

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  02/25/2025
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>38091</p> <p>Based on record review and staff interview, the facility failed to timely address and respond to voiced concerns regarding resident care and life in the facility identified by residents in resident council and food committee meetings. This had the potential to affect all residents residing in the facility. The facility census was 73.</p> <p>Findings include:</p> <p>Review of the resident council meeting minutes revealed the following documented concerns regarding staffing:</p> <ul style="list-style-type: none"> <li>- During the meeting dated 11/30/23, residents reported nightshift could be nicer.</li> <li>- During the meeting dated 01/25/24, residents reported call lights need answered faster.</li> <li>- During the meeting dated 04/25/24, residents reported nurses need to be nicer and more caring.</li> <li>- During the meeting dated 06/27/24, residents reported nurses need to be more caring and night aides need to do their jobs.</li> <li>- During the meeting dated 07/25/24, residents reported night aides need to do their jobs.</li> <li>- During the meeting dated 08/29/24, residents reported night shift needed to get better, and the staff on night shift do whatever they want. The notes additionally mentioned the aides come in the room too aggressive when answering call lights.</li> <li>- During the meeting dated 09/09/24, residents reported there was no consistency with night shift aides and nurses. Residents reported they were missing their medications and were being dressed in soiled clothing.</li> <li>- During the meeting dated 10/31/24, residents reported wanting to discuss the aides, referring to the aides as rude and nasty.</li> </ul> <p>Review of food committee meeting minutes from July 2024 through present day revealed residents had concerns related to cold food and coffee, the facility not using hot packs to keep food warm, and food palatability.</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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility was unable to provide evidence that any of the concerns or issues brought forth by residents in resident council and/or food committee meeting minutes had been investigated, reviewed, or followed up on by any facility staff member.</p> <p>Interview on 02/09/24 at 8:45 A.M. with Resident #3 revealed concerns related to sufficient facility staffing, notably on the weekends and night shift.</p> <p>Interview on 02/09/25 at 10:30 AM with Resident #46 revealed the food in the facility is bland and usually not warm.</p> <p>Interview on 02/09/25 at 11:15 A.M. with Resident #51 revealed the food in the facility does not taste good and is cold.</p> <p>Interview on 02/09/25 at 01:57 P.M. with Resident #36 revealed the food in the facility is nasty.</p> <p>Interview on 02/09/24 at 2:02 P.M. with Resident #44 revealed concerns related to sufficient facility staffing. Resident #1 further stated that he had past instances where he had missed medications due to insufficient facility staffing and believed many of his skin issues could have been solved by increased staffing levels.</p> <p>Interview on 02/10/24 at 9:12 A.M. with Resident #1 revealed concerns related to sufficient facility staffing. Resident #1 stated call lights can take up to four hours to be answered after being activated.</p> <p>Interview on 02/19/24 at 2:30 P.M. with a family member of Resident #54 revealed the facility staffing levels were horrible.</p> <p>Interview on 02/19/25 at 3:00 P.M. with Licensed Practical Nurse (LPN) #701 revealed first shift workers often complain about night shift failing to complete standard job duties.</p> <p>Interview on 02/19/25 at 3:24 P.M. with Certified Nursing Assistant (CNA) #800 revealed night shift workers are not nearly as productive as day shift workers.</p> <p>Interview on 02/19/25 at 4:10 P.M. with Resident #52 revealed call lights are often never answered and night shift is extremely understaffed.</p> <p>Interview on 02/19/25 at 4:12 P.M. with Resident #6 revealed the facility is in desperate need of more staff.</p> <p>Interview on 02/20/25 at 9:00 A.M. with Licensed Practical Nurse (LPN) #702 revealed she works both day and night shift and during night shift no one is ever here.</p> <p>Interview on 02/20/25 at 9:12 A.M. with Resident #25 revealed you can't get anything done at night due to lack of staff.</p> <p>An interview during the completion of the resident council portion of the annual recertification survey on 02/11/25 between 2:58 P.M. and 3:30 P.M. with Residents #6, #25, #44 and #51 revealed numerous concerns related to sufficient facility staffing and staffs ability to meet their needs timely.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A test tray on 02/09/25 at 6:00 P.M. was completed after half of the room trays were served. The meal consisted of a barbeque (BBQ), pork sandwich and baked beans. The BBQ pork sandwich was noted to be 115 degrees Fahrenheit (F) and the baked beans were noted to be 113.7 degrees F. Both the BBQ pork and baked beans tasted lukewarm and unappetizing. The BBQ pork had a white color and was extremely overcooked and had mushy texture and was very difficult to chew. The baked beans had no seasoning and were very bland. The temperatures and condition of the food were verified with Dietary Manager (DM) #114 at the time of the test tray.</p> <p>An interview on 02/19/25 at 10:10 A.M. with Regional Administrator (RA) #203 verified the facility had no evidence of any follow-up from any of the concerns or issues brought forth by residents during any of the resident council or food committee meetings minutes reviewed.