a facility placed alarm on his door. During a concurrent interview with Resident #28, the resident stated, That alarm drives me crazy. It wakes me up all time. It's going off all hours of the night and it wakes me up. 3. Record review for Resident #17 revealed an admitted [DATE]. Diagnoses included contracture of the right hip and need for assistance with personal care. Review of the quarterly MDS assessment, dated 07/01/24, revealed Resident #17 was cognitively intact. Resident #17 had adequate hearing. Observation on 09/25/24 at 12:54 P.M. revealed Resident #17's room was located across the hall from Resident #42, who had a facility placed alarm on his door. Interview with Resident #17 revealed the alarm woke her up, further stating Resident #42 was in and out of his room all the time, both day and night. Resident #17 stated the alarm on Resident #42's door announced every time he went in and out of his room. This deficiency represents non-compliance investigated under Master Complaint Number OH00158139.

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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 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** 42011 Based on resident interview, medical record review, review of Self-Reported Incidents (SRI), staff interview and review of facility policy, the facility failed to ensure residents were free from abuse. This affected two residents (#25 and #55) of three residents reviewed for abuse. The facility census was 60. Findings include: 1. Record review for Resident #25 revealed an admitted [DATE]. Diagnoses included a history of cerebral infarction and hemiplegia with hemiparesis affecting the left non-dominant side. Further review of the medical record revealed Resident #25 was cognitively intact. 2. Record review for Resident #55 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, neuromuscular dysfunction, anxiety disorder, macular degeneration, schizoaffective disorder and muscle weakness. Further review revealed Resident #55 was cognitively intact. Record review for Resident #42 revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included Wernicke's Encephalopathy (presence of neurological symptoms caused by biochemical lesions of the central nervous system) and post-traumatic stress disorder. Resident #42 was cognitively intact. Review of the care plan initiated 03/24/24 revealed Resident #42 had an alteration in mood/behavior/psychosocial well-being related to anxiety, mobility decline/deficit, unrealistic expectations and sexual tendencies. Interventions included attempting to identify what triggers behaviors, convey acceptance of resident, encourage resident to take an active role within the facility and introduce resident to other residents. Review of SRI tracking number 249272, dated 07/02/24 at 2:53 P.M., revealed the facility received an allegation of sexual abuse involving Resident #42 and Resident #25. Resident #42 was placed on 15-minute checks at that time. Further review revealed Resident #42 was alleged to have asked Resident #25 for a gesture of sexual nature. The SRI did not specify what the sexual gesture was. The residents were immediately separated. The SRI indicated both residents were alert and their own responsible party. Resident #25 stated that her and Resident #42 were good friends, and she enjoyed his company. Resident #25 stated she was not violated by Resident #42 in any form. After interviewing staff and residents, the facility determined there was no evidence to indicate Resident #42 sexually assaulted Resident #25. Review of the facility investigation for the incident on 07/02/24 revealed written statements from Activities Manager (AM) #280 and State tested Nursing Assistant (STNA) #326 indicating Resident #42 and Resident #25 were barricaded in Resident #42's room. The investigation revealed no witness statement or interview with Resident #25 regarding the incident. Further review of Resident #42's care plan revealed no new care plan interventions were identified or implemented following the allegation on 07/02/24. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skilled evaluation note, dated 09/01/24 at 12:47 A.M. revealed Resident #42 slept intermittently and wandered at night. Review of a behavior note, dated 09/01/24 at 2:44 A.M. revealed the nurse was made aware Resident #42 had been in and out of room [ROOM NUMBER]-1 several times, while the resident was sleeping. This nurse went in room [ROOM NUMBER], she (Resident #55) was found to be sleeping, the television (TV) and lights were off, and Resident #42 was sitting at the side of bed, next to the resident (Resident #55). The nurse asked Resident #42 to leave and allow her to sleep. Will continue to monitor and check during this tour. Additional review of Resident #42's care plan revealed on 09/01/24 an intervention was added to provide the resident with 30-minute checks (by staff). Further review of Resident #42's medical record from 09/01/24 through 09/05/24 revealed no evidence staff performed 30-minute checks on the resident. Review of SRI tracking number 251540, dated 09/05/24 at 3:04 A.M., revealed the facility received an allegation of physical abuse involving Resident #42 and Resident #55. Staff reported to the Administrator that Resident #42 was observed in Resident #55's room on the left side of the resident's bed, with his right hand in her pants. Staff immediately separated the residents. Resident #55 indicated she was ok and Resident #42 was just rubbing her. Resident #42 was immediately placed on one-on-one supervision. The Administrator interviewed both residents. Resident #55 stated she did not consent for the male resident (Resident #42) to touch her. Resident #55 stated they normally watched movies together, but now she feels uncomfortable. Resident #55 stated Resident #42 put his hands down her pants and touched her. Resident #42 stated they were just in the room watching a scary movie, while holding her hand because she was scared. The facility determined the allegation was unsubstantiated and evidence of abuse did not occur. Review of STNA #326's witness statement, dated 09/05/24, revealed around 2:15 A.M., the nurse asked if Resident #42 was allowed in Resident #55's room without the door opened because she thought he was in the room with the door closed. STNA #326 went to the room and knocked on the door. When STNA #326 entered the room, there was a chair in front of the door. The lights were on, and Resident #42 was on the left side of her (Resident #55) bed with his right hand in her pants. STNA #326 told Resident #42 she saw what he was doing and to please exit the room. Resident #42 left the room and STNA #326 went to report the incident to the nurse. Upon return, the nurse asked Resident #55 if Resident #42 was being inappropriate. Resident #55 stated not really. STNA #326 asked why Resident #42's hand was down her pants and Resident #55 stated Resident #42 was rubbing on her. The nurse asked Resident #55 if she was ok with it and the resident stated she was married and had been for [AGE] years and that she was not ok with Resident #42 touching her. STNA #326 then left the room. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Licensed Practical Nurse (LPN) #460's witness statement, dated 09/05/24, revealed she was alerted by the STNA that, upon entering Resident #55's room, Resident #42 was in his wheelchair, facing Resident #55, with is right hand in her pants. The nurse asked Resident #55 if the male resident was inappropriate with her. At first, the resident stated no. STNA #326 asked why his hands were in her pants. Resident #55 stated she had been married for [AGE] years, she and her husband did not do things like this, and he (Resident #42) was just rubbing her. The nurse stated to the resident that it was inappropriate for male residents to touch you without your permission. Resident #55 revealed she did not want him touching her. Resident #55 declined notifying the police. LPN #460 then went to Resident #42's room. Resident #42 stated nothing happened and denied having his hand down Resident #55's pants. Interview on 09/25/24 at 3:59 P.M. with the Administrator revealed Resident #42 was placed on one-on-one staff supervision on 09/05/24 because he was found in Resident #55's room. The Administrator revealed it was alleged Resident #42 had his hand in Resident #55's pants and confirmed Resident #55 told her two times the incident occurred. The Administrator stated the facility unsubstantiated the allegation because of the conflicting responses from Resident #55 and Resident #42 and there was no evidence anything occurred, just hearsay. Interview on 09/25/24 at 6:03 P.M. with Resident #25 revealed she and Resident #42 were friends. Resident #25 stated Resident #42 came into her room one night while she was sleeping, pulled the side of her incontinence brief off and put his hand down there. Resident #25 confirmed Resident #42 touched her private area and further stated, He did not ask. I told him no and he stopped. He pulled his hand part way out but then put it right back. I kept telling him no. Resident #25 stated staff asked her if she wanted him to come around and she told them no. A follow-up interview on 09/26/24 at 1:40 P.M. with the Administrator revealed she submitted the SRI on 07/02/24 related to the sexual abuse allegation involving Resident #42 and Resident #25. The Administrator stated the previous Director of Nursing (DON) completed the investigation, adding she did not read or review the investigation before closing the SRI on 07/08/24, stating I just submitted it. The Administrator stated Resident #42 was caught pulling off Resident #25's pants, further stating Resident #42 had Resident #25's pants to her ankles. An STNA entered and Resident #42 left the room. The Administrator stated she could not recall who the STNA was who witnessed the incident but stated the STNA reported Resident #25's pants were down to her ankles. The Administrator stated she interviewed Resident #25, who could not recall the incident, but stated the notes were at her home and not available for review. Concurrent review of the facility investigation related to the incident with the Administrator verified there was no witness statement from the STNA who found Resident #42 with Resident #25 and no statement from Resident #25 related to the incident. The Administrator stated the previous DON wrote the statement in the SRI that there was no evidence to indicate sexual abuse. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/26/24 at 2:14 P.M. with STNA #326 revealed she remembered Resident #42's door was barricaded, with Resident #25 inside, on 07/02/24 but did not recall anything else related to the incident. STNA #326 stated she was told it was common for Resident #42 to go into Resident #55's room at night. On 09/05/24, STNA #326 stated she was working with an agency nurse on the night shift. STNA #326 stated the nurse approached her and asked if Resident #42 was allowed to be in Resident #55's room. STNA #326 stated she went to Resident #55's room, knocked on the door and quickly entered. STNA #326 stated she observed Resident #55 in bed with Resident #42 sitting in his wheelchair, next to the bed. STNA #326 stated a movie was on, which was normal for them to watch TV together. STNA #326 stated Resident #42 had his right hand in Resident #55's pants, and he slowly took his hand out of her pants. STNA #326 stated she told Resident #42, I saw what you did. Could you please go back to your room. Resident #42 left the room without saying anything. STNA #326 stated Resident #55 just looked at her and said she and her husband were together for [AGE] years and her husband was the only one she did that stuff with. STNA #326 stated Resident #55 requested Resident #42 not be allowed back in her room. Interview on 09/26/24 at 3:00 P.M. with Resident #55 revealed Resident #42 put his hands under her incontinence brief and touched her private area. Resident #55 stated, I said please don't do that. He pulled his hand back then went back down. I told him I was married [AGE] years, and I don't do that. Resident #55 stated someone came into the room and Resident #42 left. Resident #55 stated she told staff not to let him back into her room. Resident #55 stated, He was coming in to watch movies. He would come in and we watched movies. I thought we were friends then that happened. Interview on 10/03/24 at 12:24 P.M. with [NAME] President of Operations (VPO) #451 verified the facility had no evidence Resident #42 was monitored every 15-minutes following the incident on 07/02/24 (as indicated in the SRI) or every 30-minutes as indicated in the care plan revision on 09/01/24. VPO #451 confirmed the facility did not implement any interventions following the incident on 07/02/24 and further confirmed the facility should have put additional interventions in place to prevent any further incidents by Resident #42 towards female residents. From 09/05/24 through 09/17/24, VPO #451 stated Resident #42 had one-on-one staff supervision, but the decision was made to place an alarm on Resident #42's door on 09/18/24. VPO #451 stated the alarm was used to alert staff he was leaving his room. The intent was for staff to provide on-on-one supervision until Resident #42 returned to his room. Review of the facility policy titled Abuse and Neglect - Clinical Protocol, revised March 2018, revealed sexual abuse was defined as non-consensual sexual contact of any type with a resident. This deficiency was an incidental finding discovered during the complaint investigation.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, medical record review, staff interview, hospice staff interview and review of facility policy, the facility failed to ensure residents were free from misappropriation. This affected one resident (#57) of three residents reviewed for misappropriation, with the potential to affected three additional residents (#26, #36 and #44) who also received hospice services. The facility census was 60. Findings include: Record review for Resident #57 revealed an admitted [DATE]. Diagnosis included Alzheimer's disease and age-related debility. Further review revealed Resident #57 elected hospice benefits with a start date of 02/01/24. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was severely cognitively impaired. Resident #57 was dependent on staff for personal hygiene and was always incontinent of bowel and bladder. Interview on 09/25/24 at 11:54 A.M. with State tested Nursing Assistant (STNA) #326 revealed staff Always run out of supplies. They are in the garage, and they keep the garage locked. STNA #326 further stated she has had to take Resident #57's incontinence briefs to use for other residents because there were none available in the supply closets. STNA #326 stated this occurred several times. STNA #326 stated she felt she had no choice but to take Resident #57's briefs, otherwise, other residents would not get changed. STNA #326 stated the Administrator was aware of this. Interview on 09/26/24 at 10:19 A.M. with Hospice Aid (HA) #480 revealed she had been working with Resident #57 twice a week since the resident elected benefits. HA #480 confirmed Hospice provided Resident #57's incontinence briefs and there were times she came to care for Resident #57 and all the briefs were gone. Interview on 09/26/24 at 4:56 P.M. with STNA #310 revealed two weeks ago, while working the night shift, there were no briefs available in the facility to change her residents. STNA #310 stated she used Resident #57's briefs for the other residents because they had nothing else. STNA #310 stated staff were constantly telling central supply but it did not help. Observation on 09/30/24 at 9:04 A.M. revealed Resident #57 was sitting up in her wheelchair. Resident #57 was not able to answer any questions or provide information. Continued observation revealed several packs of incontinence briefs in the resident's bathroom were a different brand from the observed facility briefs. Interview on 09/30/24 at 10:55 A.M. with Administrator confirmed Hospice provided Resident #57's supplies, including incontinence briefs. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/30/24 at 11:20 A.M. with Central Supply (CS) #364 revealed the facility overstocked briefs were locked in the garage outside. The facility had two supply rooms in the facility and one closet for staff to obtain supplies. CS #364 revealed she would get the call if supplies were low or ran out in the facility. On 09/06/24, CS #364 stated she received a call in the evening from staff indicating they were low on briefs and wipes. CS #364 revealed she told staff she would come in the next morning and get some from the garage. Interview on 10/02/24 at 5:00 P.M. with [NAME] President of Operations (VPO) #451 revealed she interviewed staff and confirmed STNAs were taking hospice residents incontinence briefs. Review of the facility policy titled Abuse Prevention Program, revised December 2016, revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This deficiency represents non-compliance investigated under Complaint Number OH00157492.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, resident interview, family interview, medical record review, staff interview and review of facility policy, the facility failed to ensure residents were free from physical restraints. This affected one resident (#42) of one resident reviewed for restraints. The facility census was 60. Findings include: Record review for Resident #42 revealed an admitted [DATE]. Diagnoses included Wernicke's Encephalopathy (presence of neurological symptoms caused by biochemical lesions of the central nervous system) and post-traumatic stress disorder. Review of the Admission Medicare Five-Day Minimum Data Set (MDS) assessment, dated 08/28/24, revealed Resident #42 was cognitively intact. Resident #42 used a walker/wheelchair for mobility. Review of the care plan initiated 03/24/24 revealed Resident #42 had an alteration in mood/behavior/psychosocial well-being related to anxiety, mobility decline/deficit, unrealistic expectations and sexual tendencies. Interventions included attempting to identify what triggers behaviors, convey acceptance of resident, encourage resident to take an active role within the facility, introduce resident to other residents. On 09/01/24, the care plan interventions were revised to include encourage resident to verbalize cause for inappropriate touching and inappropriate verbalization and every 30-minute checks by staff to ensure safety of other residents. Further review revealed on 09/05/24, and discontinued 09/18/24, the care plan was again revised to include one-on-one (staff supervision) with resident to prevent repeat behaviors and on 09/18/24 an intervention was added to include an alarm system to the door to alert staff (the intervention did not specify what staff were being alerted to or how to respond to the alarm). Observation on 09/24/24 at 4:40 P.M. revealed Resident #42 was sitting in his wheelchair in the foyer area located at the end of the hall where he resided. Continuous observation revealed no staff were present in the hall or foyer area. Resident #42 was unsupervised. Resident #42 independently propelled himself back to his room. When Resident #42 opened his room door, a loud alarm sounded. Once Resident #42 entered his room and closed the door, the alarm stopped. Further observation revealed a magnet alarm was placed near the top of the door. Coinciding interview with Resident #42 revealed the facility staff placed the alarm on the door. Resident #42 stated, I hate that thing. It's terrible. Resident #42 stated the alarm was used to monitor him so the staff were aware when he left his room. Resident #42 stated everyone could hear the alarm, so he had to hurry because it was embarrassing and humiliating. Interview on 09/25/24 at 10:39 A.M. with Licensed Practical Nurse (LPN) #446 confirmed Resident #42 had an alarm on his door to alert staff when his door opened and turned off as soon as the door closed. (continued on next page)

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Medina Center for Rehabilitation and Nursing	555 Springbrook Dr Medina, OH 44256

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 at 3:59 P.M. with the Administrator revealed Resident #42 was placed on one-on-one staff supervision on 09/05/24, after he was found in a female resident's room and an allegation of sexual abuse was made. The Administrator stated the allegation was unsubstantiated. On 09/18/24, one-on-one staff supervision was discontinued, and the alarm was placed on Resident #42's door to alert staff when the resident left the room. The Administrator stated when Resident #42 left his room, staff were to follow him and provide one-on-one supervision until he returned to his room. The Administrator revealed she did not know if that was happening. Interview on 09/26/24 at 12:30 P.M. with Staff Scheduler (SS) #364 revealed from 09/05/24 through 09/17/24, the facility scheduled a staff member to provide one-on-one supervision for Resident #42. SS #364 stated the alarm was placed on Resident #42's door and no staff were scheduled to provide one-on-one supervision for Resident #42 after that date. Interview on 10/02/04 at 10:54 A.M. with Resident #42's daughter revealed she did not think Resident #42 was treated right when the facility placed an alarm on his door. Resident #42's daughter stated it was upsetting to the resident and it scared him, further adding the alarm was very loud and made him not want to leave his room. Interview on 10/03/24 at 12:24 P.M. with [NAME] President of Operations (VPO) #451 confirmed an alarm was placed on Resident #42's door on 09/18/24 to alert staff when he left his room. VPO #451 stated if Resident #42 left his room, staff were to provide one-on-one supervision for the resident, until he returned to his room. VPO #451 stated staff were being paid to sit outside of Resident #42's room from 09/05/24 through 09/17/24. The decision was made to place an alarm on the resident's room door, instead of continuing to pay staff to just sit there, with the understanding one-on-one supervision would be provided by the floor staff from the time Resident #42 left his room, until he returned. Review of the facility policy titled Unauthorized Physical Restraints, revised September 2022, revealed residents are free from the use of any physical restraints not required to treat their medical condition. Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to a residents body, cannot be removed easily by the resident (in the same manner as it was applied by the staff) and restricts the resident's freedom of movement. Inappropriate or unauthorized use of a restraint occurs when it is used to discipline or for convenience, unnecessarily inhibits a resident's freedom of movement or activity and is not accompanied by ongoing re-evaluation of the need for the restraint. Sometimes the use of restraints is not intentional, but this does not absolve the staff of the responsibility to recognize and report the unauthorized use of restraints. Examples of physical restraints (intentional or unintentional) included using a position change alarm to monitor resident movement. This deficiency represents non-compliance investigated under Master Complaint Number OH00158139 and Complaint Number OH00158113.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 44808 Based on personnel record review, review of the Bureau of Criminal Investigation (BCI) log, review of the Ohio Board of Nursing's website and review of facility policy, the facility failed to ensure implementation of their abuse prevention policy related to pre-employment background checks. This had the potential to affect all 60 residents in the facility. The facility census was 60. Findings include: 1. Review of the personnel file for Minimum Data Set Coordinator (MDSC) #308 revealed a hire date of 10/03/23. Further review revealed MDSC #308 disclosed on her employment application she had been convicted of a felony for conspiracy to commit mail fraud. Review of Ohio Board of Nursing's website revealed MDSC #308's Licensed Practical Nurse (LPN) license had board action taken against it as a result of a felony conviction for one count of conspiracy to commit mail fraud. MDSC #308's nursing license had permanent restrictions, including not working as a LPN for agencies providing in-home care, for hospice care programs providing in-home care, for staffing agencies or pools, as an independent provider for which nursing services are reimbursed by the State of Ohio through State agencies or agents of the State, for an individual or group of individuals who directly engage her to provide nursing services for fees, compensation, or other consideration or as a volunteer. Additionally, the permanent restrictions included MDSC #308 shall not function in a position of employment where the job duties or requirements involve management of nursing and nursing responsibilities, or supervising and evaluating nursing practice, including but not limited to Director of Nursing (DON), Assistant Director of Nursing (ADON), Nurse Manager, and [NAME] President of Nursing. Lastly, the permanent restrictions indicated MDSC #308 shall not function in any position or employment where the job duties or requirements involve financial activity and/or financial transactions while working in a position for which a nursing license is required. Interview on 09/25/24 at 11:32 A.M. with Human Resources Director (HRD) #367 revealed the facility did not hire anyone with a criminal history and a felony conviction should have been an automatic no for the hiring decision. Interview on 09/25/24 at 11:52 A.M. with MDSC #308 confirmed she had a felony conviction for conspiracy to commit mail fraud (federal conviction), her nursing license was suspended for two years, and restrictions remained on her nursing license. MDSC #308 said she was hired by the previous Administrator, who was aware of her conviction, and he told her she was good to go and he would take care of everything. Interview on 09/30/24 at 10:30 A.M. with Regional Director of Operations (RDO) #450 revealed the facility's abuse policy indicated the facility would not knowingly employ anyone found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law. She stated all background checks would be reviewed to ensure this criteria was met. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 09/30/24 at 8:30 A.M. with [NAME] President of Operations (VPO) #451 revealed the company never would have hired anyone with a felony record. She stated MDSC #308's application was never sent to her for review and further stated had she reviewed MDSC #308's application, she would not have been considered for the position of MDSC because of the restriction on her license for working with financial information. 2. Review of the personnel file for Social Services Director (SSD) #301 revealed a hire date of 05/13/24. Further review revealed no evidence the BCI background check results were received. Review of the facility's BCI background check log revealed no evidence SSD #301's BCI background check results were received. Interview on 09/26/24 at 8:03 A.M. with RDO #450 confirmed the facility did not have the background check results for SSD #301 within 30 days of requesting them and SSD #301 was placed on administrative leave, pending the results of her background check. Further interview at 3:50 P.M. with RDO #450 revealed all facility employees were required to undergo a background check for employment. 3. Review of the personnel file for Human Resources Director (HRD) #367 revealed a hire date of 10/18/23. Review of the reference checks, contained within the file, revealed HR Director #367's former employer reference was not checked until 03/14/24, which was five months after hire. Interview on 10/02/24 at 8:52 A.M. with Regional Director of Operations (RDO) #450 verified HRD #367's reference check was not completed timely. Review of the facility policy titled Abuse Prevention Program, dated December 2016, revealed background checks would be conducted and the facility would not knowingly employ or otherwise engage anyone found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law. This deficiency represents non-compliance investigated under Complaint Number OH00157492.

