

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2025
NAME OF PROVIDER OR SUPPLIER Medina Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on resident and staff interview, record review, and review of the facility policy, the facility failed to ensure residents were treated with respect and dignity. This affected one resident (#37) of three residents reviewed for respect and dignity. The facility census was 70.</p> <p>Findings include:</p> <p>Record review for Resident #37 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus (DM) with diabetic neuropathy, major depressive disorder, and generalized anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was cognitively intact.</p> <p>Review of the physician orders for April 2025 for Resident #37 revealed the resident had several medications to be administered in the morning. There were specific physician orders dated 01/02/25 for medications to be administered after breakfast which included: ferrous sulfate (vitamin) 325 milligrams (mg) mg one time a day, Jardiance 10 mg give one tablet by mouth in the morning, lisinopril five mg give one tablet in the morning for hypertension (HTN), pantoprazole sodium delayed release 40 mg in the morning related to epigastric pain, sertraline 50 mg give one tablet in the morning major depressive disorder, and torseamide 20 mg by mouth one time a day for HTN.</p> <p>Review of the Medication Administration Record (MAR) for Resident #37 from 04/01/25 to 04/07/25 revealed all of the morning medications (except ergocalciferol oral capsule scheduled 8:00 A.M.) were scheduled to be administered at 7:00 A.M.; The MAR for 04/07/25 at 7:00 A.M. revealed all the medications for 7:00 A.M. and 8:00 A.M. were documented as a two indicating the drug was refused and signed by Licensed Practical Nurse (LPN) #302. Resident #37 had not refused medications on any other of the six days.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/07/25 at 2:20 P.M. with Resident #37 revealed the nurse (Licensed Practical Nurse (LPN) #302) came in with his medications at 6:57 A.M. Resident #37 told LPN #302 that he takes his medications after he eats. LPN #302 responded to him if you don't take your medications now, you will have to come find me (the nurse) later. Resident #37 told LPN #303 that if she read his medical record she would see that he receives his medications after meals. LPN #303 responded to him I don't have time to look at every expletive chart, I have 50 residents in here. LPN #303 walked out and slammed his door. The resident stated he reported this to the Administrator. The Administrator responded sorry (Resident #37), they don't always do their job around here. Resident #37 stated he also told Assistant Direct of Nursing (ADON) #234.</p> <p>Interview on 04/07/25 at 2:25 P.M. with ADON #234 revealed Resident #37 told her the nurse (LPN #302) was yelling at him because she told him to take his pills, he said he doesn't take them until after breakfast, LPN #302 said well then you will come find me because the nurse was not hunting him down, then she slammed his door. ADON #234 revealed she told Travel Administrator #277 and the Director of Nursing (DON). LPN #302 was from a staffing agency, and was recently placed on the do not return list with the agency because of her attitude. The new DON brought her back.</p> <p>Interview on 04/07/25 at 2:45 P.M. with Travel Administrator #277 revealed LPN #302 was an agency nurse and was previously on the do not return list by the previous DON who did not like her attitude. The new DON, who has been here about two weeks, said she worked with her before and brought her back. Regional Director of Operations (RDOP) #27 was present and revealed he talked to Resident #37 that morning (04/07/25). Resident #37 said there was a new girl, she was agency staff and he was afraid he was not going to receive his medications. He asked Resident #37 if he needed his medications now and Resident #37 said yes. They both went to the medication cart where LPN #302 gave him his medications. RDOP #27 revealed Resident #37 shared with him he did not feel abused, he felt not respected.</p> <p>Interview on 04/07/25 at 3:50 P.M. with the DON confirmed she was made aware of Resident #37's concerns. DON stated Resident #37 does have a lot of complaints.</p> <p>Review of the facility's undated policy titled Residents Rights Policy and Procedure revealed every resident has the right to be treated with respect and dignity.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163962.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on observation, record review, facility policy review and resident and staff interview, the facility failed to ensure residents had comfortable water temperatures to bathe in, and maintain resident rooms in a clean and sanitary manner with adequate lighting. This affected two residents (#10 and #20) and had the potential to affect 18 additional residents (#2, #4, #7, #9, #15, #28, #30, #32, #37, #41, #45, #51, #56, #57, #64, #66, #69, and #71) who received a shower in the west shower room. The facility census was 70.</p> <p>Findings include:</p> <p>1. Record review for Resident #10 revealed a re-admitted [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively intact. The MDS revealed Resident #10 was dependent on staff for bathing.</p> <p>Interview on 04/15/25 at 8:34 A.M. with Resident #10 revealed when she was given a shower, the water felt cold, she did not like it, and it was miserable. Resident #10 was observed sitting in her wheelchair in her room. The carpeting was very worn and embedded with black dirt and stains and multiple liquid spills on top of spills throughout the entire carpet excluding the edges. The dresser and window blinds had dust build up and the floor molding was missing near the bathroom door. Resident #10 stated it was terrible, the staff does not dust, and they only sweep the carpet with a broom.</p> <p>Interview on 04/15/25 at 8:39 A.M. with Housekeeper #299 revealed the carpet in Resident #10's room was in that condition when they transferred her to the room. Housekeeper #299 stated the facility refused to rent a deep cleaner to clean the carpet and stated, We tell them all time, my manager, several Administrators, they don't do anything, it's not high on their list.</p> <p>Observation on 04/15/25 at 8:41 A.M. with Regional Director of Operations #278 confirmed the condition of Resident #10's room including the carpet.</p> <p>Interview on 04/15/25 at 9:21 A.M. with Housekeeping Supervisor #227 revealed Resident #10 was good at letting the staff clean her room, she never refused. Housekeeping Supervisor #227 confirmed the facility did not have a carpet scrubber.</p> <p>Interview on 04/15/25 at 10:46 A.M. with Maintenance Supervisor #230 revealed he tested the water temperatures monthly. Review of the water temperature log provided by Maintenance Supervisor #230 revealed on 03/12/25, he tested the water temperature for the west shower room and it was 87.6 degrees Fahrenheit (F). Maintenance Supervisor #230 stated after checking the water temperatures on 03/12/25, he turned the water temperature up. The next water temperature testing was completed and documented on 04/15/25 by Maintenance Supervisor #230 and revealed the west shower room tested at 99.9 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Subsequent interview on 04/16/25 at 12:21 P.M. with Maintenance Supervisor #230 revealed the water mixing valve broke and that was why the water was not getting warm enough on the west wing. Maintenance Supervisor #230 revealed he ordered the part on 04/15/25 and it should be in next week. The residents residing on the west wing would take showers in the memory care unit until the west wing shower/water temperature was fixed. Maintenance Supervisor #230 revealed the water temperature should be 105 degrees F to 120 degrees F.</p> <p>Interview on 04/16/25 with Certified Nursing Assistant (CNA) #254 revealed she gave Resident #10 her last shower on the west side shower room on 04/14/25. The water was cool to touch, she would let it run a while, it warmed up a little but then got cool again. CNA #254 verified residents complained of cold showers.</p> <p>2. Record review for Resident #20 revealed an admitted [DATE] with diagnoses including major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact.</p> <p>Review of the care plan dated 03/17/25 revealed Resident #20 had a psychosocial well-being problem related to anxiety, inability to solve problems. Interventions included to increase communication between resident/family/caregiver about care and living environment.