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>45753</p> <p>Based on observation, interview, and policy review the facility failed to secure protected health information from the public and failed to protect the resident right to privacy. This affected one resident (#45) of four residents reviewed for privacy. The facility census was 73.</p> <p>Findings include:</p> <p>Observation on 02/11/25 at 10:46 A.M. of the facility's west hallway revealed an enclosed nursing station with a facility laptop open on top of the west medication cart parked outside the nurse station. Observation of the computer revealed Resident #45's medical chart was open to private medical information and visible to the public hallway. During the observation, two visitors and various residents and staff members were present in the direct vicinity.</p> <p>Interview on 02/11/25 at 10:48 A.M., the Regional Administrator #206 confirmed the facility laptop was open to protected health information and was visible to the public hallway. The Regional Administrator was observed shutting the laptop.</p> <p>Interview on 02/11/25 at 10:56 A.M., the Licensed Practical Nurse (LPN) #195 returned to the medication cart and stated she thought she clicked the laptop off before leaving. The LPN #195 confirmed Resident #45's chart was open to medical information and visible to the public hallway.</p> <p>Review of the facility policy titled Protected Health Information Policy And Procedure revealed protected health information (PHI) is individually identifiable health information that is transmitted or maintained by electronic media or any other form or medium. PHI will be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Standards and other applicable laws.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35768</p> <p>Based on record review, interview, and policy review the facility failed to create a plan of care for a resident who had a significant change in condition following an injury. This affected one (Resident #24) of five residents reviewed for care planning. The facility census was 73.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #24 noted an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, unspecified, muscle wasting and atrophy, major depressive disorder, and other lack of coordination.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] noted Resident #24 had intact cognition. Resident #24 required maximum assistance for mobility. Further review of the MDS's noted no documentation indicating Resident #24 had a significant change in condition.</p> <p>Review of the plan of care noted Resident #24 was at risk for falls and had an activity of daily living self-care deficit. No plan of care was created to indicate Resident #24 had a fracture of the right humerus (right arm).</p> <p>Review of nurse progress notes dated 12/06/24 through 01/01/25 noted no documentation indicating Resident #24 had a significant change in condition, which included a fracture of the right humerus. Review of a progress note dated 12/12/24 indicated Resident #24 returned to the facility wearing a brace on her right arm.</p> <p>Interview on 02/11/25 at 10:35 A.M., the Administrator verified that no plan of care was created to indicate Resident #24 had a fracture to the humerus of the right arm.</p> <p>Review of the facility policy titled Care Plans, Comprehensive Person-Centered, dated 2001 noted a plan should include measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35768</p> <p>Based on record review, interview, and facility policy review, the facility failed to complete routine oral care for residents who required assistance. This affected one resident (#47) of five residents reviewed for activities of daily living. The facility census was 73.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #47 noted an admitted [DATE]. Diagnoses included unspecified dementia, unspecified severity with agitation, and anxiety disorder.</p> <p>Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] noted Resident #47 had impaired cognition. Resident #47 required touching supervision for oral hygiene.</p> <p>Review of the plan of care dated 04/03/23 noted Resident #47 had an activity of daily living self-care deficit performance. Interventions included to monitor and document any changes and any potential for improvement, reasons for deficit, and or declines in function. No interventions were provided directing staff to assist Resident #24 with oral hygiene.</p> <p>Observation on 02/09/25 at 10:05 AM, Resident #47's bottom teeth were covered with white food debris. The white debris was located in between the teeth along the gum line. Resident #47 was unable to confirm if staff assisted her with oral hygiene. Further observations noted there was one toothbrush in the bathroom which was shared by Resident#17 and #47.</p> <p>Interview on 02/11/25 at 10:12 A.M. with Dentist #211 who was at the facility treating residents stated there was no indication in her computer system indicating Resident #47 had been seen by dental services.</p> <p>Interview on 02/11/25 at 10:17 A.M. with Certified Nurse Assistant (CNA) #188 stated she was not aware of Resident #47 and stated she usually provided oral care after breakfast.</p> <p>Interview on 02/11/25 at 10:19 A.M. with Assistant Director of Nursing (ADON) #102 verified the white debris on Resident #47's bottom teeth, verified that only one toothbrush was available for both residents. Further review with the ADON noted no documentation in the medical record indicating staff had completed oral hygiene within the last 30 days. ADON #102 stated staff were to document completion and refusal for all care.