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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** 42011 Based on staff interview, medical record review, review of Self-Reported Incidents (SRI), review of facility investigations and review of facility policy, the facility failed to accurately document and thoroughly investigate allegations of abuse. This affected three residents (#25, #55 and #49) of four residents reviewed for facility investigations. The facility census was 60. Findings include: 1. Record review for Resident #25 revealed an admitted [DATE]. Diagnoses included a history of cerebral infarction and hemiplegia with hemiparesis affecting the left non-dominant side. Further review revealed Resident #25 was cognitively intact. Review of SRI tracking number 249272, dated 07/02/24 at 2:53 P.M., revealed the facility received an allegation of sexual abuse involving Resident #42 and Resident #25. Resident #42 was placed on 15-minute checks at that time. Further review revealed Resident #42 was alleged to have asked Resident #25 for a gesture of sexual nature. The SRI did not specify what the sexual gesture was. The residents were immediately separated. The SRI indicated both residents were alert and their own responsible party. Resident #25 stated she was not violated by Resident #42 in any form. After interviewing staff and residents, the facility determined there was no evidence to indicate Resident #42 sexually assaulted Resident #25. Review of the facility investigation revealed witness statements, dated 07/02/24, from Activities Manager (AM) #280 and State tested Nursing Assistant (STNA) #326. The investigation revealed no statement or interview with Resident #25 (alleged victim). Interview on 09/26/24 at 1:40 P.M. with the Administrator revealed she submitted the SRI on 07/02/24 related to the sexual abuse allegation involving Resident #42 and Resident #25. The Administrator stated the previous Director of Nursing (DON) completed the investigation, adding she did not read or review the investigation before closing the SRI on 07/08/24, stating I just submitted it. The Administrator stated she interviewed Resident #25 regarding the incident but did not document the interview/resident's statement. The Administrator stated her notes related to the interview were at her home and she did not have them available for review. The Administrator stated an STNA found the residents and further stated Resident #42 had Resident #25's pants around her ankles. The Administrator could not recall who the STNA who witnessed the incident. The Administrator stated Resident #25 did not recall the incident. Concurrent review of the facility investigation with the Administrator verified there was no witness statement from the STNA who found Resident #42 with Resident #25 and no statement from Resident #25 related to the incident. The Administrator stated the previous DON wrote the statement in the SRI that there was no evidence to indicate sexual abuse and stated the DON was no longer employed at the facility. The Administrator stated she never saw the investigation notes and just submitted the information in the system. 2. Record review for Resident #55 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, neuromuscular dysfunction, anxiety disorder, macular degeneration, schizoaffective disorder and muscle weakness. Further review revealed Resident #55 was cognitively intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of SRI tracking number 251540, dated 09/05/24 at 3:04 A.M., revealed the facility received an allegation of physical abuse involving Resident #42 and Resident #55. Staff reported to the Administrator that Resident #42 was observed in Resident #55's room on the left side of the resident's bed with his right hand in her pants. Staff immediately separated the residents. Resident #55 indicated she was ok and Resident #55 was just rubbing her. Resident #42 was immediately placed on one-on-one supervision. The Administrator interviewed both residents. Resident #55 stated she did not consent for the male resident (Resident #42) to touch her. Resident #55 stated they normally watched movies together, but now she feels uncomfortable. Resident #55 stated resident (Resident #42) did put hands down her pants and touched her. Resident #42 stated they were just in the room watching a scary movie, while holding her hand because she was scared. The facility determined the allegation was unsubstantiated and evidence of abuse did not occur. Review of the documented interview with Resident #55, dated 09/05/24 and completed and signed by the Administrator, revealed the Administrator met with Resident #55 to discuss the allegation of inappropriate touching from a male resident. Resident #55 revealed she did not give consent for the male resident to touch her. She stated only her husband of [AGE] years touched her there. She stated they normally watch movies together and now she feels uncomfortable with him. She stated he put his hand in her brief and touched her private area. The Administrator interviewed the resident again, along with the MDS nurse as a witness, and the resident stated again the male resident put his hand in her brief. The Administrator met with the alleged perpetrator (Resident #42), who stated they were just in the room watching a scary movie while he was holding her hand because she was scared. Resident #42 revealed they were good friends. Resident #42 confirmed Resident #55 never gave him consent to touch her body and denied putting his hand in her brief. Review of STNA #326's witness statement, dated 09/05/24, revealed around 2:15 A.M., the nurse thought Resident #42 was in Resident #55's room with the door closed. STNA #326 went to the room and knocked on the door. Upon entering the room, there was a chair in front of the door. The lights were on and Resident #42 was on the left side of Resident #55's bed with his right hand in her pants. STNA #326 told Resident #42 she saw what he was doing and to please exit the room. Resident #42 left the room and STNA #326 went to report the incident to the nurse. STNA #326 and the nurse returned to Resident #55's room. The nurse asked Resident #55 if Resident #42 was being inappropriate. Resident #55 stated not really. STNA #326 asked why Resident #42's hand was down her pants and Resident #55 stated Resident #42 was rubbing on her. The nurse asked Resident #55 if she was ok with it and the resident stated she was married and had been for [AGE] years and that she was not ok with Resident #42 touching her. STNA #326 then left the room. Review of Licensed Practical Nurse (LPN) #460's witness statement, dated 09/05/24, revealed she was alerted by the STNA that Resident #42 was in Resident #55's room with his right hand in her pants. This nurse asked Resident #55 if the male resident was inappropriate with her. At first, the resident stated no. Resident #55 was asked why Resident #42's hand was in her pants and the resident stated she had been married for [AGE] years, she and her husband did not do things like this and he (Resident #42) was just rubbing her. The nurse stated it was inappropriate for male residents to touch you without your permission. Resident #55 revealed she did not want Resident #42 touching her. Resident #55 declined notifying the police. LPN #460 then went to Resident #42's room. Resident #42 stated nothing happened and denied having his hand down Resident #55's pants. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 at 3:59 P.M. with the Administrator revealed Resident #42 was placed on one-on-one staff supervision on 09/05/24 because he was found in Resident #55's room. The Administrator stated it was alleged Resident #42 had his hand in Resident #55's pants and confirmed Resident #55 told her two times the incident occurred. The Administrator stated she never asked Resident #55 if she told Resident #42 no or to stop but confirmed Resident #55 did not give consent for Resident #42 to touch her. Even though Resident #55 confirmed the incident occurred, and there was a staff witness, the facility unsubstantiated the allegation because of conflicting responses from Resident #55 and Resident #42. The Administrator further added it was just hearsay. 44808 3. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including dementia, major depressive disorder, anxiety disorder, atrial fibrillation, hypertension and localized edema. Additional diagnoses were added on 02/08/24 to include osteophyte of left hip, non-displaced fracture of base of neck of left femur, and other disorders of bone density and structure. Review of the facility investigation related to SRI, tracking number 248990, revealed Resident #49 complained of left hip pain after using the toilet on 06/16/24 and an acute left trochanter fracture was identified via x-ray on 06/24/24. The timeline and incident summary included in the facility investigation did not indicate who developed the timeline or summary and did not indicate when those documents were created. Further review revealed a skin grid assessment dated [DATE] at 5:55 P.M. was not locked and signed until 09/27/24 at 4:27 P.M. In addition, the progress note, with an effective date of 06/24/24 at 5:00 P. M., was created on 09/26/24 at 11:58 A.M. by MDS Coordinator #308 and included Resident #49's vitals taken on 09/26/24. Lastly, the in-service for facility staff related to this incident was not created until 09/25/24 at 1:37 P.M. and led by MDS Coordinator #308. The facility's investigation conclusion was The facility feels that the injury was not unknown but from osteopenia etiology. Interview on 10/03/24 at 12:54 P.M. with [NAME] President of Operations (VPO) #451 confirmed the skin grid assessment completed on Resident #49 related to the fracture was not locked and signed until 09/27/24, the progress note related to the incident was not created until 09/27/24 and the related staff in-service was not initiated until 09/25/24 (all approximately three months after Resident #49's injury was identified). Additionally, VPO #451 verified the summary and timeline for the incident were not dated or signed, so there was no evidence as to who wrote those or when they were written to validate the findings. A follow-up interview on 10/03/24 at 1:44 P.M. with VPO #451 revealed she verified the assessment and progress note with MDS Coordinator #308 and the information was not accurately documented. Review of the facility policy titled Abuse Prevention Program, revised December 2016, revealed the administration will identify and assess all possible incidents of abuse. Additionally, the administration will investigate and report any allegations of abuse. The deficiency represents an incidental finding discovered during the course of the complaint 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** 45441 Based on medical record review and staff interview, the facility failed to ensure care plans were updated when new interventions were implemented. This affected two residents (#22 and #38) of two residents reviewed for care planning. The facility census was 60. Findings include: 1. Review of the medical record for Resident #22 reveal an admitted [DATE]. Diagnoses included cerebral infarction, depression, neuropathy, heart disease, dementia and Parkinson's disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/25/24, revealed Resident #22 was severely cognitively impaired. Resident #22 required set-up assistance for eating, substantial or maximum assistance for oral hygiene, toileting and showering and most dependent for personal hygiene. He had two falls since the previous assessment and was always incontinent of bowel and bladder. Review of the physician's orders for Resident #22 for October 2024 revealed an order for a sign to be in Resident #22's room to remind him to use his call light for assistance and to encourage the resident to be up in common areas when close to meal time or out of bed. Both orders began 07/03/24. Review of the fall risk assessment dated [DATE] revealed Resident #22 was at high risk for falls. Review of the care plan dated 07/18/24 revealed Resident #22 was at risk for falls due to confusion and being unaware of his safety needs. Interventions included encouraging the resident to be in common areas when awake or close to meal time, a sign in the room to call for assistance and to toilet before and after meals. Review of the fall note dated 09/24/24 at 2:06 A.M. revealed Resident #22 had a fall at 11:50 P.M. Resident #22's call light was on and he was sitting on a mat on the floor with his legs bent. He was leaning against the bed and holding onto the side rail. He was wearing non-slip socks. Vital signs were obtained and within normal limits. An immediate intervention was implemented, which included a bolster (a long, thick pillow that is placed under other pillows for support) to the left side of the bed and the right side of the bed placed against the wall. The environment was described as clean and free of clutter. The light was on and the floor was dry. Review of the interdisciplinary team (IDT) progress note dated 9/24/24 at 1:50 P.M. revealed Resident #22 was observed sitting on the floor mat with his legs bent, leaning against the wall and holding on to the side rail at 11:50 P.M. He was wearing non-skid socks. A head-to-toe observation and assessment was completed, Resident #22 was found to have three discolored areas to his right buttocks. Vital signs were obtained and within normal limits. The note indicated the care plan and kardex were updated to include the new intervention of bolsters on his bed and the opposite side against the wall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #22's care plan revealed no evidence the care plan was revised to include the new interventions implemented on 09/24/24 (bolster on the bed and the opposite side against the wall). 2. Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included dementia, bladder cancer, restlessness, depression and insomnia, Review of the quarterly MDS assessment, dated 8/14/24, revealed Resident #38 was rarely or never understood. He required partial or moderate assistance for eating and was dependent for oral care, toileting, showering, dressing and hygiene. He was always incontinent of bowel and had one fall since his last assessment. Review of the fall risk assessment dated [DATE] revealed Resident #38 was at moderate risk for falls. Review of the care plan dated 5/14/24 revealed resident #38 was at risk for falls due to confusion, incontinence and poor communication. Interventions included anticipating the resident's needs, ensuring the call light was in reach and ensuring the resident had a small object in his hand when ambulating. Review of the fall investigation for Resident #38's fall on 09/23/24 at 5:15 P.M. revealed a new intervention for a well lit room was implemented. Further review of Resident #38's care plan revealed no evidence the care plan was updated to include the new fall intervention for a well lit room. Interview on 10/03/24 at 11:22 A.M. with [NAME] President of Operations (VPO) #451 confirmed Resident #22's care plan was not updated to include new interventions for bolsters on his bed and the opposite side against the wall and Resident #38's care plan was not updated to include the new intervention for a well lit room. This deficiency represents an incidental finding discovered during the complaint survey.

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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** 42011 Based on observation, family interview, medical record review, review of shower schedules, review of shower/bath sheets, staff interview and review of facility policy, the facility failed to provide routine showers for residents dependent for care. This affected one resident (#46) of three residents reviewed for showers. The facility census was 60. Findings include: Review of Resident #46's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, cognitive communication deficit and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/14/24, revealed Resident #46 was rarely or never understood. Resident #46 was (staff) dependent for all activities of daily living (ADLs), including bathing/showers. Review of the care plan dated 09/26/23 revealed Resident #46 had an ADL self-care performance deficit. Interventions included total assistance by staff for bathing/showering. Review of the shower schedule revealed Resident #46 was scheduled to receive showers on Wednesdays and Saturdays on second shift. Review of Resident #46's shower/bath sheets from 07/01/24 through 09/30/24 revealed Resident #46 received a total of eight showers (07/06/24, 07/20/24, 07/25/24, 07/28/24, 08/10/24, 08/15/24, 08/24/24 and 09/30/24) of 26 showers that were scheduled during that period. Observation on 09/24/24 at 4:21 P.M. of Resident #46 revealed the resident was sitting in a chair in her room. Resident #46's hair appeared oily and unkempt. Resident #46's husband was present in the resident's room. Concurrent interview with Resident #46's husband revealed he visited the resident daily and stated she did not receive routine showers. Resident #46's husband stated he frequently had to request for the resident to receive a shower. Attempt to interview Resident #46 was unsuccessful as the resident was not able to answer questions. Interview on 09/24/24 at 4:34 P.M. with State tested Nursing Assistant (STNA) #331 confirmed Resident #46's hair was oily and unkept. Interview on 09/25/24 at 10:39 A.M. with Licensed Practical Nurse (LPN) #446 revealed residents did not always receive showers because the STNAs would not do them, even after being instructed to do so. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/02/24 at 12:10 P.M. with Regional Clinical Director (RCD) #447 revealed a shower/bath sheet was completed on every resident for every shower by the STNA. RCD #447 stated showers were also documented on the Medication Administration Record (MAR). Review of Resident #46's MAR from 07/01/24 through 10/01/24, with RCD #447, verified no showers were documented for the resident and further confirmed only eight showers (07/06/24, 07/20/24, 07/25/24, 07/28/24, 08/10/24, 08/15/24, 08/24/24 and 09/30/24) were documented on shower/bath sheets for the same time period. RCD #447 verified the facility had no evidence Resident #46 received showers twice weekly, as scheduled. Review of the facility policy titled Activities of Daily Living, Supporting, revised March 2018, revealed appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). This deficiency represents non-compliance investigated under Complaint Number OH00157355.