</p> <p>Observation on 04/09/25 at 9:52 A.M. revealed Resident #20 was sitting up in his chair in his room. The carpeting in Resident #20's room, excluding the edges was observed embedded with black dirt and grime. There were multiple large spills on top of spills covering greater than 50% of the carpet. The remainder carpet fibers excluding the edges, was flattened due to embedded dirt. The bathroom light did not turn on. The bathroom sink had dirt and grime on the inside and outside of the sink covering the entire sink. The faucets were also covered with grime. The toilet including the bowl and top and bottom of the lid had urine and stool throughout along with dirt and grime on the base of the bowl and floor. The bathtub floor and sides had a large black area under the faucet with visible dirt and grime throughout. At the time of the observation, interview with Resident #20 revealed, I use my shower, it's disgusting. Resident revealed staff did not offer to clean his room.</p> <p>Observation and interview on 04/09/25 at 9:57 A.M. with Administrator confirmed the flooring and bathroom conditions in Resident #20's room. Resident #20 stated his bathroom light had not worked for weeks. The Administrator revealed Resident #20 refused housekeeping. Resident #20 revealed he refused housekeeping sometimes but not all the time.</p> <p>Interview on 04/09/25 10:02 A.M. with Housekeeper #298 revealed Resident #20 has let housekeeping clean but he usually refused. In the past when Resident #20 refused housekeeping, the Administrator would go in and speak to him and then he would allow staff to clean his room.</p> <p>Interview on 04/09/25 at 10:12 A.M. with the Maintenance Supervisor #230 revealed he was not aware the light was not working in Resident #20's bathroom and stated he had only been at the facility for a month.</p> <p>Interview on 04/09/25 at 10:15 A.M. with the Administrator confirmed she was new and never been in Resident #20's room until today (04/09/25) and stated she was aware some Administrators had to go in there.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 04/15/25 at 9:22 A.M. with Housekeeping Supervisor #227 revealed Resident #20 frequently refused housekeeping but he would usually allow her but at time also refused. Housekeeping Supervisor #227 stated in the past if he refused after three days, they would go to the old Administrator, and he would comply if the old Administrator went in.</p> <p>Review of the facility's undated policy titled Routine Cleaning and Disinfection revealed it is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.</p> <p>Review of the facility's undated policy titled Quality of Life - Homelike Environment revealed comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and home-like environment.</p> <p>Review of the facility's undated policy titled Residents Rights Policy and Procedure revealed each resident has a right to a safe, clean, comfortable homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility shall provide a safe, clean, comfortable homelike environment.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00163962 and OH00163963.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on observation, record review, facility policy review and interview, the facility failed to ensure Resident #59 was free from an incident of neglect. This affected one resident (#59) of three residents reviewed for abuse/neglect. The facility census was 70.</p> <p>Findings include:</p> <p>Record review for Resident #59 revealed an admitted [DATE] with diagnoses including cerebral infarction, chronic obstructive pulmonary disease (COPD), and gastroesophageal reflux disorder (GERD).</p> <p>Review of the care plan dated 09/13/22 revealed Resident #59 had GERD. Interventions included to avoid lying down for at least one hour after eating. Keep head of the bed elevated. Resident #59 had shortness of breath related to COPD. Interventions included to elevate the head of the bed to alleviate shortness of breath while lying flat. Position resident for proper body alignment for optimal breathing pattern. Resident #59 had a pressure wound to the left heel. Interventions included to provide treatment to the left heel as ordered. Resident #59 was at risk for impaired skin integrity related to fragile skin, impaired mobility and incontinence. Interventions included a low air loss mattress to bed, and peri care after each incontinent episode. Resident #59 received hospice services related to end stage diagnosis, cerebral vascular accident, COPD, and acute respiratory failure. Interventions included to promote emotional support and comfort measures.</p> <p>Review of the physician orders for Resident #59 dated 02/28/25 included orders for the resident to wear bilateral heel protectors while in bed as tolerated. An order dated 03/11/25 for Resident #59 revealed left heel, clean with normal saline apply medihoney cover with ABD pad and wrap with kerlix every day shift for treatment and as needed. The treatment was scheduled 6:00 A.M.; An additional order dated 03/25/25 included lay pillowcase over left foot to keep dry every shift for preventative dated 03/25/25.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was moderately cognitively impaired. Resident #59 had impairment on one side of the upper extremity and both sides of the lower extremities. Resident #59 required set up or clean up assistance with eating, dependent on staff for toileting hygiene, dressing, personal hygiene, and bed mobility. Resident #59 was always incontinent of bowel and bladder. Resident #59 did not have a condition or chronic disease that may result in a life expectancy of less than six months.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/07/25 at 2:00 P.M. revealed three Certified Nursing Assistants (CNA) #294, #295, and #296 and Assistant Director of Nursing (ADON) #234 were standing in the hall outside the nurse's station. Observation revealed a resident down the hall was overheard repeatedly yelling, Hello, I need help. No staff members were moving to assist or acknowledge the resident's repeated call for assistants. Observation while following the continued repeated yell, Hello, I need help revealed Resident #59 lying in bed. Resident #59's call light was also on, and the call light was blinking above Resident #59's door, but made no sound. Resident #59 stated, Please, I need help, I need changed. A foul strong odor of urine was present in the room. No staff were present. Resident #59 had tears in his eyes while asking for assistance. Observation revealed Resident #59 was on a low air loss mattress. The upper portion of the mattress was mostly deflated. Resident #59's head and shoulders were several inches lower than his body. Resident #59 had a t-shirt and brief on, no pants, blanket or sheet. The bottom sheet, bed pad and dressing on Resident #59's foot (that was contracted up to his peri area) were all saturated with urine. Resident #59's hair was unkept and oily, his facial hair was untrimmed. Resident #59 had dry flaky skin on his face and arms, his fingernails were long, uneven, and embedded with a dark substance. Resident #59 had no heel protectors on. Resident #59's again repeated, Please help me while audible respiratory gurgling could be heard in his voice as he spoke. The surveyor returned to the nurse's station to find the same staff members, CNA #294, #295, #296 and ADON #234 standing outside the nurse's station. Interview with ADON #234 confirmed they could hear Resident #59 yelling for help. ADON #234 stated, He yells all the time, the nurse who gave me report a few minutes ago said she just walked out, he only wanted a drink.</p> <p>Observation of Resident #59 on 04/07/25 at 2:09 P.M. with CNA #294, CNA #296 and ADON #234 confirmed Resident #59 had a foul strong odor of urine. Resident #59's low air loss mattress was deflated on the upper portion and Resident #59's head and shoulders were several inches lower than his body. CNA #294 stated, Oh that's the beeping I been hearing it all day. CNA #294 revealed she started her shift at 7:00 A.M. and Resident #59's bed, with his head lowered, was in that position since she started her shift. All staff present confirmed the sheet, bed pad and dressing on Resident #59's contracted foot were all saturated with urine. Resident #59's hair was unkept and oily, his facial hair was untrimmed. Resident #59 had dry flakey skin on his face and arms, his fingernails were long, uneven, and embedded with a dark substance. During observation of incontinence care for Resident #59 revealed a dark red area with a purple center on Resident #59's sacral area, the spinal area and left gluteal fold also had red areas. CNA #296 revealed she told the nurse this morning about the wound to the sacral area and stated, She said he had a patch on it, I told her there was no patch on it, she never came in to look at it. CNA #294 confirmed those wounds were there when she assisted CNA #294 to change Resident #59 that morning; ADON #234 entered the room and confirmed the wound to the sacral area and the gluteal fold were non-blanchable (an important sign of tissue damage). ADON #294 confirmed Resident #59 did not have any current treatment orders for the areas to the sacral wound or gluteal fold.