</p> <p>Interview on 02/12/25 at 3:32 P.M., Social Services Designee (SSD) #115 stated Resident #47 refused a lot, however, no documentation was provided to indicate Resident #47 refused dental care in 2024.</p> <p>Review of the facility policy titled Activities of Daily Living (ADL), Supporting, Comprehensive Person-Centered, dated 2001 noted appropriate care and services would be provided for residents who were unable to carry out ADL's independently, with the consent of the resident in accordance with the plan of care, including appropriate support and assistance with oral care.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51518</p> <p>Based on staff interviews and record review, the facility failed to arrange for transportation to outside medical appointments. This affected one (Resident #46) resident out of three residents reviewed for transportation to outside appointments. The facility census was 73.</p> <p>Findings include:</p> <p>Resident #46 was admitted on [DATE] with diagnosis of multiple sclerosis, neuromuscular dysfunction of bladder and morbid obesity.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 was cognitively intact and was dependent on one staff person for completing activities of daily.</p> <p>Further review of Resident #46's medical record revealed that Resident #46 had an outside appointment on 01/09/25 at 8:55 A.M. at a local hospital with a plastic surgeon for wound care services. No evidence was present in the medical record that Resident #46 attended her scheduled appointment on 01/09/25. The medical record also noted that Resident #46 attended another outside wound care appointment on 01/16/25 with instructions to follow up in three weeks. No other appointments were attended or scheduled for Resident #46 in her medical record.</p> <p>Interview on 02/10/25 at 2:40 P.M. with Director of Nursing (DON) and Assistant Director of Nursing (ADON) #102 verified Resident #46 did not attend her wound care appointment on 01/09/25 and had no other wound care appointments scheduled. The DON reported she was unsure why Resident #46 did not attend her appointment on 01/09/25, and had to phone the outside provider's office who reported the resident was listed as a no-show for the 01/09/25 appointment. The DON additionally confirmed it was the facility's responsibility to arrange for transportation to outside appointment and the resident had not refused to go to any outside appointments.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00161426 and OH00161390.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35768</p> <p>Based on observation, record review, facility policy review and interview, the facility failed to ensure Resident #24, a resident dependent on staff, was safely secured in the wheelchair in the facility bus when transporting to outside appointments to prevent a fall with injury.</p> <p>Actual harm occurred on 12/12/24 when Bus Driver (BD) #118 failed to properly secure Resident #24 in her wheelchair during a facility bus transport resulting in the resident being propelled out of her chair approximately three feet, onto the bus floor when Bus Driver #118 stopped abruptly. The resident sustained a right humerus (arm) fracture as a result of the incident. This affected one resident (#24) of three residents reviewed for accidents. Additionally, the facility failed to ensure a non-flammable protective cover was provided to a resident known to drop cigarette ashes during smoking, placing the resident at risk for more than minimal harm which did not rise to Actual Harm. This affected one resident (#30) of 11 residents reviewed for smoking. The facility census was 73.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, unspecified, muscle wasting and atrophy, major depressive disorder, and other lack of coordination.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] noted Resident #24 had intact cognition. The assessment revealed Resident #24 required maximum (staff) assistance for activities of daily living and utilized an electric wheelchair for mobility.</p> <p>Review of the undated plan of care revealed Resident #24 was at risk for falls and had an activity of daily living self-care deficit.</p> <p>Review of nurse progress notes dated 12/06/24 through 01/01/25 revealed no documentation indicating Resident #24 had experienced a change in condition.</p> <p>Review of a progress note dated 12/12/24 indicated Resident #24 returned to the facility wearing a brace on her right arm. No additional progress notes were provided that indicated Resident #24 had sustained a significant injury, a fracture of the right humerus, on 12/12/24.</p> <p>Review of emergency room documentation dated 12/12/24 noted Resident #24 sustained a shoulder, leg, and head injury. Resident #24 received a computed tomography scan (CT) of the brain, cervical, right elbow and shoulder. The results of the CT's noted a fracture to Resident #24's right humerus.</p> <p>Review of the statement from Resident #24 dated 12/12/24 revealed BD #118 had to stop abruptly causing her to fall out of her wheelchair. Resident #24 stated she needed to be secured facing 90 degrees from the front of the bus (facing sideways) because it allowed her to have her leg rest on the electric wheelchair fully extended as her leg was in a brace and the electric wheelchair did not fit facing forward.