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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** 42011 Based on resident interview, family interview, staff interview, medical record review, review of hospital documents and review of transportation service communication, the facility failed to ensure transportation was arranged for Resident #02's outside appointments. This affected one resident (#02) of two residents reviewed for transportation services. Additionally, the facility failed to ensure a physician ordered follow-up appointment was scheduled for Resident #42. This affected one resident (#42) of two residents reviewed for coordination of care. The facility census was 60. Findings include: 1. Record review for Resident #02 revealed an admitted [DATE]. Diagnoses included multiple sclerosis and neuromuscular dysfunction of the bladder. Review of the annual Minimum Data Set (MDS) assessment, dated 09/06/24, revealed Resident #02 was cognitively intact. Resident #02 had progressive neurological conditions, impairment to both sides of the lower extremities, was dependent for toileting and bed mobility and had an indwelling catheter. Review of the care plan dated 11/04/18 revealed Resident #02 required an indwelling foley catheter as evidence by urinary retention. The goal included bladder elimination would be maintained through an indwelling suprapubic catheter (a thin, flexible tube that drains urine from the bladder through a small incision in the lower abdomen) with no signs or symptoms of a urinary tract infection (UTI). Interventions included to change the suprapubic catheter per orders and drainage bag as needed for blockage, leakage, signs and symptoms of urinary infection or when the closed system has been compromised; intake and output (I & O) every shift; and observe for clinical signs and symptoms of a UTI, monitor urine color, hematuria, flank or abdominal pain, elevated temperature or absence of urine daily. Report positive findings to the physician. Review of the nursing note, dated 03/20/24 at 8:20 A.M. and completed by Licensed Practical Nurse (LPN) #472, revealed physician in to see the resident. No new orders were obtained regarding the suprapubic catheter. Per the physician, urology to address the resident's suprapubic catheter at the appointment next month. Review of Resident #02's physician orders revealed the following: on 03/18/24, an appointment was scheduled at Urology Clinic (UC) #470 for 04/10/24 at 9:00 A.M.; on 04/08/24, an appointment was scheduled at UC #470 for 05/15/24 at 9:30 A.M.; on 06/18/24, an appointment was scheduled at UC #470 for 06/20/24 at 2:40 P.M.; on 06/20/24, an appointment was scheduled at UC #470 for 07/03/24 at 11:10 A.M.; and on 07/19/24, an appointment was scheduled at UC #470 for 07/26/24 at 11:00 A.M. Further review of Resident #02's medical record revealed no documentation indicating the resident was transported to the appointments at UC #470 or evidence the resident was seen by UC #470 at any of the scheduled appointments documented in the physician orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 at 1:03 P.M. with LPN #456 revealed Resident #02's suprapubic catheter had not been working for a long time, further stating it would not even flush. LPN #456 revealed Resident #02 had urology appointments scheduled, but she was told they kept getting canceled or rescheduled. Interview on 09/25/24 at 1:05 P.M. with Resident #02 revealed the suprapubic catheter was placed several years ago because she was unable to urinate on her own. Resident #02 stated the suprapubic catheter had not worked in five months. Resident #02 revealed UC #470 required her to go to appointments by stretcher, but her appointments kept getting canceled because the facility did not have stretcher transport. Interview on 09/30/24 at 3:55 P.M. with LPN/MDS Nurse #308 revealed the floor nurses scheduled physician follow-up appointments for all residents, including Resident #02. LPN/MDS Nurse #308 revealed she scheduled all transportation to those appointments. LPN/MDS Nurse #308 stated Ambulance Service (AS) #474 was the only contract the facility had for stretcher transportation and UC #470 required Resident #02 to arrive via stretcher for her appointments. LPN/MDS Nurse #308 stated AS #474 always had an excuse as to why they could not provide transportation. LPN/MDS Nurse #308 stated she just scheduled transportation for appointments, and she wrote down when transportation could not take Resident #02 to her appointments. LPN/MDS #308 confirmed there was no documentation in Resident #02's medical record indicating reasons why the resident's appointments with UC #470 were canceled or rescheduled. LPN/MDS Nurse #308 stated transportation schedules were documented in a book and the previous medical records staff took the book when she left so the facility had no evidence of transportation scheduled for Resident #02's urology appointments. Interview on 10/01/24 at 8:17 A.M. with [NAME] President of Operations (VPO) #451 revealed she saw the transportation schedule book on LPN/MDS Nurse #308's desk. VPO #451 retrieved the transportation schedule book and revealed she was not able to find where transportation for Resident #02 was scheduled for the urology appointments. Review of an electronic mail (e-mail) communication dated 10/01/24 at 3:31 P.M. from Director of Business Operations (DBO) #465 with AS #474 verified the facility never scheduled transportation for Resident #02's appointments at UC #470 on 04/10/24, 05/15/24, 06/20/24, 07/03/24 or 07/26/24. 2. Record review for Resident #42 revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included local infection of the skin and subcutaneous tissue and cellulitis of the right lower limb. Review of the Admission Medicare Five-Day MDS, dated [DATE], revealed Resident #42 was cognitively intact. Resident #42 had one venous and arterial ulcer with application of dressing. Resident #42 had a wound infection and received antibiotics. Review of the care plan initiated 08/18/24 revealed Resident #42 was exhibiting signs of cellulitis to the right lower extremity. Interventions included elevating the extremity affected and monitor for edema, redness, pain and warmth. Review of a progress note, dated 08/18/24 at 11:25 P.M. and completed by Registered Nurse (RN) #467 revealed Resident #42 was sent to the hospital for further evaluation of lower extremities due to increased symptoms of pain, redness and swelling bilaterally. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note, dated 08/21/24 at 9:44 P.M. and completed by LPN #468, revealed Resident #42 returned to the facility (from the hospital). Resident #42 had three open areas accompanied by redness and swelling noted to the right lower extremity, with mild purulent drainage. Review of the hospital after-visit summary, dated 08/21/24, revealed Resident #42 to follow-up with the primary care physician in one to two weeks and the wound care center in one week. Review of a physician order, dated 08/22/24, revealed a single order to schedule an appointment with primary care physician by 08/29/24 with wound care center. Further review of Resident #42's medical record revealed no evidence of follow-up with the wound care center. Interview on 09/30/24 at 9:31 A.M. with LPN #446 verified Resident #42 returned from the hospital on 08/21/24 with physician orders to follow-up with the wound care center in one week. LPN #446 confirmed the appointment for follow-up at the wound care center was not scheduled. Interview on 10/02/24 at 10:30 A.M. with Resident #42 revealed he was unaware he had orders for the wound care center after returning from the hospital and further stated he would have wanted to follow-up for treatment of his wound. Interview on 10/02/04 at 10:54 A.M. with Resident #42's daughter revealed she was not made aware of the physician order for the resident to follow-up with the wound care center. Interview on 10/03/24 at 11:43 A.M. with VPO #451 revealed the nurse who entered the order for Resident #42 to follow-up with the primary care physician and the wound care center combined the two appointments together in the order. VPO #451 verified nursing staff never scheduled the follow-up appointment with the wound care center. This deficiency represents non-compliance investigated under Complaint Number OH00158113 and OH00157355.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45441 Based on observation, resident interview, medical record review, staff interview and review of facility policy, the facility failed to ensure smoking devices were secured. This affected one resident (#9) of one resident reviewed for smoking. Additionally, the facility failed to ensure thorough fall investigations were completed. This affected five residents (#20, #22, #38, #44 and #61) of five residents reviewed for falls. The facility census was 60. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE]. Diagnoses included vertebrae fracture, urinary tract infection, paraplegia, cannabis use and nicotine dependence. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/06/24 revealed Resident #9 was cognitively intact. He required setup assistance for eating and oral hygiene, supervision for toileting, partial to moderate assistance for personal hygiene and substantial or maximum assistance for showering. Resident #9 was a smoker. Review of the smoking assessment dated [DATE] revealed Resident #9 required supervision while smoking. Review of the care plan dated 08/30/24 revealed Resident #9 was at risk for injury due to smoking. Interventions included providing supervision at all times when smoking, smoking items to be kept at the nurses' station and encouraging the resident to express his frustrations and feelings. Observation on 10/02/24 at 9:52 A.M. of Resident #9 revealed a vaporizing nicotine pen on the bedside table and two on a night stand. Concurrent interview with Resident #9 confirmed they belonged to him. Interview on 10/02/24 at 9:55 A.M. with Licensed Practical Nurse (LPN) #446 revealed she was unaware of any residents using vaporizing nicotine pens. She confirmed Resident #9 had three vaporizing nicotine pens in his room. Review of the facility's smoking policy, dated July 2023, revealed all smoking paraphernalia including lighters, cigarettes and e-cigarettes (vaporizing pens) would be locked in a box at the nurses station. Review of the smoking agreement, signed by Resident #9 on 10/30/23, revealed smoking paraphernalia, including cigarettes,e-cigarettes, pipes and cigars we're not allowed to be stored in his room. 2. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included dementia, heart disease, Vitamin D deficiency and insomnia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS assessment, dated 09/02/24, revealed Resident #20 was rarely or never understood. She required supervision for eating and was dependent for oral hygiene, personal hygiene, showering and bathing. Resident #20 was always incontinent of bowel and bladder and had no falls since the previous assessment. Review of the physician's orders for October 2024 revealed an order for Resident #20's bed to be against the wall and an order for a dycem (non-slip pad) to Resident #20's wheelchair. Both orders began 05/03/24. Review of a fall risk assessment dated [DATE] revealed Resident #20 was at high risk for falls. Additional review of a fall risk assessment dated [DATE] revealed Resident #20 was at moderate risk for falls. Review of the care plan dated 03/29/24 revealed Resident #20 was at risk for falls due to confusion, incontinence and poor communication. Interventions included ensuring the call light was in reach, having her bed against the wall, dycem to wheelchair, encouraging her to be in common areas when out of bed and toileting before and after meals and before bed as tolerated. Further review revealed on 08/26/24 additional interventions were added to the care plan to include anti tippers to Resident #20's wheelchair, no foot rests on her wheelchair and non-skid socks when the resident was out of bed. Review of the fall note dated 07/04/24 at 8:52 P.M. revealed Resident #20 was found sitting on her buttocks in the hall, a few steps away from her wheelchair. Vital signs were obtained at the time and within normal limits. Resident #20 had a skin tear to her left thumb measuring 1.5 by (x) 0.2 and bruising across her left knuckles measuring 1.4 x 1.0. The area was cleansed and a band aid was applied. Resident #20's physician and responsible party were notified. Review of the fall note dated 09/13/24 at 6:38 P.M. revealed at 3:30 P.M., Resident #20 was observed lying on the floor in a different room between the bed and the night stand. Resident #20 was trying to get up and turning from face down to the right side. The resident's vital signs were taken and within normal limits. The resident had a contusion to the left side of her face above her eyelid. Neurological (neuro) checks were initiated and ice was applied to the left forehead. The physician and resident's representative were notified and Resident #20 was sent to the emergency department (ED). Review of the nursing note dated 09/13/24 at 11:21 P.M. revealed Resident #20 returned from the hospital at 10:45 P.M. with an order for ice to be applied above her left eye for 20 minutes four times a day. Review of the fall investigation for Resident #20 on 07/04/24 revealed no evidence a dycem was in place at the time of the fall. Further review revealed no evidence witness statements were obtained from the staff working at the time of the fall and the investigation contained no information regarding when the resident had last been toileted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the fall investigation for Resident #20 on 09/13/24 revealed no evidence if the resident was using her wheelchair at the time of the fall, no witness statements from staff working at the time of the fall, no evidence of the resident wearing non-skid socks, no information regarding when the resident was last toileted and her vital signs were obtained at 5:48 P.M., over two hours after the fall occurred (fall was documented as occurring at 3:30 P.M.). 