</p> <p>Record review of the Change in Condition Evaluation for Resident #59 dated 04/07/25 at 3:09 P.M. completed by ADON #234 revealed Resident #59 had a skin wound or ulcer that started on 4/07/25. The area was a grade two or higher-pressure ulcer/injury on the sacrum that was red purple in color and measured three centimeters (cm) in length by three cm in width and was non-blanchable. The second new area was on the left gluteal fold, red, measured one cm in length by one cm in width and was non-blanchable.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Activities of Daily Living (ADL), Supporting revised March 2018 revealed residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Review of the facility policy titled, Abuse and Neglect - Clinical Protocol revised March 2018 revealed Neglect as defined at 483.5 means the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00163962 and OH00163963.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on observation, record review, facility policy review and interview, the facility failed to ensure residents received timely, adequate and necessary staff assistance with activities of daily living (ADLs) to maintain proper grooming and hygiene. This affected three residents (#25, #15, and #39) of four residents reviewed for ADL care. The facility census was 70.</p> <p>Findings include:</p> <p>1. Record review for Resident #25 revealed a re-admitted [DATE] with a diagnosis including Parkinson's disease.</p> <p>Review of the care plan dated 03/25/24 revealed Resident #25 had functional abilities impaired self-care and mobility deficit. Interventions included to assist with personal hygiene including combing hair and shaving.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #25 was cognitively intact. The assessment revealed Resident #25 required substantial/ maximal (staff) assistance with personal hygiene.</p> <p>Observation on 04/07/25 at 1:20 P.M. revealed Resident #25 was sitting up in his chair in his room. Resident #25's face had dry flaky skin with long unkept facial hair present. An interview with the resident at the time of the observation revealed a concern that staff only shaved him once every week to two weeks. Resident #25 revealed he preferred to be clean shaved, but indicated staff reported they just didn't have time.</p> <p>Observation on 04/16/25 at 11:52 A.M. revealed Resident #25 was sitting up in his chair in his room. Resident #25's face had dry flaky skin and his long unkempt facial hair appeared the same. An interview with Resident #25 at the time of the observation revealed the staff still had not shaved him, he was still waiting.</p> <p>Interview on 04/07/25 at 11:44 A.M. with Certified Nursing Assistant (CNA) #300 revealed she assisted Resident #25 out of bed this A.M. CNA #300 confirmed Resident #25 had long facial hair and he was unkempt and his face had was dry and flaky. At the time of the interview, CNA #300 revealed she had not offered to wash Resident #25's face or shave him as part of his A.M. care on this date.</p> <p>Review of the facility policy titled, Activities of Daily Living (ADL), Supporting revised March 2018 revealed residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>2. Record review for Resident #39 revealed an admitted [DATE] with diagnoses including dementia and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan for Resident #39 dated 04/03/23 revealed Resident #39 had an ADL self-care performance deficit related to dementia and limited mobility. Interventions included to encourage the resident to participate to the fullest extent possible with each interaction.</p> <p>Review of the annual MDS assessment dated [DATE] revealed Resident #39 was severely cognitively impaired. The assessment revealed Resident #39 required (staff) set up or clean up assistance for meals and supervision or touch assistance with oral hygiene, bed mobility, transfers and ambulation.</p> <p>Observation on 04/15/25 at 8:59 A.M. revealed Resident #39 was lying in bed. Resident #39 was observed to have a thick yellow build-up with food between her teeth.</p> <p>Interview on 04/15/25 at 9:01 A.M. with CNA #301 verified the condition of Resident #39's mouth and confirmed Resident #39 had not been offered or provided with oral care before or after breakfast on this date.</p> <p>3. Record review for Resident #15 revealed an admitted [DATE] with diagnoses including Alzheimer's disease and muscle weakness.</p> <p>Review of the care plan for Resident #15 updated 04/21/24 revealed a plan related to the resident's oral care routine which included to brush teeth, clean gums with toothette and rinse mouth with wash.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #15 was rarely or never understood and dependent on staff for all ADL care.</p> <p>Observation on 04/09/25 at 8:52 A.M. with CNA #255 revealed Resident #15's teeth had a thick yellow build-up between the teeth. At the time of the observation, interview with CNA #255 revealed she had not offered or provided oral care, including cleaning Resident #15's teeth before or after breakfast on this date. CNA #255 revealed she does not always have time to do oral care for the residents she was assigned to care for, including Resident #15.</p> <p>Review of the facility policy titled, Activities of Daily Living (ADL), Supporting revised March 2018 revealed residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00163962 and OH00163963. This is an example of continued non-compliance from the survey dated 02/25/25.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on observation, record review, facility policy review and interview, the facility failed to develop and implement a comprehensive and individualized plan of care for Resident #15 related to the presence of bilateral hand contractures to prevent skin impairment. This affected one resident (#15) of three residents reviewed for quality of care and treatment. The facility census was 70.</p> <p>Findings include:</p> <p>Record review for Resident #15 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, muscle weakness, and disorders of bone density and structures.</p> <p>Review of the care plan dated 01/28/25 revealed Resident #15 was at risk for infection and or discomfort related to bilateral hand and finger contractures resulting in skin impairment to the resident's bilateral palms. No interventions were noted to be in place on the care plan.</p> <p>Review of the physician's orders for Resident #15 dated 01/29/25 revealed an order for treatment for the left palm. The order indicated to cleanse with normal saline, skin prep and wrap with Kerlix daily and as needed every day shift for wound treatment. The resident also had an order for treatment to the right palm, to cleanse with normal saline, skin prep, wrap with Kerlix under contractured fingers and secure to hand daily and as needed.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was rarely or never understood and dependent on staff for all activities of daily living (ADLs).</p> <p>Review of the Treatment Administration Record (TAR) for April 2025 revealed the physician ordered treatments for the palms were not completed as ordered on 04/03/25, 04/07/25, or 04/10/25.