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the written statement from BD #118 dated 12/12/24 revealed he had slammed on the brakes to prevent hitting a vehicle who was in front of him. BD #118 stated Resident #24 came out of her chair, he called emergency services who then transported Resident #24 to the hospital.</p> <p>Review of an undated folder provided by the Administrator for bus training and information noted a training packet titled Sure-Lok, Safe and Secure. The training consisted of pre-trip assessment, sensitivity training, securing the wheelchair, securing the occupant, system care and maintenance, and hands-on training. The Securing the Wheelchair, section of the training indicated correctly securing the wheelchair is extremely important for the safety and comfort of the passenger as well as for your peace of mind. Injury or death may result from improper securement. The section indicated residents should be facing the front of the vehicle.</p> <p>Review of the Securing the Occupant, section of the training indicated to attach the lap belt around the passenger by threading the belt through the opening between the side panel or the seat back and the seat cushion. Position the lap belt around the occupant's pelvis zone near the hip, with the buckle of the lap belt placed opposite to the side where the shoulder belt is attached to the wall.</p> <p>Review of a facility investigation file following the 12/12/24 incident, provided by the Administrator, contained a certificate for Bus Driver (BD) #118 titled Defensive Driving Training, dated 04/15/22, an electronic receipt indicating the facility purchased an online course titled Passenger Assistance Safety and Sensitivity, (PASS), dated 12/16/24 for BD #118 and #119, a certificate of completion for the PASS program dated 01/15/25 for BD #118, and a written statement from Resident #24. The investigative file contained no additional staff interviews, interviews with residents who used a wheelchair and were transported on the facility bus, and no additional staff training records. There was no evidence the bus had been audited or inspected for proper harness functioning following the 12/12/24 incident.</p> <p>Review of personnel file revealed BD #118 was hired on 05/01/21. Further review noted no evidence BD #118 received training related to resident safety when transporting residents. A document titled Risk Management, policy, Driving/Vehicle Fleet Safety Program consisting of driver responsibilities indicated BD #118 reviewed and signed the training 04/15/22 and again on 02/11/25. No documentation was provided to indicate BD #118 received the Sure-Lok, Safe and Secure training.</p> <p>Review of personnel file noted BD #119 was hired on 09/17/24 in housekeeping. BD #119 stated started driving the facility bus in November 2024. Further review noted no evidence BD#119 received training related to resident safety when transporting residents. A document titled Risk Management, policy, Driving/Vehicle Fleet Safety Program consisting of driver responsibilities indicated BD #119 reviewed and signed the initial training 02/11/25. No documentation was provided to indicate BD#118 and #119 received the Sure-Lok, Safe and Secure training.</p> <p>An interview on 02/09/25 at 10:35 A.M. with Resident #24 revealed (on 12/12/24) she was on the facility bus heading for a pre-operative appointment. The bus driver slammed on the brakes, she flew out of her wheelchair, and fractured her right arm. Resident #24 reported BD #118 did not secure her wheelchair correctly in the bus causing it to fall on its side allowing her to fall out during the transport. Following the incident, Resident #24 stated her right arm fracture was deemed non-surgical. She received occupational therapy to treat and utilized oral pain medication to control the right arm pain.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 02/10/25 at 8:54 A.M. with BD #118 revealed (on 12/12/24) he was taking Resident #24 to an appointment when he had to slam on the brakes to prevent hitting a vehicle in front of him due to icy road conditions. BD #118 stated Resident #24 fell out of her wheelchair and he called emergency services who transported Resident #24 to the hospital. BD #118 stated Resident #118 was facing sideways in the facility bus. BD #118 reported the wheelchair was difficult to secure due to the width and he had to figure out a way to secure the harness because the harness would not tighten. BD #118 stated in a joking manner that he could have jimmed out of the harness.</p> <p>An interview on 02/10/25 at 11:21 A.M. with the Administrator revealed she was notified of the incident (on 12/12/24) with Resident #24 and the facility bus after being alerted by the [NAME] President of the company, who was driving down the road and observed the facility bus pulled over on the side of the road. The Administrator stated the bus driver called emergency services to transport Resident #24 to the hospital. Following the incident, the facility interviewed the bus driver and Resident #24. The Administrator reported she arranged online driver safety training for BD #118 and the one other facility bus driver, BD #119.</p> <p>An interview on 02/10/25 at 3:28 P.M. with BD #119 revealed she started driving (the facility bus) in November 2024 and she always positioned residents facing forward. A follow-up interview on 02/11/25 at 9:17 A.M. revealed BD #119 stated she was unsure if she received formal training related to driving the facility bus. BD #119 stated she did receive hands-on training from BD #118, who showed her how to secure residents in wheelchairs in a perpendicular position (facing the side of the bus). BD #119 stated she placed residents forward-facing as she did not feel comfortable positioning residents in the perpendicular position. BD #119 confirmed she had not yet completed the online PASS training yet.