3. Review of the medical record for Resident #22 reveal an admitted [DATE]. Diagnoses included cerebral infarction, depression, neuropathy, heart disease, dementia and Parkinson's disease. Review of the quarterly MDS assessment dated [DATE] revealed Resident #22 was severely cognitively impaired. He required setup help for eating, substantial or maximum assistance for oral hygiene, toileting and showering and most dependent for personal hygiene. He had two falls since the previous assessment and was always incontinent of bowel and bladder. Review of the October 2024 physician's orders for Resident #22 revealed an order for a sign to be in Resident #22's room to remind him to use his call light for assistance and to encourage the resident to be up in common areas when close to meal time or out of bed. Both orders began 07/03/24. Review of the fall risk assessment dated [DATE] revealed Resident #22 was at high risk for falls. Review of the care plan dated 07/18/24 revealed Resident #22 was at risk for falls due to confusion and being unaware of his safety needs. Interventions included encouraging the resident to be in common areas when awake or close to meal time, a sign in the room to call for assistance and to toilet before and after meals. Review of the fall note dated 09/24/24 at 2:06 A.M. revealed Resident #22 had a fall at 11:50 P.M. Resident #22's call light was on and he was sitting on a mat on the floor, with his legs bent, and he was leaning against the bed and holding onto the side rail. He was wearing non-slip socks. Vital signs were obtained and within normal limits. An immediate intervention was implemented which included a bolster (a long, thick pillow that is placed under other pillows for support) to the left side of the bed and the right side of the bed against the wall. The environment was described as clean and free of clutter. The light was on and the floor was dry. Review of the interdisciplinary team (IDT) progress note dated 9/24/24 at 1:50 P.M. revealed Resident #22 was observed sitting on the floor mat with his legs bent, leaning against the wall holding on to the side rail at 11:50 P.M. He was wearing non-skid socks. A head-to-toe observation and assessment was completed and Resident #22 was found to have three discolored areas to his right buttocks. Vital signs were obtained and within normal limits. The care plan and kardex were updated to include the new intervention of bolsters on his bed and the opposite side against the wall. Review of the fall note dated 09/24/24 at 6:58 P.M. revealed resident #22 had a fall at 6:15 P.M. Resident #22 was observed lying on the floor, on his back and not responding per baseline. The resident fell from his bed. His vital signs were obtained and an assessment was attempted; however, Resident #22 was unable to participate due to his level of consciousness. Resident #22 was only responding to vigorous stimuli. Resident #22's physician and responsible party were notified and he was sent to the ED. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nursing note dated 9/25/24 at 1:11 A.M. Revealed resident #22 returned from the hospital with a diagnosis of anemia and dehydration. The resident had orders for routine laboratory (lab) work, a urinalysis and to follow-up with his physician. Review of the fall investigation for Resident #22 for the fall on 09/24/24 at 6:58 P.M. revealed no evidence when Resident #22 was last toileted, whether or not he hit his head, if bed bolsters were in place, if the bed was against the wall, what the condition of the environment was and no witness statements were obtained from staff working at the time of the fall. 4. Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included dementia, bladder cancer, restlessness, depression and insomnia, Review of the quarterly MDS assessment dated [DATE] revealed Resident #38 was rarely or never understood. He required partial or moderate assistance for eating and was dependent for oral care, toileting, showering, dressing and hygiene. He was always incontinent of bowel and had one fall since his last assessment. Review of the fall risk assessment dated [DATE] revealed Resident #38 was at moderate risk for falls. Review of the care plan dated 5/14/24 revealed resident #38 was at risk for falls due to confusion, incontinence and poor communication. Interventions included anticipating the residents needs, ensuring the call light was in reach and ensuring the resident had a small object in his hand when ambulating. Review of the fall note dated 9/23/24 at 5:37 P.M. revealed Resident #38 had a fall at 5:15 P.M. The resident was found on the floor next to his bed by the State tested Nursing Assistant (STNA). The fall was not witnessed, his vital signs were obtained and within normal limits, neuro checks were initiated and an assessment was completed. A new intervention was added to ensure the resident's room was well lit. Review of the fall investigation for Resident #38's fall on 09/23/24 at 5:15 P.M. contained no witness statements from staff working at the time of the fall, no information regarding call light accessibility and the care plan was not updated to include a well lit room. 5. Review of the medical record for Resident #44 revealed an admitted [DATE]. Diagnoses included dementia, right wrist fracture, depression, kidney disease, urinary incontinence and osteoarthritis. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #44 was rarely or never understood. She required partial or moderate assistance for eating, substantial or maximum assistance for oral hygiene and dressing and was dependent for toileting, showering and hygiene. She was always incontinent of bowel and bladder and had two or more falls since the previous assessment. Review of the fall risk assessment dated [DATE] revealed Resident #44 was at moderate risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October 2024 physician's orders revealed Resident #44 had an order initiated 05/17/24 for non-skid socks while in bed, an order initiated 06/09/24 to toilet the resident before and after meals and an order dated 09/10/24 to anticipate the residents needs more frequently. Review of the care plan dated 04/18/24 revealed Resident #44 was at risk for falls due to confusion, balance problems and being unaware of her safety needs. Interventions included anticipating and meeting the residents needs, ensuring the call light was within reach and encouraging the resident to ambulate slowly when getting up. Review of the fall note dated 06/10/24 at 9:30 A.M. revealed Resident #44 had a fall at 7:00 A.M. The resident was observed sitting on the floor in the doorway of another room. Resident #44 had blood on her hands, pants, legs and top. The resident was walking down the hall at the time of the fall. A door jam was observed near where the resident fell . Resident #44 received a skin tear to her right pinky and right elbow. Her vital signs were obtained and within normal limits, neuro checks were initiated and her finger and elbow were cleansed and dressings were applied. The physician and resident #44's responsible party were notified. Review of the fall investigation for resident #44's fall on 6/10/24 at 7:00 A.M. revealed no witness statements were obtained from staff working at the time of the fall and no evidence the neuro checks were completed. 6. Review of the closed medical record for Resident #61 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included dementia, rib fracture, hypotension, sepsis, asthma and diabetes. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #61 was severely cognitively impaired. She required supervision for eating, substantial or maximum assistance for oral hygiene and was dependent for toileting, showering and hygiene. The resident had one fall since the previous assessment. Review of the fall risk assessment dated [DATE] revealed Resident #61 was at high risk or falls. Review of the care plan dated 07/23/24 revealed Resident #61 was at risk for falls due to confusion, incontinence, balance issues and being unaware of her safety needs. Interventions included anticipating and meeting the residents needs, ensuring the call light was in reach, ensuring the bed was in the lowest position and placing a sign in the resident's room reminding her to call for assistance. Review of the fall note dated 08/01/24 at 6:33 P.M. revealed resident #61 had a fall at approximately 4:30 P. M. Resident #61 was observed in her room, lying mostly on her left side, on the floor near her bed. Her vital signs were obtained and within normal limits. Resident #61 had abrasions to her left upper arm and was complaining of her head hurting. There was a lump to the left side of her head. The physician and responsible party, as well as Hospice, were notified and the resident was sent to the ED. Resident #61 returned from the hospital at approximately 11:30 P.M. Review of the fall investigation for resident #61's fall on 08/01/24 at 4:30 P.M. revealed no evidence witness statements were obtained from staff working at the time of the fall and no evidence neuro checks were initiated prior to sending her to the ED. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/03/24 at 11:22 A.M. with [NAME] President of Operations (VPO) #451 confirmed a thorough fall investigation should be completed for each fall, which should include a review of what was happening with the resident prior to the fall, when the resident was last toileted, if appropriate, and a determination of the root cause of the fall. VPO #451 also confirmed witness statements would be obtained for all falls, whether witnessed or unwitnessed, neuro checks should be initiated for all head injuries and unwitnessed falls and there should be a clear timeline for all fall investigations. VPO #451 verified she was aware there were significant issues with fall investigations to include witness statements not obtained, interventions not identified as being in place and timely assessments not being completed for Residents #20, #22, #38, #44 and #61. Review of the facility policy titled Fall and Fall Risk, Managing, dated December 2007, revealed the facility would identify interventions related to residents' risk for falls and try to prevent and minimize complications from falls. This deficiency represents noncompliance investigated under Complaint Number OH0157355.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	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** 42011 Based on observation, medical record review, facility policy review and interviews with Resident #02, facility staff and the Physician Assistant (PA), the facility failed to provide adequate monitoring, appropriate treatment and follow-up for a non-functioning suprapubic catheter (a thin, flexible tube that drains urine from the bladder through a small incision in the lower abdomen) for Resident #02. Actual Harm occurred beginning on 03/05/24 when staff documented Resident #02 had no output from her suprapubic catheter. Documentation between 03/05/24 and 10/02/24 noted the suprapubic catheter continued to malfunction, resulting in decreased urinary output, urinary retention, and increased pain and discomfort during this time with no evidence of adequate follow-up or interventions. An interview with Resident #02 revealed she reported daily pain (rated at times a seven on a scale of one to 10 with 10 being the most severe pain) and/or really bad pain as a result of the catheter not functioning properly during this time period. The non-functioning suprapubic catheter placed Resident #02 at increased risk of complications including infection, sepsis and, if the catheter was unable to be removed, surgery. This affected one resident (#02) of one resident identified by the facility with a suprapubic catheter. The facility census was 60. Findings include: Review of Resident #02's medical record revealed an admitted [DATE]. Diagnoses included multiple sclerosis and neuromuscular dysfunction of the bladder. The resident had a suprapubic catheter in place. Review of the care plan, initiated 11/04/18, noted Resident #02 required an indwelling catheter as evidence by urinary retention. The goal included bladder elimination would be maintained through an indwelling suprapubic catheter with no signs or symptoms of a urinary tract infection (UTI). Interventions included to change the suprapubic catheter per orders and drainage bag as needed for blockage, leakage, signs and symptoms of a UTI or when the closed system had been compromised. Additional interventions included intake and output (I & O - amount of fluids consumed and the amount of urine output) every shift, observe for clinical signs and symptoms of a UTI, monitor urine color, hematuria (red blood cells in urine), flank or abdominal pain, elevated temperature or absence of urine daily. Report positive findings to the physician. Review of a nursing progress note dated 03/05/24 at 9:00 P.M. and completed by Licensed Practical Nurse (LPN) #404 revealed Resident #02 was wet and there was no output in the foley. The note indicated the nurse changed the resident's catheter. Review of a nursing progress note dated 03/15/24 at 7:00 P.M., and completed by Registered Nurse (RN) #419, revealed Resident #02 was wet and the catheter was not draining. Attempt to irrigate the catheter was unsuccessful. Review of a physician order, dated 03/18/24, revealed Resident #02 had appointment at the Urology Clinic (UC) #470 on 04/10/24 at 9:00 A.M. with Urologist #471. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing progress note dated 03/20/24 at 8:20 A.M., and completed by LPN #472, revealed Primary Physician (PP) #473 was in to see Resident #02. No new orders were obtained regarding the resident's suprapubic catheter. Per PP #473, urology to address Resident #02's suprapubic catheter at the appointment next month (scheduled for 04/10/24 per the medical record). New orders were obtained for labs to be drawn on 04/17/24. Review of a physician order, dated 03/20/24, revealed laboratory (lab) orders for a complete blood count (CBC) and a comprehensive metabolic panel (CMP) to be drawn on 04/17/24 and every three months thereafter. Review of a nursing progress note dated 03/20/24 at 10:24 P.M., and completed by LPN #404, revealed Resident #02's catheter was changed due to no urinary output in the drainage bag and the resident was wet. Review of a nursing progress note dated 03/26/24 at 1:35 A.M., and completed by RN #419, revealed Resident #02's brief and bed were wet. The nurse was unable to irrigate the catheter. The catheter was changed. Review of a physician order, dated 04/08/24, revealed Resident #02 had an appointment at UC #470 on 05/15/24 at 9:30 A.M. with the PA. Review of a nursing progress note dated 04/12/24 at 3:29 P.M., and completed by RN #365, revealed Resident #02 continued to urinate large amounts via what appears to be the vaginal area. Further review of the medical record revealed no evidence the resident's suprapubic catheter function was checked or the physician (MD) was notified of the change in condition. Review of Resident #02's electronic medical record (EMR) and hard chart revealed no lab results for 04/17/24 or any lab results thereafter. Review of physician orders for Resident #02, dated 04/22/24, revealed to flush foley catheter with 60 milliliters (ml) of normal saline (NS) or distilled water everyday shift for patency, change suprapubic catheter and drainage bag every four weeks and as needed for blockage, leakage, signs and symptoms of urinary infection or when closed system has been compromised with a 20 French (FR), 30 cubic centimeter (cc) balloon. Review of a physician order, dated 04/24/24, revealed intake and output (I & O) every day and night shift. Review of Resident #02's medical record from 04/24/24 through 09/30/24, including the Medication Administration Record (MAR) and the Treatment Administration Record (TAR), revealed the TAR included check marks documented for I & O, but no fluid or urine output amounts were documented. Review of a nursing progress note dated 05/18/24 at 11:15 A.M., and completed by LPN #472, revealed Resident #02 was provided incontinence care twice so far during the shift and the resident had been shouting I need checked and changed repetitively all morning. Redirection, reeducation, and all non-pharmacological interventions exhausted and ineffective. Further review of the medical record revealed no evidence the resident's suprapubic catheter function was checked or the MD was notified of the change in condition. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of a physician order, dated 06/18/24, revealed Resident #02 had an appointment at UC #470 on 06/20/24 at 2:40 P.M. with the physician assistant (PA). Review of a physician order, dated 06/20/24, revealed Resident #02 had an appointment at UC #470 on 07/03/24 at 11:10 A.M. with the PA. Review of a physician order, dated 07/19/24, revealed Resident #02 had an appointment at UC #470 on 07/26/24 at 11:00 A.M. Review of the annual Minimum Data Set (MDS) assessment, dated 09/06/24, revealed Resident #02 was cognitively intact. Resident #02 had progressive neurological conditions, had impairment to both sides of the lower extremities, was (staff) dependent for toileting and bed mobility and had an indwelling catheter. Review of Resident #02's medical record from 04/10/24 through 10/02/24 revealed no evidence the facility arranged transportation for the resident's appointments with UC #470 on 04/10/24, 05/15/24, 06/20/24, 07/03/24 or 07/26/24. Additionally, there was no evidence Resident #02 received follow-up care for the malfunctioning suprapubic catheter and no further urology appointments were scheduled after 07/26/24. Review of Resident #02's medical record from 04/12/24 through 09/29/24 revealed no evidence the MD was notified of any changes in condition related to Resident #02's suprapubic catheter malfunction or follow-up with urology. Observation on 09/24/24 at 4:27 P.M. revealed Resident #02 was lying in bed. A catheter bag was hanging on the side of the bed. Continued observation revealed there was no urine in the catheter bag or tubing. Interview on 09/25/24 at 1:03 P.M. with LPN #456 revealed Resident #02's suprapubic catheter had not functioned for a long time, stating it would not even flush. LPN #456 revealed Resident #02 had follow-up urology appointments scheduled, but she was told they kept getting canceled or rescheduled. LPN #456 stated since the catheter was not functioning, staff rolled Resident #02 side to side to release the urine from the urethra (carries urine from the bladder out of the body). Observation on 09/25/24 at 1:05 P.M. of suprapubic catheter care for Resident #02, and provided by LPN #456, revealed the dressing removed from the insertion site had a small amount of serosanguinous (fresh blood) and mucous drainage. The insertion site had hyper granulating tissue (a condition where there is too much tissue in a wound bed) present. The tissue surrounding the catheter was red. Continued observation revealed there was no urine in the suprapubic catheter tubing or drainage bag. Concurrent interview with Resident #02 revealed the suprapubic catheter was placed several years ago because she was unable to urinate on her own. Resident #02 stated the suprapubic catheter had not worked in five months. Resident #02 stated follow-up appointments had been scheduled with UC #470; however, UC #470 required she come to her appointments on a stretcher and the appointments kept getting canceled because the facility had no stretcher transportation available. Coinciding interview with LPN #456 verified the observation of the suprapubic catheter and insertion site. LPN #456 confirmed nurses were not monitoring Resident #02's I & O and stated they just know she urinates. LPN #456 further confirmed there were no bladder assessments completed for Resident #02 to determine urine retention. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/30/24 at 3:55 P.M. with LPN/MDS Nurse #308 revealed the floor nurses scheduled physician follow-up appointments for all residents, including Resident #02. LPN/MDS Nurse #308 revealed she scheduled all transportation to those appointments. LPN/MDS Nurse #308 stated Ambulance Service (AS) #474 was the only contract the facility had for stretcher transportation and UC #470 required Resident #02 to arrive via stretcher for her appointments. LPN/MDS Nurse #308 stated AS #474 always had an excuse as to why they could not provide transportation. LPN/MDS Nurse #308 went on to state Resident #02 required a Hoyer lift for transfers and she always had some urine in the catheter drainage bag. LPN/MDS Nurse #308 stated she was still working on getting Resident #02 another appointment at UC #470 and she was going to contact PP #473 to see what they could do in the interim. LPN/MDS Nurse #308 stated she did not know when Resident #02's catheter initially malfunctioned, stating the floor staff did not always tell her when there were problems. LPN/MDS Nurse #308 stated she had been at the facility for one year and Resident #02 had not followed-up with urology during that time. LPN/MDS Nurse #308 stated she just scheduled transportation for appointments, and she wrote down when transportation could not take Resident #02 to her appointments. LPN/MDS #308 confirmed there was no documentation in Resident #02's medical record indicating reasons why the resident's appointments with UC #470 were canceled or rescheduled. LPN/MDS Nurse #308 stated transportation schedules were documented in a book and the previous medical records staff took the book when she left so the facility had no evidence of transportation scheduled for Resident #02's urology appointments. Interview on 09/30/24 at 4:07 P.M. with Regional Clinical Director (RCD) #447 revealed she had been the acting Director of Nursing (DON) at the facility for approximately one month. RCD #447 stated it had never been reported to her Resident #02's suprapubic catheter had no urinary output. A follow-up interview on 09/30/24 at 4:21 P.M. with Resident #02 revealed she could tell when she had to urinate because her bladder felt full and uncomfortable. Resident #02 stated she would call staff to turn her from side to side, which would allow urine to release from her bladder. Resident #02 stated she experienced pain at a level of seven out of a scale of one to ten when her bladder was full. Resident #02 stated she experienced pain daily as a result of her suprapubic catheter not functioning and her bladder not emptying. Resident #02 stated once staff rolled her, and she urinated, the pain would be relieved. Resident #02 stated if she had to wait any amount of time for assistance with rolling to cause urination, the pain got really bad. Interview on 09/30/24 at 4:21 P.M. with RN #475 verified Resident #02's suprapubic catheter had not functioned in a long time (unable to determine when the malfunction began). RN #475 confirmed the nurses did not measure Resident #02's I & O and further confirmed there was no way for the staff to measure or know the amount of residual urine left in the resident's bladder after urination. RN #475 confirmed there were no bladder assessments completed for Resident #02. Review of a progress note dated 09/30/24 at 9:45 P.M. and completed by LPN/Minimum Data Set (LPN/MDS) Nurse #308 revealed the nurse attempted to change Resident #02's suprapubic catheter. Balloon deflated as per protocol. Attempt to remove catheter from ostomy site was met with resistance. The resident requested for this nurse to stop the procedure and leave the catheter in place. The balloon was reinflated. Resident tolerated the procedure fair. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/01/24 at 8:17 A.M. with [NAME] President of Operations (VPO) #451 revealed the nursing staff attempted to change Resident #02's suprapubic catheter the previous night (09/30/24) but could not get the catheter out. When asked about the transportation schedule book, VPO #451 stated she saw the transportation schedule book on LPN/MDS Nurse #308's desk. VPO #451 retrieved the transportation schedule book and revealed she was not able to find where transportation for Resident #02 was scheduled for the urology appointments. A follow-up interview on 10/01/24 at 10:00 A.M. with RCD #447 verified the labs (CBC and CMP) ordered by the physician for Resident #02 on 03/20/24, to be drawn on 04/17/24 then every three months thereafter, were not completed. RCD #447 also verified Resident #02's I & O were not documented as ordered. Review of an electronic mail (e-mail) communication dated 10/01/24 at 3:31 P.M. from Director of Business Operations (DBO) #465 with AS #474 verified the facility never scheduled transportation for Resident #02's appointments at UC #470 on 04/10/24, 05/15/24, 06/20/24, 07/03/24 or 07/26/24. Interview on 10/02/24 at 9:14 A.M. with LPN #324 revealed she frequently worked with Resident #02. LPN #324 stated she had not been able to flush Resident #02's suprapubic catheter for greater than 3 months. LPN #324 stated Resident #02 was supposed to go to the urologist, but the appointments were canceled, and she was unsure why. LPN #324 revealed Resident #02 urinated when she was turned, stating, Turn her one way she goes then turn her the other way she goes. There is no way to tell if she empties (her bladder). Interview on 10/02/24 at 10:25 A.M. with Receptionist #476 at UC #470 revealed Resident #02 was seen at the clinic in 2018 and 2019 and had not been seen for any follow-up since. A telephone interview on 10/02/24 at 2:34 P.M. with urology PA #477 revealed the facility should have called and ensured follow-up as soon as Resident #02's suprapubic catheter malfunctioned. PA #477 revealed multiple complications could occur when urine stops flowing from the suprapubic catheter or when the catheter was no longer functioning properly, including an increased risk for infection, sepsis and, if the catheter was unable to be removed, the resident may require surgery. Review of the facility policy titled, Catheter Care, Urinary, revised August 2022, revealed to observe the resident's urine level for noticeable increases or decreases, report it to the physician or supervisor. Observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately if the resident indicates that his or her bladder is full or that he or she needs to urinate, or if signs or symptoms of urinary retention occur. This deficiency represents non-compliance investigated under Complaint Number OH00157492 and OH00157355.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44808 Based on observation and staff interview, the facility failed to ensure daily staffing information was posted. This had the potential to affect all 60 residents in the facility. The facility census was 60. Findings include: Observation on 09/30/24 at 7:53 A.M. revealed the posted daily staffing information was dated 09/26/24. Further observation revealed no evidence staffing information was posted for 09/27/24, 09/28/24 or 09/29/24. Concurrent interview with the Administrator verified the posted staffing information was for 09/26/24. The Administrator further stated the staffing information for 09/27/24 through 09/29/24 would be available soon. This deficiency is an incidental finding discovered during the complaint survey.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 44808 Based on observation, staff interview, review of posted meal times and review of the dietary staff schedule, the facility failed to ensure sufficient dietary staff to provide resident meals in a timely manner. This affected all 60 residents in the facility. The facility census was 60. Findings include: Review of the facility posted meal times revealed lunch was to be served beginning at 11:30 A.M. Interview on 09/30/24 at 10:50 A.M. with Dietary Manager (DM) #302 revealed lunch tray line would begin at 11:30 A.M. Observation on 09/30/24 from 11:16 A.M. to 1:38 P.M. of the lunch tray line services revealed there was one dietary aide (DA) and DM #302 was the acting cook. Continuous observation revealed the lunch meal service began at 12:24 P.M., which was 54 minutes later than the posted meal time. The residents in the dining room applauded when the kitchen door was opened. Concurrent interview with DM #302 confirmed the lunch meal was served late. DM #302 said the kitchen ran later on Mondays because of staffing issues. DM #302 stated dietary staff who worked on the weekend had Mondays off. DM #302 further stated the facility did not pull dietary staff to assist on the units anymore because they were so short staffed in the kitchen. Further observation revealed at 12:26 P.M., Activities Director (AD) #380 joined the tray line and stated she helped out in the kitchen on the days they were short staffed. At 1:05 P.M., DM #302 stated the DA who was scheduled to arrive at 12:30 P.M. never arrived for their shift. Review of the dietary staff schedule for 09/30/24 revealed Dietary Manager (DM) #302 was the only scheduled cook for the entire day from 6:00 A.M. to 8:30 P.M., there was one dietary aide scheduled for 7:00 A.M. to 2:30 P.M. and there was one dietary aide scheduled from 12:30 P.M. to 8:30 P.M. This deficiency represents non-compliance investigated under Complaint Number OH00157492.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on observation, medical record review, review of the production meal sheet and staff interview, the facility failed to ensure all pureed food items identified on the menu were provided. This affected six residents (#6, #16, #23, #35, #37 and #44) of six residents identified by the facility as having orders for puree food texture. The facility census was 60. Findings include: 1. Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including dementia, hypertension and type two diabetes mellitus. Review of the nutrition care plan, revised 10/03/23, revealed Resident #6 had nutritional problems related to type two diabetes mellitus, hypertension, hyperlipidemia, dementia, hyperglycemia, therapeutic diet order, altered texture diet, poor blood sugar control, edentulous, weight fluctuations, diuretic therapy and need for supplement. Interventions included provide and serve diet as ordered, monitor and record meal intakes and consistent carbohydrate diet with puree texture. Review of the physician's orders for September 2024 revealed and order dated 03/18/24 for a consistent carbohydrate diet with puree texture. 2. Review of the medical record for Resident #16 revealed an admitted [DATE] and re-admitted [DATE]. Diagnoses included Alzheimer's disease, hyperlipidemia, hypertension and dysphagia. Review of the nutrition care plan, revised 01/31/23, revealed Resident #16 had a nutritional problem related to Alzheimer's disease, hypothyroidism, hypertension, hyperlipidemia, liver disease, underweight, history of weight loss, altered texture diet, history of less than optimal intake and need for nutritional supplement. Interventions included provide and serve diet as ordered, monitor and record meal intakes and regular diet with pureed texture and nectar thick liquids. Review of the physician's orders for September 2024 revealed an order dated 01/26/24 for a regular diet with puree texture and nectar thickened liquids. 3. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including dementia, hypertension, major depressive disorder and anxiety. Review of the nutrition care plan, revised 07/30/24, revealed Resident #23 was at nutritional risk related to dementia, hypertension, history of weight fluctuations, altered texture diet and need for supplement. Interventions included provide diet as ordered, regular diet with pureed texture and thin liquids. Review of the physician's orders for September 2024 revealed an order dated 06/13/24 for a regular diet with puree texture and thin liquids. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medina Center for Rehabilitation and Nursing	555 Springbrook Dr Medina, OH 44256