</p> <p>Observation on 04/07/25 at 8:52 A.M. with Certified Nursing Assistant (CNA) #255 confirmed Resident #15's bilateral hands/fingers were contracted. Resident #15's nails that could be seen were long and uneven, the remaining nails were contracted into the palms of the resident's hands and not visible. Resident #15 did not have any dressings on either hand at the time of the observation. At the time of the observation, interview with CNA #255 revealed she worked full time three days a week, often with Resident #15. Per CNA #255 Resident #15 used to wear palm guards but the CNA stated the resident had not worn them or anything else for a very long time. CNA #255 then attempted to open Resident #15's fingers but was unable to</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Resident #15 on 04/07/25 at 11:13 A.M. with Assistant Director of Nursing (ADON) #234 confirmed Resident #15 did not have any dressings on either of her contracted hands/fingers. ADON #234 confirmed Resident #15's visible nails were long and uneven. The third and fourth fingers on the right hand were contracted into the palm of the hand and the nails were not visible. The third, fourth, and fifth fingers on the left hand were contracted into the palm of the hand and the nails were not visible. ADON #234 attempted and verified she was unable to see if Resident #15's nails were embedded into her palm. ADON #234 confirmed Resident #15 was supposed to have her hands wrapped with gauze to prevent her nails from digging in to the palms of her hands causing wounds. ADON #234 revealed she had not seen them wrapped for a few weeks on the days/times she worked. ADON #234 revealed Resident #15 would no longer be able to remove the dressings on her hands herself but if she did, the nurses should have replaced the dressings. Review of the TAR and medical record with the ADON for April 2025 confirmed there was no documentation the dressings on Resident #15's hands came off after being applied, nor the as needed dressings re-applied if they were removed.</p> <p>Review of the facility policy titled, Activities of Daily Living (ADL), Supporting revised March 2018 revealed residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163963. This is an example of continued non-compliance from the survey dated 02/25/25.</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on record review, review of an emergency squad run report, review of hospital records, facility policy and procedure review, review of the information contained on the Medscape website, resident and staff interviews, resident representative interview, and interview with pharmacy staff, the facility failed to ensure Resident #63 was free from significant medication errors, when Resident #63 who had a seizure diagnosis was not administered the anti-convulsant medication (Vimpat) as ordered by the physician. This resulted in Immediate Jeopardy and actual harm beginning on 03/31/25 when Resident #63 began having clonic tonic seizures (a type of seizure characterized by both a tonic phase (muscle stiffening) and a clonic phase (jerking movements), often accompanied by a loss of consciousness) at the facility which required the resident's transfer to the hospital for evaluation and treatment of seizures. While hospitalized the resident required multiple doses of intravenous anti-convulsant medications, was intubated (placed on life-support), and was subsequently life-flighted to a larger hospital as a result of the resident's medical needs following the significant medication error that occurred at the facility. Subsequently, the resident was admitted to the Neuro Intensive Care Unit (ICU) for ongoing care and treatment.</p> <p>In addition, the facility failed to ensure Resident #8 was free from significant medication errors when Resident #8 did not receive his Fentanyl patch as physician ordered for management of the resident's pain which placed the resident at potential risk for more than minimal harm that was not Immediate Jeopardy. This affected two residents (#8 and #63) of six residents reviewed for significant medication errors. The facility census was 70.</p> <p>On 04/10/25 at 3:52 P.M., the Administrator, Travel Administrator (TA) #277, [NAME] President of Clinical Operations (VPCO) #280, and Regional Director of Operations (RDO) #278 were notified Immediate Jeopardy began on 03/31/25 when Resident #63 did not receive the physician ordered medication Vimpat and subsequently was not administered the medication twice on 04/01/25 for the 7:00 A.M. dose and 4:00 P. M. dose. Consequently, on 04/01/25 at 7:10 P.M., Resident #63 began having seizure activity at the facility and was transferred to a local hospital for evaluation and treatment. At the local hospital, the resident was administered medications, was intubated, and ultimately life flighted to another hospital, where the resident was admitted to the Neuro ICU due to the significant medication error.</p> <p>The Immediate Jeopardy was removed on 04/10/25 when the facility implemented the following corrective actions:</p> <p>On 04/02/25 the facility pharmacy was contacted and delivered Resident #63's Vimpat to the facility.</p> <p>On 04/02/25 an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to discuss the root cause analysis of Resident #63 not receiving Vimpat, staff education, and ongoing medication audits. The Administrator, DON, ADON #234, Social Services #292, Minimum Data Set Nurse #293, and Medical Director #270 were in attendance.</p> <p>On 04/10/25 Regional Director of Clinical Services (RDSCS) #279 educated the DON, ADON #234, and Unit Manager #700 on re-ordering resident medications.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 04/10/25 the DON and ADON #234 completed a whole house audit to ensure all in-house residents had all ordered medications available.</p> <p>On 04/10/25 the Administrator/designee educated the nurses who were currently working on re-ordering of medications and the procedure if the fax machine was not functioning properly. All remaining nurses would be educated prior to the beginning of their next shift. Nursing leadership (DON, ADON #234, Unit Manager position, and Night Shift Supervisor position) would add education to the nursing agencies the facility utilized to educate their staff on the facility's procedure of re-ordering medications and what to do if the fax machine was not working. Education would also be added to orientation for all new hire nurses. The facility also had a plan in place to hire a unit manager to begin employment on 04/21/25 for night shift supervision.</p> <p>On 04/10/25 the Administrator checked the facility fax machines and all three were in working order at this time.</p> <p>Beginning 04/10/25 the DON/designee would audit all resident medications three times weekly for four weeks then two times weekly for two weeks, then one time for two weeks to ensure all in-house residents have all ordered medications available. Any concerns identified would be reviewed in Ad Hoc QAPI by the interdisciplinary team.</p> <p>Beginning 04/10/25 nursing leadership would ensure all resident medications would be re-ordered when no less than five days remaining of the medication. Nursing leadership would be responsible for providing any prior authorization requests to the physician and/or nurse practitioner (NP) and following up to ensure the prior authorization request was returned to pharmacy timely.</p> <p>Beginning 04/10/25 staff would contact the Administrator or nursing leadership to inform them if the fax machine is not working. If a prescription was needed, the physician and/or NP would be contacted by staff or nursing leadership to request the prescription. Staff/nursing leadership would follow up with pharmacy to ensure the physician ordered was received.</p> <p>Although the Immediate Jeopardy was removed on 04/10/25, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not immediate jeopardy) as the facility is still in the process of implementing their corrective actions and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #63 revealed the resident was admitted to the facility on [DATE] with diagnoses including traumatic brain injury and unspecified epilepsy without status epilepticus.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 was severely cognitively impaired. The assessment revealed Resident #63 had no impairment to the upper or lower extremities, used a walker, and required partial/moderate assistance with personal hygiene.</p> <p>Review of the physician orders for Resident #63 revealed a current order (initiated 05/05/24) for the anti-convulsant medication Vimpat (lacosamide) 200 milligrams (mg), one tablet by mouth two times a day.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Medication Administration Record (MAR) for Resident #63 dated March 2025 revealed Vimpat was placed on the MAR to be administered at 7:00 A.M. and 4:00 P.M. Vimpat was not documented as administered on 03/31/25 at 4:00 P.M., the signature box for administration contained the number two (2), which indicated drug refused.</p> <p>Review of the progress note for Resident #63 dated 03/31/25 at 3:43 P.M. revealed Vimpat tablet 200 mg medication was not available. The progress note included the reason (for the medication not being administered) was different than what was documented on the MAR for 03/31/25.</p> <p>The MAR dated April 2025 for Resident #63 revealed Vimpat was included on the MAR to be administered at 7:00 A.M. and 4:00 P.M. On 04/01/25 Resident #63 did not receive the 7:00 A.M. or 4:00 P.M. dose of Vimpat. The signature box for administration contained the number nine (9), which indicated other/see nurses notes.