</p> <p>An interview on 02/11/25 at 10:35 A.M. with the Administrator revealed she did not think the bus drivers received formal training, rather the new staff were just trained by other staff. The Administrator stated the Risk Management policy should be reviewed and signed yearly by the bus drivers, and verified BD #118 did not review and sign an acknowledgement of the policy in 2024. The Administrator also verified BD #119 did not review and sign acknowledgement of the policy before moving into a bus driver role.</p> <p>During an interview on 02/11/25 at 4:04 P.M., the Regional Director of Operations (RDOO) #206, [NAME] President of Clinical Operations (VPCO) #202, and [NAME] President of Operations (VPO) #116, were informed of the survey team's concerns related to the fall incident, lack of fall investigation, lack of training, failure to report the incident to the State Agency, and the lack of documentation in Resident #24's medical record related to the 12/12/24 incident. VPO #116 verified the findings and shared the facility had begun to implement corrective action.</p> <p>Observation of the facility bus and interview on 02/12/25 at 8:22 A.M. with Regional Maintenance Director (RMD) #205 revealed there is no safe way to secure a wheelchair or the resident when it is placed perpendicular to the front of the bus. I would never transport a resident placed perpendicular to the front of the bus.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Medina Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  555 Springbrook Dr Medina, OH 44256	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the facility bus and interview on 02/12/25 at 9:35 A.M. with BD #118, who was called into the facility to complete driver training, revealed he was learning a lot with the training. BD #118 stated he never knew he was not supposed to transport residents facing sideways. BD #118 demonstrated the hands-on steps he took to secure Resident #24 in a perpendicular position. BD #118 stated he used the shoulder straps and noted they were difficult to use due to the resident's size, wheelchair, and position of the wheelchair. BD #118 proceeded to illustrate where Resident #24 fell and slid. Further observations of the bus indicated Resident #24 fell forward approximately three feet before hitting the floor and then slid an additional four feet, landing in the aisle on her right side.</p> <p>An interview on 02/12/25 at 10:00 A.M. with Paramedic #201, who responded to the scene on 12/12/24, revealed Resident #24's wheelchair was upright and secured to the floor of the bus. Upon arrival, Resident #24 was positioned on her right side on the floor of the bus.</p> <p>Review of the facility policy titled Abuse Prohibition Policy and Procedure, dated 2023 defined neglect as failure to provide goods and services necessary to avoid physical harm, mental-anguish, or mental illness.</p> <p>Review of the facility policy titled Residents Right to Freedom from Abuse, Neglect, and Exploitation, dated 2023 noted the facility would investigate any allegations made alleging abuse, neglect, and exploitation of residents. The facility would ensure that any suspicion of resident abuse, or neglect was coordinated with the facilities Quality Assurance and Performance Improvement (QAPI) program.</p> <p>38523</p> <p>2. Resident #30 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, hemiplegia affecting the left non-dominant side, contracture of unspecified hand, and nicotine dependence.</p> <p>Review of Resident #30's physician's orders revealed an order dated 05/05/24 for the resident to be supervised while smoking.</p> <p>Resident #30's smoking assessment dated [DATE] revealed the resident was noted to have cognitive loss. Resident #30 was referenced to have a dexterity problem. Resident #30 was noted to smoke between five and ten cigarettes per day and smoked in the morning, afternoon, evening and night. Resident #30 was not able to light his own cigarettes and required supervision. The assessment noted the facility stored the resident's lighter and cigarettes.</p> <p>Review of Resident #30's MDS annual assessment dated [DATE] revealed the resident was cognitively intact. Resident #30 was noted to have a functional limitation in range of motion with an impairment on one side of both the upper and lower extremities. Resident #30 was noted to use a wheelchair and was dependent on staff for activities of daily living.</p> <p>Review of Resident #30's smoking care plan dated 02/04/25 revealed he was at risk for injury related to smoking. Interventions included maintaining a safe environment during smoking, provide supervision at all times for smoking and smoking items are to be kept at the nurses station.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 02/19/25 at 1:46 P.M. of Resident #30 revealed many burn holes in his blanket, when the blanket was removed by staff, there were numerous burn holes in his sweatpants. An interview at the time of observation with Agency CNAs #211 and #212 confirmed the burn holes present in the resident's sweatpants and blanket.