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, type two diabetes mellitus, dementia, adult failure to thrive and personal history of transient ischemic attack and cerebral infarction. Review of the nutrition care plan, revised 09/24/24, revealed Resident #35 had a nutritional problem and risk of malnutrition related to Alzheimer's disease, type two diabetes mellitus, dementia, adult failure to thrive, constipation, hyperlipidemia, overweight, history of weight loss, therapeutic diet order, poor blood sugar control, and need for supplement. Interventions included provide and serve diet as ordered, monitor and record meal intakes and consistent carbohydrate diet with pureed texture and thin liquids. Review of the physician's orders for September 2024 revealed an order dated 01/09/24 for a consistent carbohydrate diet with puree texture and thin liquids. 5. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including dementia, obesity, hypertension and dysphagia. Review of the physician's orders for September 2024 revealed an order dated 06/04/24 for dysphagia pureed level one diet with honey thickened liquids. Review of the nutrition care plan, revised 10/01/24, revealed Resident #37 was at nutritional risk related to dementia, hypothyroidism, hypertension, dysphagia, schizophrenia, colostomy, mechanically altered diet texture, history of gastrointestinal bleed, history of weight loss, need for supplement and adaptive equipment. Interventions included provide diet as ordered, regular diet with pureed texture and honey thickened liquids. 6. Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including dementia, vitamin B12 deficiency anemia, hypertension and chronic kidney disease. Review of the nutrition care plan, revised 08/06/24, revealed Resident #44 had a nutritional problem related to dementia, hypertension, chronic kidney disease, gastroesophageal reflux disease, vitamin B12 deficiency anemia, underweight, altered texture diet, need for supplement, weight loss and hospice status. Interventions included provide and serve diet as ordered, monitor and record meal intakes, and regular diet with pureed texture and nectar thick liquids. Review of the physician's orders for September 2024 revealed an order dated 04/18/24 for a regular diet with pureed texture and nectar thick fluids consistency. Review of the production sheet for the lunch meal on 09/30/24 revealed puree trays were to have pureed chili con carne, seasoned cream of rice, pureed carrots, and pureed chocolate cake. Observation on 09/30/24 from 11:16 A.M. to 1:38 P.M. of the lunch tray line revealed residents with puree food texture received pureed creamed corn, pureed chili con carne and pudding. Coinciding interview with Dietary Manager (DM) #302 verified the contents of the puree trays. DM #302 stated he forgot to make pureed rice and none of the puree trays received pureed rice, as indicated on the production sheet for the lunch meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/01/24 at 10:30 A.M. with Registered Dietitian (RD) #452 revealed it was unacceptable that residents with orders for puree food texture did not receive a starch at lunch on 09/30/24. This deficiency represents non-compliance investigated under Complaint Number OH00157492.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44808 Based on observation and staff interview, the facility failed to serve food in a manner that was palatable and attractive. This had the potential to affect all 60 residents in the facility. The facility census was 60. Findings include: Observation on 09/30/24 from 11:16 A.M. to 1:38 P.M. of the lunch tray line revealed the chili con carne (soup) was served on a plate, including pureed meals, alongside rice and corn. The chili ran into the other food items on the plate. Concurrent interview Dietary Manager (DM) #302 verified the chili con carne was served on a plate rather than a bowl. DM #302 stated the bowls they had did not keep soups hot, further stating, with the chili on a plate, he could use a plate warmer and domed lid to keep it warm. DM #302 verified it was not appealing to look at and some residents might have issues with the chili spreading out over the plate and touching all the other food items. DM #302 said he would serve the chili in a bowl if he could figure out how to keep it hot. Interview on 10/01/24 at 10:30 A.M. with Registered Dietitian (RD) #452 revealed the chili con carne should have been served in an insulated bowl and not on a plate. This deficiency represents non-compliance investigated under Complaint Number OH00157492.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on observation and staff interview, the facility failed to provide food items free of listed allergens for Resident #2. This affected one resident (#2) and had the potential to affect five additional residents (#11, #30, #39, #47, and #57) identified by the facility as having food allergies. The facility census was 60. Findings include: Review of the medical record for Resident #2 revealed an admitted [DATE] and a re-admitted [DATE]. Diagnoses included multiple sclerosis, osteomyelitis of the left shoulder, major depressive disorder and anxiety disorder. Further review of the medical record revealed Resident #2 had allergies to Prednisone, eggs and shellfish. Observation on 09/30/24 at 12:41 P.M. of the lunch tray line revealed Resident #2's tray ticket indicated an allergy to eggs. Further observation of Resident #2's tray revealed chocolate cake on the tray. Interview on 09/30/24 at 12:50 P.M. with Resident #2 confirmed she had an egg allergy and stated she did not always get what she was supposed to at meals. Interview on 09/30/24 at 12:55 P.M. with State tested Nurse Aide (STNA) #310 confirmed Resident #2 had chocolate cake on her lunch tray. Interview on 09/30/24 at 1:38 P.M. with Dietary Manager (DM) #302 confirmed Resident #2 had an egg allergy identified on her meal ticket. DM #302 further stated it was not an actual allergy and it was only added as an allergy to prevent putting eggs on the tray at breakfast. Concurrent observation revealed the mix that was used to prepare the chocolate cake contained eggs. DM #302 verified the chocolate cake mix contained eggs. Interview on 10/01/24 at 10:30 A.M. with Registered Dietitian (RD) #452 revealed allergies on the meal tickets must match the allergies in the medical record. RD #452 stated all documented allergies should have been treated as an actual allergy regardless of whether staff believed it was just a preference. This deficiency represents non-compliance investigated under Complaint Number OH00157492.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, resident interview, medical record review and staff interview, the facility failed to provide adaptive equipment during meals for nine residents (#41, #37, #16, #6, #58, #25, #2, #50, and #29) of nine residents identified by the facility who utilized adaptive equipment. The facility census was 60. Findings include: 1. Review of Resident #41's medical record revealed an admitted [DATE]. Diagnoses included dementia, abnormal weight loss, need for assistance with personal care and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/20/24, revealed Resident #41 was rarely or never understood and required (staff) supervision or touch assistance with eating. Review of the care plan dated 03/21/23 revealed Resident #41 had a nutritional problem related to Dementia and abnormal weight loss. Observation on 09/25/24 at 12:04 P.M. revealed Licensed Practical Nurse (LPN) #456 was assisting Resident #41 with the lunch meal in the main dining room. Resident #41 had three beverages, in regular glasses, placed in front of her. LPN #456 assisted Resident #41 with drinking from the glasses. Concurrent review of the diet instruction sheet, dated 09/25/24, revealed Resident #41 utilized adaptive equipment and was to receive a sippy cup with all meals. No sippy cup was observed for Resident #41's use. Coinciding interview with LPN #456 revealed she was unaware Resident #41 was to receive a sippy cup. LPN #456 reviewed the diet instruction sheet and confirmed it indicated Resident #41 was to have a sippy cup for fluids and further verified the resident did not receive a sippy cup for her fluids with the meal. Interview on 09/25/24 at 3:08 P.M. with Director of Rehabilitation (DOR) #458 revealed she was uncertain of the implementation date but verified therapy recommended the use to a sippy cup for Resident #41 to assist her with drinking fluids independently, without spilling on herself, during meals. 2. Review of Resident #37's medical record revealed an admitted [DATE]. Diagnoses included dementia, lack of coordination and muscle weakness. Review of the quarterly MDS assessment, dated 08/06/24, revealed Resident #37 was rarely or never understood and required substantial/maximum (staff) assistance with meals. Review of the care plan, dated 07/16/24, revealed Resident #37 was at nutritional risk related to dementia, hypothyroidism, hypertension (HTN), dysphagia and schizophrenia. Review of the diet instruction sheet for Resident #37, dated 09/25/24, revealed the resident utilized adaptive equipment and was to receive a nosey cup with all meals. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/25/24 at 12:08 P.M. revealed State tested Nursing Assistant (STNA) #457 was assisting Resident #37 with eating her lunch meal in the main dining room. Resident #37 had three beverages (milk, juice and water) served in six-ounce plastic cups sitting next to her plate of food. An empty nosey cup (a drinking cup with a cut-out for the nose that allows the user to drink without tilting their head back) was sitting off to the side, behind Resident #37's drinks. Continued observation revealed STNA #457 picked up the cup of water and assisted Resident #37 to drink. Coinciding interview with STNA #457 revealed she was uncertain what the empty nosey cup was for and further stated, I am just agency. Interview on 09/25/24 at 3:09 P.M. with DOR #458 confirmed a nosey cup was recommended for Resident #37 for independence with drinking fluids without tipping her head back due to forward flexion (bending) of her head. 3. Review of Resident #16's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, lack of coordination and muscle weakness. Review of the quarterly MDS assessment, dated 07/05/24, revealed Resident #16 was rarely or never understood and was (staff) dependent with meals. Review of the care plan, dated 01/31/23, revealed Resident #16 had a nutritional problem. Interventions included nosey cups for all liquids. Review of the diet instruction sheet, dated 09/25/24, revealed Resident #16 utilized adaptive equipment and was to receive a nosey cup with all meals. Observation on 09/25/24 at 12:12 P.M. revealed Resident #16 was in the dining room eating her lunch meal. Resident #16 had three six-ounce cups of fluids sitting in front of her. Resident #16 did not have a nosey cup for any of the drinks. Concurrent interview with LPN #456 confirmed Resident #16's diet instruction sheet indicated the resident was supposed to have a nosey cup for all meals and verified the resident did not have one. LPN #456 went on to state she was agency staff and did not know Resident #16 was supposed to have a nosey cup. LPN #456 walked to the kitchen entrance and asked about Resident #16's nosey cup. A female voice was heard yelling from the kitchen, stating they only had one nosey cup. Interview on 09/25/24 at 12:17 P.M. with Dietary Aid (DA) #316 confirmed she was the voice heard from the kitchen. DA #316 revealed the facility only had one nosey cup and no sippy cups for the entire facility. DA #316 revealed it had been over six months that only one cup was available. Interview on 09/25/24 at 2:08 P.M. with the Administrator revealed Dietary Manager (DM) #302 asked central supply to order adaptive cups. The Administrator stated she did not know how long the facility had been out of adaptive cups. Interview on 09/25/24 at 3:11 P.M. with DOR #458 revealed Resident #16 used a nosey cup to help with independence due to decreased range of motion in her neck. 4. Review of Resident #6's medical record revealed an admitted [DATE]. Diagnoses included dementia and lack of coordination. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the annual MDS assessment, dated 08/07/24, revealed Resident #6 was severely cognitively impaired and required (staff) supervision or touch assistance with meals. Review of the care plan, dated 10/03/23, revealed Resident #6 had a nutritional problem. Further review revealed no interventions for the use of adaptive equipment. Review of the diet instruction sheet, dated 09/25/24, revealed Resident #6 utilized adaptive equipment and was to receive a two-handled sippy cup with meals. Interview on 09/25/24 at 3:13 P.M. with DOR #458 revealed Resident #6 was to receive a two handled sippy cup to increase independence with fluids due to unsteadiness with one hand. 5. Review of Resident #25's medical record revealed an admitted [DATE]. Diagnoses included history of cerebral infarction (stroke) and hemiplegia with hemiparesis affecting the left non dominant side. Review of the quarterly MDS assessment, dated 08/07/24, revealed Resident #25 was cognitively intact. Resident #25 required substantial/maximum (staff) assistance with eating. Review of the care plan dated 06/18/24 revealed Resident #25 had a nutritional problem. Interventions included provide and serve diet as ordered and two-handled cups. Review of the diet instruction sheet, dated 09/25/24, revealed Resident #25 utilized adaptive equipment and was to receive a two-handled sippy cup with all meals. Observation on 09/30/24 at 1:08 P.M. revealed Resident #25 sitting up in bed eating her lunch independently. The resident did not have a two-handled sippy cup. Concurrent interview with Resident #25 revealed she was able to feed herself and stated a sippy cup would be helpful, to prevent spillage, but she could not recall the last time she was provided one. Interview on 09/30/24 at 1:09 P.M. with STNA #310 confirmed Resident #25 was able to feed herself. STNA #310 verified Resident #25 was not provided a two-handled sippy cup to help prevent spilling her beverages. Interview on 09/25/24 at 3:15 P.M. with DOR #458 revealed Resident #25 was to receive a two-handled sippy cup to promote independence and to control the cup due to unsteadiness with her arms. 6. Review of Resident #58's medical record revealed an admitted [DATE]. Diagnoses included lack of coordination and mild protein calorie malnutrition. Review of the quarterly MDS assessment, dated 08/19/24, revealed Resident #58 was severely cognitively impaired and required set-up or clean-up assistance with meals. Resident #58 had impaired vision. Review of the care plan dated 06/11/24 revealed Resident #58 had a nutritional problem. Interventions included red handled utensils and a colored plate. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Occupational Therapy (OT) Discharge Summary dated 02/28/23 for Resident #58 revealed the resident required set-up feeding assistance with the use of low vision aids and adaptive equipment (Makkak Redware tableware) for the resident to locate items on the meal tray and scoop food. Prognosis was good with consistent staff follow-through. Review of the diet instruction sheet, dated 09/25/24, revealed Resident #58 utilized adaptive equipment and was to receive red handled utensils with all meals. Interview on 09/25/24 at 3:17 P.M. with DOR #458 revealed Resident #58 required red handled utensils due to poor vision. DOR #458 explained the red handles assisted Resident #58 to see the utensils to feed himself independently. 7. Review of Resident #2's medical record revealed an admitted [DATE]. Diagnoses include multiple sclerosis, muscle weakness and lack of coordination. Review of the annual MDS assessment, dated 09/06/24, revealed Resident #2 was cognitively intact and required supervision or touch assistance with meals. Review of the care plan dated 04/18/23 revealed Resident #2 was at nutritional risk. Interventions included foam built-up utensils with meals. Review of the diet instruction sheet, dated 09/25/24, revealed Resident #2 utilized adaptive equipment and was to receive foam utensils with all meals. Interview on 09/25/24 at 3:19 P.M. with DOR #458 revealed Resident #2 used foam utensils for grip due to decreased range of motion in her hand. Observation on 09/25/24 at 6:20 P.M. of Resident #2 during dinner meal service revealed the resident eating her meal with a regular fork with her left hand. Resident #2 was observed to spill food onto her clothing. Concurrent interview with Resident #2 revealed she sometimes received the foam handled fork and spoon with meals, but not every meal and not each day. Resident #2 stated she was right hand dominant but could no longer use her right hand due to weakness and contracture. Resident #2 stated it was much easier to eat her meals without spilling when she had foam handled utensils. Interview on 09/25/24 at 6:28 P.M. with Admissions #382 verified Resident #2 did not have foam handled utensils during the dinner meal. 8. Review of Resident #50's medical record revealed an admitted [DATE]. Diagnoses included mild protein-calorie malnutrition, fibromyalgia and muscle weakness. Review of the quarterly MDS assessment, dated 09/12/24, revealed Resident #50 was severely cognitively impaired and required (staff) supervision or touch assistance with eating. Review of the care plan dated 06/12/24 revealed Resident #50 had a nutritional problem. Further review revealed interventions did not include adaptive equipment. Review of the OT Discharge Summary, dated 05/22/24, revealed Resident #50 utilized utensils with built-up handles. Discharge prognosis was good with consistent staff follow-through. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the diet instruction sheet, dated 09/25/24, revealed Resident #50 utilized adaptive equipment and was to receive a handled cup and built-up utensils with all meals. Interview on 09/25/24 at 3:20 P.M. with DOR #458 revealed Resident #50 was to receive a one handled cup and built-up eating utensils to assist with grasping and maintain independence. 9. Review of Resident #29's medical record revealed an admitted [DATE]. Diagnoses included Williams syndrome and adult failure to thrive. Review of the quarterly MDS assessment, dated 09/04/24, revealed Resident #29 was cognitively intact and required (staff) supervision or touching assistance with eating. Review of the care plan dated 08/27/24 revealed Resident #29 had a nutritional problem. Further review revealed no interventions related to the use of adaptive equipment. Review of the diet instruction sheet, dated 09/25/24, revealed Resident #29 utilized adaptive equipment and was to receive a sippy cup with all meals. Interview on 09/25/24 at 2:15 P.M. with DM #302 verified the facility had insufficient adaptive equipment for resident use during meals. DM #302 stated he attempted to order sippy cups, nosey cups and built-up silverware but did not get them because the central supply staff left the facility. DM #302 revealed the facility had three residents who needed built-up silverware, but the facility only had two sets. DM #302 verified there was only one nosey cup in the facility and further confirmed the facility had no sippy cups, no two handled sippy cups and no two handled regular cups. DM #302 stated, It's been at least three months since we had the cups and silverware available. DM #302 stated the dietary staff rotated the residents each meal who received needed adaptive equipment. Interview on 09/25/24 at 3:21 P.M. with DOR #458 revealed Resident #29 used a sippy cup for fluids to increase independence. DOR #458 stated potential negative outcomes associated with not following recommendations for the use of adaptive equipment included a loss of independence and decreased food/fluid intake, which could cause poor nutrition and weight loss. DOR #458 stated she would expect the facility to provide and implement adaptive equipment once the recommendation was made. This deficiency represents non-compliance investigated under Complaint Number OH00157492.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44808 Based on observation, review of the dishwasher temperature logs and staff interview, the facility failed to maintain dishwasher water temperatures at the manufacturer's minimum water temperature during the wash cycle. This had the potential to affect all 60 residents in the facility. The facility census was 60. Findings include: Observation on 09/30/24 at 11:35 A.M. to 11:44 A.M. of the facility dishwasher revealed a manufacturer's label indicating the minimum water temperature for the wash cycle was 155 degrees Fahrenheit (F) Continued observation revealed the dishwasher water temperature did not meet the minimum wash cycle temperature of 155 degrees F after being run for three consecutive cycles. Concurrent interview with Dietary Aide (DA) #316 verified the dishwasher did not reach the minimum temperature for the wash cycle during the observation. Review of the dishwasher temperature logs with DA #316 also verified there were multiple days on the temperature log that were less than the required minimum wash temperature. DA #316 further stated it normally took multiple runs to get the machine up to temperature due to plumbing issues in the building. Coinciding interview with Dietary Manager (DM) #302 stated there was a plumbing issue in the building that affected the hot water flow to the dishwasher. Review of the dishwasher temperature logs for September 2024 revealed the documented temperature for the wash cycle was less than the manufacturer's minimum temperature of 155 degrees F on 19 days at breakfast, four days at lunch, and five days at dinner. Interview on 10/01/24 at 10:30 A.M. with Registered Dietitian (RD) #452 revealed he conducted monthly audits to ensure dishwasher temperature logs were completed. RD #452 stated he did not notice the temperatures recorded on the log were below the minimum required temperature for the dishwasher machine. This deficiency was an incidental finding discovered during the complaint investigation.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on medical record review, review of facility self-reported incidents (SRI) and staff interview, the facility failed to ensure complete and accurate medical records. This affected five (#39, #49, #42, #25 and #55) of five residents reviewed for accurate medical records. The facility census was 60. Findings include: 1. Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses including dementia, Alzheimer's disease and major depressive disorder. Further review of the medical record revealed Resident #39 had allergies to chicken and turkey. Review of the care plan, dated 10/26/17, revealed Resident #39 was allergic to chicken and turkey with interventions to document the allergy and notify all disciplines of the allergy, monitor for signs and symptoms of an allergic reaction, and relay the allergy if the resident transfers out of the facility. Interview on 10/03/24 at 10:42 A.M. with [NAME] President of Operations (VPO) #451 confirmed Resident #39 had documented allergies to chicken and turkey with the reaction for both listed as not true allergy prefers no poultry and she was unable to provide an explanation as to why it was documented this way. 2. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including dementia, major depressive disorder, anxiety disorder, atrial fibrillation, hypertension and localized edema. New diagnoses were added on 02/08/24 to include osteophyte of the left hip, non-displaced fracture of the base of neck of left femur, and other disorders of bone density and structure. Review of the facility's investigation related to SRI tracking number 248990, created 06/24/24, revealed a skin grid assessment dated [DATE] at 5:55 P.M. that was not locked and signed until 09/27/24 at 4:27 P.M. and a progress note with an effective date of 06/24/24 at 5:00 P.M. that was created on 09/26/24 at 11:58 A.M. by Minimum Data Set Coordinator (MDSC) #308 that included vitals taken on 09/26/24. Interview on 10/03/24 at 12:54 P.M. with VPO #451 confirmed the date on the skin grid assessment and the progress note related to the incident. A follow-up interview on 10/03/24 at 1:44 P.M. with VPO #451 revealed she confirmed the skin grid assessment and progress note with MDS Coordinator #308 and the information was not accurately documented. 42011 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365667	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medina Center for Rehabilitation and Nursing	555 Springbrook Dr Medina, OH 44256

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review for Resident #42 revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included Wernicke's Encephalopathy (presence of neurological symptoms caused by biochemical lesions of the central nervous system) and post-traumatic stress disorder. Review of SRI tracking number 249272, created 07/02/24, revealed a sexual abuse allegation involving Resident #42. The SRI indicated Resident #42 was placed on 15-minute checks. Review of Resident #42's medical record revealed no information related to the incident on 07/02/24 or evidence of the 15-minute checks initiated following the allegation. Review of the behavior note dated 09/01/24 at 2:44 A.M. revealed the nurse was made aware Resident #42 had been in and out of room [ROOM NUMBER]-1 several times while the resident in room [ROOM NUMBER]-1 was sleeping. Resident #42 was asked to let the other resident sleep. Will continue to monitor. Further review of Resident #42's medical record revealed the resident was placed on 30-minute checks following the incident on 09/01/24. Additional review revealed no evidence of the 30-minute checks being completed. Review of SRI tracking number 251540, created 09/05/24, revealed an allegation of physical abuse involving Resident #42. Review of Resident #42's medical record revealed no documentation of the incident occurring 09/05/24. Interview on 10/03/24 at 12:24 P.M. with VPO #451 confirmed Resident #42 had no documentation in his medical record of the incidents occurring on 07/02/24 or 09/05/24. VPO #451 further verified there was no evidence of 15-minute checks, initiated on 07/02/24, or the 30-minute checks initiated on 09/05/24. 4. Record review for Resident #25 revealed an admitted [DATE]. Diagnoses included a history of cerebral infarction and hemiplegia with hemiparesis affecting left non dominant side. Review of SRI tracking number 249272, created 07/02/24, revealed an allegation of sexual abuse, with Resident #25 identified as the alleged victim. Review of Resident #25's medical record revealed no documentation related to the incident on 07/02/24. Interview on 10/03/24 at 12:25 P.M. with VPO #451 verified there was no documentation in Resident #25's medical record related to the incident on 07/02/24. 5. Record review for Resident #55 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, neuromuscular dysfunction, anxiety disorder, macular degeneration, schizoaffective disorder and muscle weakness. Review of SRI tracking number 251540, created 09/05/24, revealed an allegation of physical abuse, with Resident #55 identified as the alleged victim. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #55's medical record revealed no documentation related to the incident on 09/05/24. Interview on 10/03/24 at 2:30 P.M. with VPO #451 verified there was no documentation in Resident #55's medical record related to the incident on 09/05/24. VPO #451 further confirmed documentation of incidents should be documented in the resident's medical record. This deficiency represents non-compliance investigated under Complaint Number OH00157492.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 44808 Based on review of the Payroll Based Journal (PBJ) Staffing Data Report, review of staff schedules, review of staff time sheets and staff interview, the facility failed to accurately report staffing to the Centers for Medicare and Medicaid Services (CMS). This had to the potential to affect all 60 residents. The facility census was 60. Findings include: Review of the CMS PBJ Staffing Data Report for fiscal year 2024, quarter two (January 1 through March 31) revealed the facility triggered for a one star staff rating and excessively low weekend staffing. Review of staff schedules and time sheets for randomly selected dates, including 01/19/24, 01/21/24, 01/22/24, 02/11/24, 02/19/24, 03/02/24, 03/03/24 and 03/22/24, revealed the staffing information did not accurately reflect the number of staff hours worked on those dates. Interview on 10/02/24 at 10:51 A.M. with Staff Scheduler (SS) #364, Staffing and Recruiting Analyst (SRA) #453, and Regional Director of Operations (RDO) #450 confirmed the information reported to CMS for January 2024 through March 2024 did not accurately reflect staffing on those dates. This deficiency was an incidental finding discovered during the complaint survey.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 42011 Based on personnel record review and staff interview, the facility failed to provide annual behavioral health/dementia education. This had the potential to affect 32 residents (#1, #4, #5, #6, #11, #12, #16, #18, #20, #22, #23, #26, #29, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #43, #44, #46, #49, #53, #54, #55, #57 and #60) of 32 residents identified by the facility with a diagnosis of dementia. The facility census was 60. Findings include: Review of State tested Nursing Assistant (STNA) #364's personnel record, with Regional Director of Operations (RDO) #450, revealed a hire date of 03/15/13. Further review revealed no evidence behavioral health/dementia education was completed in 2023 or 2024. Interview on 10/02/24 at 4:45 P.M. with STNA #364 confirmed she had not received any behavioral health/dementia training since 2021. Interview on 10/02/24 at 4:48 P.M. with RDO #450 verified the facility had no evidence that any staff had received behavioral health/dementia training since 2021. RDO #450 confirmed the facility had a dementia/behavior unit where residents with dementia resided. This deficiency represents and incidental finding discovered during the course of the complaint survey.