</p> <p>The progress note dated 04/01/25 at 9:06 A.M. revealed Vimpat tablet 200 mg was on order. On 04/01/25 at 4:51 P.M., the facility was waiting on the pharmacy to deliver the Vimpat 200 mg.</p> <p>The progress note dated 04/01/25 at 6:43 P.M. revealed the nurse spoke to a representative (Representative #281) at the pharmacy and she stated Vimpat would be delivered to the facility that night (04/01/25).</p> <p>There was no documentation in the medical record from 03/31/25 through 04/01/25 at 4:00 P.M. of the physician for Resident #63 being notified of the three consecutive missed doses of Vimpat.</p> <p>The progress note dated 04/01/25 at 7:35 P.M. revealed a Certified Nursing Assistant (CNA) reported to the nurse that Resident #63 was observed on his back in bed with tremors. Resident #63 was unresponsive to verbal and tactile stimuli. Resident #63 did have a pulse and was breathing. The note indicated the resident's seizure started at 7:10 P.M. and tremors began at 7:18 P.M. Documentation included emergency 911 was called.</p> <p>Review of the emergency squad run report for Resident #63 dated 04/01/25 at 7:20 P.M. revealed the primary impression was seizures with status epilepticus (a life-threatening neurological emergency that occurs when a seizure lasts longer than five minutes). Upon arrival, Resident #63 was in clonic tonic (grand mal) seizure state. Resident #63 had been on Vimpat but had been out of the prescription for an unknown amount of time. Resident #63 was flushed, dry and warm, had elevated blood pressures, pulses from 104 to 140 (normal 60-100) ranges. Respiration rates from 30-34 (normal 12-20) with room air saturations from mid-70's to 91% (ideal 96 - 99%). Intravenous (IV) in right hand, nasal trumpet (nasopharyngeal airway) inserted into right nostril successfully, and oxygen six liters per minute. Initial 2.5 milligrams (mg) Versed (treatment of status epilepticus) given IV without affect, another 2.5 mg Versed given IV push after four minutes with eventual five mg Versed given IV push over the next 10 minutes. Seizure clonic tonic subsided once for about two minutes before returning to status epilepticus throughout the rest of the resident contact.</p> <p>The progress note dated 04/01/25 at 9:20 P.M. revealed the nurse called Hospital #275 for an update on Resident #63. The Power of Attorney (POA) for Resident #63 was at the bedside and called the facility nurse back with the hospital nurse on speaker. The facility nurse was advised Resident #63's seizures were unable to be controlled. Resident #63 was sedated and intubated and life-flighted to Hospital #276.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of medical record information from Hospital #276 revealed Resident #63 presented to Hospital #275 on 04/01/25 with concerns for breakthrough seizure and status epilepticus. Resident #63 did not receive his prescribed dose of Vimpat for 48 hours. He was found to have continuous seizure on 04/01/25 and Emergency Medical Services (EMS) could not stop the seizures. In the emergency department at Hospital #275, Resident #63 was intubated for airway protection, Ativan (anti-anxiety medication) and Keppra (anti-convulsant) were administered and seizure then aborted. However, recurrent eye and left twitching recurring so was transferred to Hospital #276 on 04/01/25. The resident received continuous electroencephalogram (EEG) (measures electrical activity in the brain) monitoring and management of status. Resident #63 self-extubated on 04/04/25 and was stable. Resident #63 was discharged to the facility on [DATE]. Hospital discharge orders included oxygen administration one liter continuously via nasal cannula (NC) and Vimpat 200 mg twice daily.</p> <p>Interview on 04/09/25 at 11:30 A.M. with ADON #234 verified Resident #63 did not receive the medication Vimpat (ordered for seizures) for several doses. The ADON revealed this was due to the facility fax machines being down for several days (to send orders to the pharmacy). There were three fax machines in the facility, one on the east side, one on the west and one in the business office. The fax machine on the east side and the west side went down and the nurses were told the fax machine in the business office was still working. The residents who needed refills for their narcotics required a new prescription sent to the pharmacy for the refills. The physician would sign the prescription, then the nurse would fax it to the pharmacy. The nurse was supposed to call the pharmacy after faxing it to make sure the pharmacy got the prescription. The ADON revealed the nurse faxed Resident #63's prescription to the pharmacy from the business office. The nurse did not call the pharmacy to verify they received the prescription like they were supposed to and later found that the fax machine in the business office was not working either, so the pharmacy never received the new prescription for the Vimpat for Resident #63. The nurses also never notified the physician Resident #63 did not have his Vimpat. The ADON revealed the physician would have been able to fax the prescription from his office or call it in for an emergency three-day supply. ADON #234 stated Resident #63 had been stable and did not have any seizures for several months prior to this incident and never had a seizure this bad while at the facility.</p> <p>Interview on 04/09/25 at 11:55 A.M. with TA #277 confirmed he was at the facility at the time the fax machines went down. There were three fax machines that were down from 03/19/25 until 04/01/25 due to issues with the telephone lines. TA #277 stated he did not know what nurses were doing for faxes to and from the pharmacy or physician offices. TA #277 stated he was aware of Resident #63 running out of his medication. The family spoke with the DON, and it was his understanding there were fax machine issues and a lack of communication. TA #277 stated the facility was still looking into what exactly happened and waiting for reports to find out what happened.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 04/09/25 at 1:05 P.M. with DON revealed the facility had not completed their investigation to determine what happened with Resident #63's Vimpat and why the pharmacy did not send his medication before he ran out. The DON revealed her first day of employment as the facility's DON was 03/31/25 and Resident #63 had his seizure on 04/01/25 which resulted in hospitalization . The DON revealed two house nurses, and two agency nurses failed to properly follow up on Resident #63's Vimpat not being on order. The DON stated Resident #63 did not need a prescription and she did not know why the pharmacy did not send the medication. The DON revealed nurses were educated on the ordering process on 04/02/25. Review of the in-service from 04/02/25 with the DON titled Learning Circle revealed course topic was medication reordering. Type of presentation revealed: All nursing staff and nursing staff management correctly re-order and notify physicians regarding missed medications. The form included six nurse's signatures: DON, ADON #234, Agency Nurse #283, Registered Nurse (RN) #269, Licensed Practical Nurse (LPN) #253, and LPN #258. The DON confirmed these were all the nurses in serviced and confirmed there was no other signature log. The DON revealed the Administrator had the in-service form that had the information on how to reorder the medication, she just had the signature log. During the interview, the DON verified Resident #63 had three missed doses of Vimpat on 03/31/25 4:00 P.M. and 04/01/25 7:00 A.M. and 4:00 P.M.</p> <p>Interview on 04/09/25 at 1:46 P.M. with Resident #63's legal guardian, (LG) #291 revealed Resident #63 was still in the hospital as of this date. LG #291 revealed the resident had a history of seizures that started seven years ago due to a brain injury from a vehicle accident. Resident #63 had been taking Vimpat since the accident to control the seizures. LG #291 reported Resident #63 had a small seizure while at the fair in August 2024, he was just staring off, there were no tremors, and he had not had any seizures since then. On 04/01/25, the nurse called her and told her Resident #63 was having seizures, and said he missed a couple of days of medications because they were not available. LG #291 stated she had told the facility if Resident #63 refused his medications they were supposed to notify the LG. LG #291 revealed the hospital told her that Vimpat had a 13-hour half-life, Resident #63 had no Vimpat in his system at all and that's why he had seizures. Resident #63 went to Hospital #275 then he was life-flighted to Hospital #276 because they could not get his seizures under control. They had to intubate him, and he was on the ICU. The LG revealed Resident #63 was never on oxygen before but now he may need to be on oxygen the rest of his life.