</p> <p>Observation on 02/19/25 at 4:00 P.M. during the smoke break revealed Resident #30 and 10 other Residents (#06, #14, #35/#169, #45, #46, #51, #52, #59, #68 and #174) were supervised by Dietary Aide #135. During the smoke break, Resident #30 was observed dropping hot ashes from his cigarette onto his blanket. Resident #51 proceeded to wipe the ashes off of Resident #30, onto the ground. Resident #06 noticed and thanked Resident #51 for swiping the hot ashes off Resident #30's blanket as she was going to swipe them off too. Resident #06 was observed to have burn holes in her coat.</p> <p>Interview on 02/19/25 at 4:04 P.M. with Dietary Aide #135 verified no residents were wearing a smoking apron, blanket, or other non-flammable protective cover to protect from hot ashes or burns. Dietary Aide #135 also verified multiple burn holes in the blanket of Resident #30 from hot ashes falling from his cigarette. She stated Resident #30 needed a smoking apron, but she did not know where they were kept, or which residents required a smoking apron She also verified two other Residents (#06 and #52) were also noted with burn holes in their clothing and/or coat.</p> <p>Smoking observation on 02/20/2025 at 9:15 A.M. revealed Housekeeper #143 was supervising the smoke break. Hot ashes were observed to fall from Resident #30's cigarettes, onto his blanket, which had numerous burn holes present. When the surveyor pointed out the hot ashes landing on Resident #30's blanket, Housekeeper #143 proceeded to brush the ashes off of Resident #30's blanket. Housekeeper #143 revealed there were no smoking aprons available but there was a smoking blanket inside the building.</p> <p>Interview with the [NAME] President of Clinical Operations #202 on 02/20/2025 at 12:30 P.M. revealed the facility did not have a policy addressing smoking safety including residents wearing smoking aprons for residents who require them per their smoking assessment.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161426.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>38091</p> <p>Based on record review, resident interview, staff interview, review of the resident council meeting minutes, review of the grievance log, and facility policy review, the failed to be adequately staffed to meet the needs of its residents. This had the potential to affect all residents. The facility census was 73.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Interview on 02/09/24 at 8:45 A.M. with Resident #3 revealed concerns related to sufficient facility staffing, notably on the weekends and night shift.</li> <li>2. Interview on 02/09/24 at 2:02 P.M. with Resident #44 revealed concerns related to sufficient facility staffing. Resident #1 further stated that he has missed medications due to insufficient facility staffing and is of the belief many of his skin related to issues could have been solved by increased staffing levels.</li> <li>3. Interview on 02/10/24 at 9:12 A.M. with Resident #1 revealed concerns related to sufficient facility staffing. Resident #1 stated call light response time is often up to four hours.</li> <li>4. Interview on 02/19/24 at 2:30 P.M. with the family member of Resident #54 revealed staffing is horrible.</li> <li>5. Interview on 02/19/25 at 3:00 P.M. with Licensed Practical Nurse (LPN) #701 revealed first shift workers often complain about night shift completing standard job duties.</li> <li>6. Interview on 02/19/25 at 3:24 P.M. with Certified Nursing Assistant (CNA) #800 revealed night shift workers are not nearly as productive as day shift workers.</li> <li>7. Interview on 02/19/25 at 4:10 P.M. with Resident #52 revealed call lights are often never answered and night shift is extremely understaffed.</li> <li>8. Interview on 02/19/25 at 4:12 P.M. with Resident #6 revealed the facility is in desperate need of more staff.</li> <li>9. Interview on 02/20/25 at 9:00 A.M. with Licensed Practical Nurse (LPN) #702 revealed she works both day and night shift and during night shift no one is ever here.</li> <li>11. Interview on 02/20/25 at 9:12 A.M. with Resident #25 revealed you can't get anything done at night due to lack of staff.</li> <li>12. Review of the minutes from the resident council meeting revealed the following documented concerns about staffing ratios and/or quality of staff during the resident council meetings held on 11/30/23, 01/25/24, 04/25/24, 06/27/24, 07/25/24, 08/29/24, 09/09/24, and 10/31/24.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>13. An interview during the completion of the resident council portion of the annual recertification survey on 02/11/25 between 2:58 P.M. and 3:30 P.M. with Residents #6, #25, #44 and #51 revealed numerous concerns related to sufficient facility staffing and staffs ability to meet their needs timely.</p> <p>14. Review of the grievance log revealed Resident #44 filed a formal grievance on 09/09/24 regarding concerns related to night shift staffing. No resolution was noted on the log.</p> <p>15. Review of the quality assurance performance improvement report from the facilities Human Resources/Staffing Coordinator and/or the Administrator from 03/27/24, 06/26/24, 07/11/24, 08/21/24, 09/20/24,10/23/24, 11/13/24, and 01/16/25 revealed concerns/goals of the facility to hire more staff, reduce staff turnover and increase customer service from staff.</p> <p>Review of the policy entitled Staffing, Sufficient and Competent Nursing dated 08/01/22 revealed the facility provides sufficient numbers of nursing staff with appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. The policy further noted minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161426 and OH00161390.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>38091</p> <p>Based on record review and staff interview the facility failed to ensure the service of a Registered Nurse (RN) for at least eight hours a day seven days a week as required. This had the potential to affect all residents. The facility census was 73.