

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 08/14/2025
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure Residents #46 and #68, on the secured dementia unit, were provided activities to meet their interests and psychosocial needs. This affected two residents (#46 and #68) and had the potential to affect 12 additional residents (#3, #14, #19, #21, #22, #28, #32, #40, #41, #43, #53, and #71) who resided on the memory care unit. The facility census was 71. Findings include: Observations made on 08/13/25 during the complaint survey revealed no organized activities nor any type of individual activities were available for any of the residents on the memory care unit. Review of the memory care unit's activity calendar for August 2025 revealed that on 08/13/25 the following activities should have been held at 11:00 A.M. an activity titled, Science Experiment, at 2:00 P.M. an activity titled, Parachute Popcorn, and at 3:30 P.M. an activity titled, Name that Tune. Interview on 08/13/25 at 1:20 P.M. with Family of Resident #46 revealed that she was pleased with the care provided by the facility but would like to see more activities for the residents. Interview on 08/13/25 at 1:41 P.M. with Certified Nursing Assistant (CNA) #343, verified activities staff rarely came to the memory care unit and stated between two and three residents would attend BINGO on the non-secured unit. CNA #343 stated residents residing on the memory care unit needed more activities. Interview on 08/13/25 at 2:49 P.M. with Resident #68 revealed he resided on the secured memory care unit. Resident #68 reported staff take care of his needs, but stated there was nothing to do. Interview on 08/13/25 at 3:00 P.M. with Registered Nurse (RN) #307 revealed that she did not see any activities on the memory care unit and felt there should be more stimulation for the residents. Interview on 08/13/25 at 3:09 P.M. with CNA #306 revealed that there used to be activities held in the memory care unit, but not in a long time. She stated that there are a couple of residents that would be taken off the unit to occasionally attend activities. Interview on 08/13/25 at 3:27 P.M. with Activity Assistant (AA) #308 revealed that she works 9:00 A.M. to 5:00 P.M. Monday through Friday and does not do activities in memory care. She does have one resident that she must see at least once a week for one-on-one visits that reside on the memory care unit. AA #308 stated that the memory care unit does not have a different activity calendar, and only three residents come to activities outside of memory care. AA #308 reported if residents from memory care get restless during activities, they are taken back to the memory care unit. AA #308 reported there was a dedicated activity staff member for the memory care unit, but she only works every other weekend.</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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