</p> <p>Telephone interview on 04/09/25 at 2:12 P.M. with Facility Pharmacist (FP) #284 revealed the facility did not reorder Vimpat for Resident #63 before running out. The medication was not automatically refilled because it was a narcotic and required a new prescription. The pharmacy received the refill request on 04/01/25 at 6:44 P.M. FP #284 explained someone might miss two days of Vimpat and be fine, others might miss one dose and not be fine. There were variables, and the half-life for Vimpat was 13 hours, which was why the medication was given two times a day.</p> <p>Interview on 04/09/25 at 2:33 P.M. with Case Manager #271 at Hospital #276 revealed Resident #63 transferred from Hospital #275 on 04/01/25 to Hospital #276 with concerns breakthrough seizures and status epilepsy. On arrival Resident #63 had been intubated and sedated and was admitted to neuro ICU. He was found to have continuous seizure, Vimpat was given, and seizures were aborted. Resident #63 continued to receive impatient care at Hospital #276 but had no further seizures (since resuming the medication).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 04/09/25 at 3:08 P.M. with RN #285 revealed she was an Agency Nurse. RN #285 revealed she would have to think about what she would do at her other job to know how to order residents narcotics at this facility. RN #285 stated she would order the narcotics in the electronic medical system then fax the pharmacy the order.</p> <p>Interview on 04/09/25 at 3:12 P.M. with LPN #258 revealed he was a facility staff nurse but he stated he did not know how to order a residents' narcotics.</p> <p>Interview on 04/10/25 at 8:35 A.M. with TA #277 revealed the nurses worked 12-hour shifts, there were typically three nurses on day shift and three nurses on night shift.</p> <p>A telephone interview on 04/13/25 at 9:06 P.M. with RN #269 revealed she was a facility nurse and worked the night shift. RN #269 confirmed she signed an in-service on 04/02/25 and confirmed the content of the in-service being only two pages, one signature page and one with three numbered instructions. RN #269 revealed the in-service was left at the nurse's station for staff to read and sign. RN #259 stated there were no further instructions with the in-service including what to do if the fax machine went out again. RN #259 revealed when the fax machine broke, the nurses took pictures on their personal cell phones of residents' laboratory results to send the results to the medical providers.</p> <p>Review of the website titled Medscape revealed withdraw Vimpat (lacosamide) gradually over one week; do not discontinue abruptly because of risk for increased frequency of seizures. Stopping Vimpat suddenly can cause serious problems. The elimination half-life of lacosamide was approximately 13 hours.</p> <p>Review of the facility policy titled Administering Medication revised April 2019 revealed medications were administered in a safe and timely manner, and as prescribed. Medication administration times were determined by resident need and benefit, not staff convenience. Factors that were considered include enhancing optimal therapeutic effect of the medication.</p> <p>2. Record review for Resident #8 revealed an admitted [DATE] with diagnoses including stable burst fracture of fourth thoracic vertebra and paraplegia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact. Resident #8 received routine scheduled and as needed (PRN) pain medications. Pain frequency was occasionally and occasionally pain interfered with activities of daily living (ADLs).</p> <p>Review of the physician orders for Resident #8 revealed an order dated 03/30/25 for Fentanyl transdermal patch (treats severe pain) 72-hour 25 micrograms (mcg), apply one patch transdermally every 72 hours for pain and remove per schedule.</p> <p>Review of the medication administration record (MAR) for April 2025 for Resident #8 revealed the Fentanyl transdermal patch was due to be applied on 04/08/25 at 9:00 P.M. The signature box for administration contained the number nine (9), which indicated other/see nurses notes.</p> <p>Review of the progress note for Resident #8 dated 04/09/25 at 12:49 A.M. revealed Fentanyl transdermal patch on order.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The progress note dated 04/09/25 at 10:11 A.M. completed by Director of Nursing (DON) included the pharmacy was contacted regarding medication on order. The pharmacist indicated the prescription prior authorization was denied but would be submitted again for potential approval. The primary care physician (PCP) signed prior authorization to be filled. A verbal order was received from the PCP to apply the patch upon arrival.</p> <p>An additional physician order was written 04/09/25 for the Fentanyl patch to be on hold, due to awaiting arrival of the patch.</p> <p>Interview on 04/09/25 at 10:23 A.M. with Registered Nurse (RN) #289 revealed Resident #8 did not have his Fentanyl pain patch available.</p> <p>Interview on 04/09/25 at 11:30 A.M. with ADON #234 revealed Resident #8 was frequently running out of prescriptions for his narcotics because the nurses were not getting the prescriptions timely and sending them to the pharmacy.</p> <p>Interview on 04/10/25 at 10:43 A.M. with Resident #8 revealed he was hurting all over. Resident #8 rated his pain an 8.5 (pain scale from zero to no pain and ten being the most severe pain). Resident #8 stated the facility told him it was the doctor's fault because no one put the order in for his pain patch.</p> <p>Interview on 04/10/25 at 11:13 A.M. with RN #290 and the DON revealed RN #290 indicated the pharmacy was supposed to deliver Resident #8's Fentanyl patch the previous night, but they didn't. The DON stated the pharmacy was waiting on Resident #8's prior authorization, the insurance was not wanting to pay, and the insurance wanted prior authorization. The DON stated that was why Resident #8's Fentanyl patch did not get delivered to the facility.</p> <p>A telephone interview on 04/10/25 at 1:45 P.M. with Facility Pharmacist (FP) #284 revealed Resident #8 did need a prior authorization but that was not holding up Resident #8 receiving his Fentanyl patches from the pharmacy. FP #284 explained the facility never sent in the required prescription from the physician, but Resident #8 could still receive the medication. The pharmacy just needed the prescription because it was a narcotic medication. FP #284 confirmed the pharmacy could not send the Fentanyl patch because the facility never sent the required prescription.</p> <p>Review of the undated guidance from Medscape for the medication Fentanyl transdermal revealed Fentanyl was used for chronic pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Patients who were opioid tolerant were those receiving, for one week or longer, at least 25 mcg/day transdermal Fentanyl. Do not abruptly discontinue Fentanyl patch. It was unknown at what dose level transdermal may be discontinued without producing the signs and symptoms of opioid withdrawal.</p> <p>Review of the facility policy titled Administering Medication revised April 2019 revealed medications were administered in a safe and timely manner, and as prescribed. Medication administration times were determined by resident need and benefit, not staff convenience. Factors that were considered include enhancing optimal therapeutic effect of the medication.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00164543 and Complaint Number OH00163962.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>42011</p> <p>Based on record review, observation, resident interview, staff interview and review of facility policy, the facility failed to ensure resident meals were palatable and at a safe, appetizing temperature. This had the potential to affect all residents residing at the facility except for two residents, Resident #1 and #3 identified by the facility to receive nothing by mouth (NPO). The facility census was 70.</p> <p>Findings include:</p> <p>Observation on 04/07/25 at 11:30 A.M. of the meal tray line revealed residents tray were being prepared to serve.</p> <p>Interview on 04/07/25 at 11:47 A.M. with Resident #14 and Resident #58 revealed the chicken served was awful, it had a bad flavor and was like chewing jerky.