</p> <p>Findings include:</p> <p>Review of the staffing schedule and posted nursing staff information for 12/21/24 revealed the facility did not have eight hours of Registered Nurse (RN) coverage as required. The facility had evidence of only four total hours of RN coverage on 12/21/24.</p> <p>Interview with Scheduler #111 on 02/19/25 at 11:11 A.M. verified the lack of required RN hours.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161426 and OH00161390.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35768</p> <p>Based on record review, observation and interview, the facility failed to ensure medications were properly secured. This affected two residents (#11 and #52) of six residents observed for medication administration. The facility census was 73.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, bi-polar disorder, schizoaffective disorder, type two diabetes, dementia with behavioral disturbance, and depressive disorder.</p> <p>Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] noted Resident #11 had intact cognition.</p> <p>Observation on 02/09/25 at 10:24 A.M. noted medications located in a medication cup on Resident #11's bedside table. Interview during the observation, Resident #11 stated I didn't take my medications yet.</p> <p>Interview on 02/09/25 at 10:27 A.M. with Unit Manager #103 verified the resident's medications were left at the bedside.</p> <p>Interview on 02/09/25 on 02/09/25 at 10:30 A.M., Licensed Practical Nurse (LPN) #204 identified the medications as divalproex (an anti-seizure medication), duloxetine (an antidepressant), levetiracetam (an anticonvulsant), aspirin, iron, cranberry, amlodipine (antihypertensive), metoprolol (antihypertensive), sucralfate (an anti-ulcer medication), and hydralazine (antihypertensive). LPN #204 stated yep, that was my fault and she should not have left the medications at the resident's bedside.</p> <p>38523</p> <p>2. Resident #52 was admitted to the facility on [DATE] and continues to reside in the facility. Diagnoses included Wernicke's encephalopathy (a serious neurological condition caused by a vitamin deficiency which can cause confusion and lack of muscle coordination), chronic obstructive pulmonary disease (COPD) and alcohol abuse.</p> <p>Review of Resident #52's Medication Administration Record (MAR) dated 02/2025 revealed 7:00 A.M. medications signed off at that time included aspirin, cholecalciferol (vitamin supplement), donepezil (used to treat cognitive impairments), escitalopram (antidepressant), finasteride (used to treat urinary retention), folic acid, lasix (diuretic), lisinopril (antihypertensive), meloxicam (nonsteroidal anti-inflammatory drug used to treat pain), multivitamin with minerals, potassium chloride, thiamine (supplement) cimetidine (used to treat stomach ulcers), and senna (laxative).</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 02/09/25 at 3:09 P.M. with Resident #52 revealed a medicine cup with four tablets of Tums (used to decrease stomach acid) in it on the nightstand. A second medication cup on the bedside table revealed at least nine pills in the cup of his morning medications. When asked about the cup of pills, Resident #52 stated he had not yet taken his 7:00 morning medications. He picked out the green pill &amp; tossed it on the bed. He said he was not going to take that one and did not know what it was for. A follow up interview at 3:24 P.M. with Resident #52 reported his medications are sometimes left at his bedside by various nursing staff members. Resident #52 stated he takes the medications if and when he wants to.</p> <p>Interview on 02/09/25 at 3:56 P.M. with LPN #204 verified four Tums in a medication cup on the night stand and he confiscated them and compared them to the bottle of TUMS in the cart. LPN #204 additionally confirmed he left a medication cup of Resident #52's 7:00 A.M. ordered medications at the resident's bedside and recorded them as administered without watching the resident ingest his ordered morning medications.</p> <p>Review of the facility policy titled Medication Labeling and Storage, policy dated 2001 indicated staff were responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161426.</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>51518</p> <p>Based on observation, resident interview, and record review revealed the facility failed to provide palatable food to residents. This had the potential to affect all residents residing in the facility. The facility census was 73.</p> <p>Findings include:</p> <p>Review of food committee meeting minutes from July 2024 through February 2025 revealed residents had concerns related to cold food and coffee, the facility not using hot packs, and food palatability.</p> <p>Review of grievance logs between August 2024 and February 2025 revealed on 08/26/24, Resident #56 reported there were no hot plates (to keep food warm) provided and that residents were unhappy with their meals. On 09/09/24, Resident #10 reported their food was cold. On 01/30/25, Resident #6 reported the meat is trash.</p> <p>Interview on 02/09/25 at 10:30 AM with Resident #46 revealed the food is bland and usually not warm.</p> <p>Interview on 02/09/25 at 11:15 A.M. with Resident #51 revealed the food does not taste good and is cold.</p> <p>Interview on 02/09/25 at 01:57 P.M. with Resident #36 revealed the food is nasty.