</p> <p>Observation on 04/07/25 at 12:46 P.M. revealed a test plate of the lunch meal was served from the steam table and the food temperature was tested by the Dietary Manager (DM) #297. The test tray was served immediately after the last resident received their lunch tray from the food delivery cart. Observation of the test tray with DM #297 revealed the chicken appeared very small in portion size. DM #297 revealed the chicken shrinks in size after cooking and revealed it was not the correct proportion size, it was too small and revealed each piece should be at least four ounces and stated, There is no way that is four ounces. DM #297 confirmed the temperature of the chicken was 108.1 degrees Fahrenheit (F). The mashed potatoes were 125.4 degrees (F), the baked beans was 115.2 degrees (F) and the milk was 52.3 degrees (F). The appearance of the meal was unfavorable. The chicken tasted dry and not warm enough, the potatoes tasted instant and had a very strong garlic flavor and the baked beans were watery, not warm enough and had little to no flavor. DM #297 confirmed the food temperatures and revealed he heard several complaints from residents about the food and revealed he agreed with them. DM #297 revealed he was only permitted to order a few seasonings so all meals/food were seasoned with the same seasonings daily, no matter what the dish; all food items came frozen, nothing was fresh except some vegetables which frequently needed thrown out upon delivery due to mold. DM #297 revealed residents expressed the food was like prison food, it just tasted bad.</p> <p>Interview on 04/07/25 between 1:08 P.M. and 1:17 P.M. with Resident #27, #60, and #67 revealed the food served for lunch and in general was bland, dry, did not taste good and was not hot enough.</p> <p>Review of the Resident Council Minutes dated 03/20/25 revealed residents in attendance (Resident #14, #18, #73, #7, #52, and #36) voiced concerns the the mixed vegetables were full of water.</p> <p>Review of the facility undated policy titled, Food, Nutrition and Dietary Services Policy and Procedure revealed the purpose and policy was to ensure each resident of (the facility) was provided with a nourishing, palatable, well-balanced diet that meets his or her nutritional and special dietary needs, taking into consideration the preferences of each resident. Each resident shall receive, and the facility shall provide food prepared by methods that conserve nutritive value, flavor and appearance. The facility must serve food in appropriate quantity and at an appropriate temperature.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility undated policy titled, Record of Food Temperatures revealed hot foods would be held at 135 degrees (F) or greater.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163962. This is an example of continued non-compliance from the survey dated 02/25/25.</p>

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>42011</p> <p>Based on resident and staff interviews, and review of the facility policy, the facility failed to honor residents' drink preferences to include caffeinated coffee. This had the potential to affect all residents residing at the facility except for two residents (#1 and #3) identified by the facility as being nothing by mouth (NPO). The facility census was 70.</p> <p>Findings include:</p> <p>Interview on 04/07/25 at 3:55 P.M. with Dietary Aide #220 revealed the facility did not have caffeinated coffee/tea to offer residents. Dietary Aide #220 stated the residents were not allowed to have regular coffee, it was a stimulant, and they can have decaffeinated.</p> <p>Interview on 04/09/25 at 9:32 A.M. with Medical Director #270 revealed he did not know residents could not have regular coffee and confirmed he was not aware of that. Medical Director #270 revealed there was no reason he knew of that they could not have regular caffeinated coffee.</p> <p>Interview on 04/09/25 at 10:19 A.M. with Resident #37 stated he preferred regular coffee but was told by the facility could not put it in the budget.</p> <p>Interview on 04/09/25 at 10:30 A.M. with Administrator confirmed the facility did not provide caffeinated coffee for the residents. The Administrator stated the previous Director of Nursing (DON) told them not to provide it to the residents.</p> <p>Interview on 04/09/25 at 10:45 A.M. with Resident #14 revealed he was the Resident Council President. Resident #14 stated the residents were not allowed to get caffeinated coffee. The nurse said it was because it interferes with medications. Resident #14 said trust me I wish we could have regular coffee. He stated he hated decaffeinated, and so does a lot of the residents. Resident #14 said the residents were recently told they were not allowed to have caffeinated coffee or tea.</p> <p>Review of the facility's undated policy titled Food, Nutrition and Dietary Services Policy and Procedure revealed the purpose and policy was to ensure each resident of (the facility) is provided with a nourishing, palatable, well-balanced diet that meets his or her nutritional and special dietary needs, taking into consideration the preferences of each resident. Each resident shall receive and the facility shall provide drinks including water and other liquids consistent with residents needs and preferences.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163962.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on observation, record review, review of Centers for Disease Control and Prevention (CDC) guidance, facility policy review and interview, the facility failed to ensure staff maintained infection control practices including appropriate hand washing and the use of personal protective equipment (PPE) when required. This affected three residents (#44, #68, and #74) of 70 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Record review for Resident #74 revealed an admitted [DATE] with a diagnosis including multiple sclerosis.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #74 was cognitively intact. Resident #74 required assistance with activities of daily living (ADL's).</p> <p>Review of the care plan dated 03/18/25 revealed Resident #74 had multiple sclerosis. Interventions included to give medications as ordered.</p> <p>Observation on 04/07/25 at 10:36 A.M. of medication administration with the Director of Nursing (DON) revealed the DON prepared Resident #74's oral medications (13 pills) for administration. The DON did not wash her hands or use hand sanitizer prior to preparing the medication. The DON then entered Resident #74's room and assisted Resident #74 to take his medications. The DON then exited the room and returned to the medication cart without washing her hands or using hand sanitizer. The DON then began preparing Resident #44's medications.</p> <p>Observation on 04/07/25 at 11:14 A.M. of medication administration with the DON revealed the DON prepared Resident 74's topical medication patch (lidocaine patch 4 %) for application. The DON did not wash her hands or use hand sanitizer prior to opening and preparing the medication patch. The DON then entered Resident #74's room and applied the medicated patch topically. The DON then exited the room and returned to the medication cart without washing her hands or using hand sanitizer.</p> <p>Interview on 04/07/25 at 11:24 A.M. with the DON confirmed she never washed her hands or used hand sanitizer during the observations of medication administration for Resident #44 and #74.</p> <p>Review of the facility policy titled, Hand washing/Hand Hygiene revised October 2023 revealed the facility considers hand hygiene the primary means to prevent the spread of healthcare -associated infections. All personnel were expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene was indicated immediately before touching a resident; after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching a resident's environment; before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal.</p> <p>2. Record review for Resident #44 revealed an admitted [DATE] with a diagnosis including multiple sclerosis.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan initiated 02/10/25 revealed Resident #44 had multiple sclerosis. Interventions included to give medications as ordered.</p> <p>Observation on 04/07/25 at 10:56 A.M. of medication administration with the DON revealed the DON prepared Resident 44's oral medications for administration. The DON did not wash her hands or use hand sanitizer prior to preparing the medication. The DON then entered Resident #44's room and assisted Resident #44 to take his oral medications. The DON then exited the room and returned to the medication cart without washing her hands or using hand sanitizer. The DON then began preparing Resident #74's topical medication patch (lidocaine patch 4 %) for application. The DON did not wash her hands or use hand sanitizer.</p> <p>Interview on 04/07/25 at 11:24 A.M. with the DON confirmed she never washed her hands or used hand sanitizer during the observations of medication administration for Resident #44 and #74.</p> <p>Review of the facility policy titled, Hand washing/Hand Hygiene revised October 2023 revealed the facility considers hand hygiene the primary means to prevent the spread of healthcare -associated infections. All personnel were expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene was indicated immediately before touching a resident; after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching a resident's environment; before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal.</p> <p>3. Record review for Resident #68 revealed an admitted [DATE] with diagnoses including local infection of the skin and subcutaneous tissue, chronic venous hypertension with inflammation bilateral lower extremity, and cellulitis of unspecified part of limb.</p> <p>Review of the Clinical Admission assessment dated [DATE] revealed Resident #68 was alert and oriented to person, place and time. Resident #68 had a pressure injury to the left lateral calf, right medial calf. Resident #68 also had a venous wound to the front of the right lateral lower leg, a skin tear to the left lateral foot, and a wound to the left medial foot.</p> <p>Review of the care plan for Resident #68 dated 04/01/25 revealed Resident #68 had signs and symptoms of wound infection. Resident #68 required use of intravenous (IV) for medications. Peripherally inserted Central Catheter (PICC) in the left upper extremity. Interventions included administering medications per the physician orders.</p> <p>Review of the physician orders for Resident #68 revised 03/31/25 revealed an order for Cefepime HCL solution two grams (gm)/100 milliliters (ml), use two gm IV every eight hours for infection. Normal saline flush solution, use 10 ml IV every shift for line patency.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/09/25 at 2:45 P.M. revealed Resident #68's door to his room was open. On the outside of the door was a sign that revealed Resident #68 was on Transmission Based Precautions. Observation from the hall revealed Registered Nurse (RN) #289 was applying a new dressing on Resident #68's right lower leg. Observation revealed RN #289 was not wearing an isolation gown. Continued observation while in Resident #68's room revealed Resident #68 had a PICC line in the right upper arm. RN #289 continued with care and unwrapped the dressing on Resident #68's left lower leg. The dressing was heavily soiled with a brownish/serosanguinous drainage on the outside and inside of the dressing. RN #289. RN #289 did not wash her hands or use hand sanitizer after removing the soiled dressing and before applying the clean dressing. RN #289 completed wound care to Resident #68's bilateral lower extremities with no isolation gown. After completion of wound care, RN #289 confirmed Resident #68 was on transmission-based precautions and confirmed she did not wear the appropriate Personal Protective Equipment (PPE) to include an isolation gown.</p> <p>Review of the facility policy titled, Hand washing/Hand Hygiene revised October 2023 revealed the facility considers hand hygiene the primary means to prevent the spread of healthcare -associated infections. All personnel were expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene was indicated immediately before touching a resident; after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching a resident's environment; before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal.</p> <p>Review of the facility policy titled, Isolation - Categories of Transmission - Based Precautions revised September 2022 included transmission-based precautions were initiated when a resident develops signs or symptoms of a transmissible infection; arrives on admission with symptoms of an infection, or is at risk for transmitting the infection to other residents. Transmission - based precautions are additional measures that protect staff, visitors and other residents from becoming infected.</p> <p>Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.</p> <p>Review of CDC guidance titled Clinical Safety: Hand Hygiene for Healthcare Workers found at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html and dated 02/27/24 revealed hand hygiene protects both healthcare personnel and patients. Cleaning your hands reduces the potential spread of deadly germs to patients. Recommendations included on know when to wear (and change) gloves stated gloves are not a substitute for hand hygiene. If your tasks requires gloves, perform hand hygiene before donning gloves and touching the patient or the patients surroundings; always clean your hands after removing gloves. When to change gloves and clean hands included if gloves become soiled with blood or body fluids after a task, if moving from work on a soiled body site to a clean body site on the same patient or if clinical indication for hand hygiene occurs, and before exiting a patient room.</p> <p>This was an incidental finding during the course of the complaint investigation. This is an example of continued non-compliance from the survey dated 02/25/25.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on record review, facility policy review and interview, the facility failed to timely fix a broken water mixing valve to ensure residents who utilized the west shower room were provided water at a comfortable temperature for showering/bathing. This affected one resident (#10) and had the potential to affect 19 additional residents, Resident #2, #4, #7, #9, #15, #20, #28, #30, #32, #37, #41, #45, #51, #56, #57, #64, #66, #69, and #71 who received a shower in the west shower room. The facility census was 70.</p> <p>Findings include:</p> <p>Record review for Resident #10 revealed a readmitted [DATE] with diagnoses including unspecified dementia, and spastic hemiplegia affecting the left nondominant side.</p> <p>Review of the care plan dated 05/14/24 revealed Resident #10 had an activity of daily living self-care performance deficit related to a history of cerebral vascular accident (CVA) with hemiparesis. Interventions included the resident preferred to have a shower on Mondays and Thursdays.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively intact and dependent on staff for bathing.</p> <p>Interview on 04/15/25 at 8:34 A.M. with Resident #10 revealed when she was given a shower, the water felt cold, she did not like it, it was miserable.</p> <p>Interview on 04/15/25 at 10:46 A.M. with Maintenance Supervisor #230 revealed he tested the water temperatures monthly. Review of the water temperature log provided by Maintenance Supervisor #230 revealed on 03/12/25 he tested the water temperature for the west shower room and it was 87.6 degrees Fahrenheit (F). Maintenance Supervisor #230 revealed after checking the water temperatures on 03/12/25 he turned the water temperature up. The next water temperature testing was completed and documented on 04/15/25 by Maintenance Supervisor #230 and revealed the west shower room tested at 99.9 degrees F.</p> <p>Interview on 04/16/25 at 12:21 P.M. with Maintenance Supervisor #230 revealed the water mixing valve broke and that was why the water was not getting warm enough on the west wing. Maintenance Supervisor #230 revealed he ordered a part on 04/15/25 and it should be in next week. The facility plan was for residents residing on the west wing to take showers on the memory care unit until the west wing shower/water temperature was fixed. Maintenance Supervisor #230 revealed the hot water temperatures should be maintained between 105 degrees F to 120 degrees F.</p> <p>Interview on 04/16/25 with Certified Nursing Assistant (CNA) #254 revealed she gave her last shower on the west side shower room on 04/14/25. The water was cool to touch, she would let it run a while, it warmed up a little but then got cool again. CNA #254 verified residents complained of cold showers. There was no evidence residents were provided another option for showering/bathing timely once it was identified the water in the [NAME] side shower room was not reaching a comfortable temperature.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility undated policy titled, Residents Rights Policy and Procedure revealed each resident had a right to a safe, clean, comfortable homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility shall provide a safe, clean, comfortable homelike environment.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00163962 and OH00163963. This is an example of continued non-compliance from the survey dated 02/25/25.</p>		