</p> <p>An observation and interview on 02/09/25 at 6:00 P.M. revealed a test tray was completed after half of the room trays were served. The meal consisted of a barbeque (BBQ), pork sandwich and baked beans. The BBQ pork sandwich was noted to be 115 degrees Fahrenheit (F) and the baked beans were noted to be 113.7 degrees F. Both the BBQ pork and baked beans tasted lukewarm and appeared unappetizing. The BBQ pork had a white color, was overcooked, had a mushy texture yet was difficult to chew. The baked beans had no seasoning and tasted bland. The temperatures and condition of the food were verified with Dietary Manager (DM) #114 at the time of the test tray.</p> <p>Interviews conducted with residents during the completion of the resident council portion of the annual survey on 02/11/25 between 3:00 P.M. and 3:30 P.M. with Residents #6, #8, #28 and #51 revealed multiple food quality concerns.</p> <p>An observation and interview on 02/18/25 at 12:24 P.M. revealed a test tray was completed after all room trays were served. The meal consisted of pasta, brussels sprouts, and crushed pineapple. The pasta was noted to be 121 degrees F, the brussels sprouts were noted to be 127.2 degrees F, and the crushed pineapple was noted to be 51.6 degrees F. The temperatures were verified with DM #114 at the time of the test tray.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161426.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51518</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect all 73 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation and interview on 02/09/25 between 8:52 A.M. and 9:35 A.M. with [NAME] #118 during a kitchen tour revealed the following:               <ol style="list-style-type: none"> <li>a. One bottle of vanilla with expiration date of 02/10/24.</li> <li>b. The shelf under tray line had rust, food debris, and crumbs on it.</li> <li>c. The ice machine had noticeable rust on the door hinge.</li> <li>d. Significant areas of crumbs and food debris were observed on the floor in the dry storage area.</li> <li>e. The air vent next to the food preparation area was rusted and had a thick layer of grime on it.</li> <li>f. A large brown stain and crack on ceiling above the three-compartment sink was noted.</li> <li>g. The seal on the refrigerator door was falling off and not attached to door.</li> <li>h. The walk-in freezer had an ice cream tub wedged underneath a pipe. The pipe had dripped water onto the ice cream tub and a large ice chunk had formed on the lid. The ice cream tub was unable to be opened. The walk-in freezer was observed to have large ice chunks on the floor from the pipe.</li> </ol> </li> </ol> <p>An interview at the time of observation with [NAME] #118 confirmed the above findings. [NAME] #118 stated he had worked at the facility for eight years, and the walk-in freezer had always been in that condition.</p> <ol style="list-style-type: none"> <li>2. Observation and interview on 02/11/25 at 2:45 P.M. with Dietary Manager #114 and Dietician #193 revealed the dementia unit kitchen was noted to have splatter and food debris on kitchen cabinets and the microwave was soiled with food debris. A resident's slippers were in the kitchen next to the trash can with a broom and dust pan placed on top of them. The findings were confirmed at the time of observation with Dietary Manager #114 and Dietician #193.</li> </ol>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>51518</p> <p>Based on observation and staff interview, the facility failed to maintain its garbage disposal area in a clean and sanitary condition. This had the potential to affect all 73 residents in the building.</p> <p>Findings include:</p> <p>Observation on 02/09/25 at 9:10 A.M. revealed one of two outside dumpsters did not have a lid and there were multiple latex gloves, a large cardboard box near the woods and other miscellaneous trash on ground around the dumpster. Additional trash and debris was observed to have blown into the grass and woods behind the dumpster.</p> <p>Observation and interview on 02/09/25 at 3:48 P.M. with Dietary Manager (DM) #114 verified that the dumpster did not have a cover and confirmed observation of trash around dumpster.</p>

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<p>F 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38091</p> <p>Based on review of the facility assessment and staff interview, the facility failed to ensure the facility assessment contained all required information. This had the potential to affect all 73 residents residing in the facility. The facility census was 73.</p> <p>Findings Include:</p> <p>Review the facility assessment dated [DATE] revealed the assessment did not contain evidence of direct input into the assessment from direct care staff (including but not limited to input from Registered Nurses (RN), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs)) and a plan to maximize recruitment and retention of direct care staff.</p> <p>Interview on 02/20/25 at 11:11 A.M. with Regional Administrator (RA) #206 verified the assessment did not contain all required information.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45753</b></p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to maintain an infection prevention program to prevent, recognize, and control transmission of communicable disease. This affected two residents (#32 and #33) of four residents sampled and had the potential to affect all facility residents. The facility census was 73.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the medical record for Resident #32 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included cognitive communication deficit, moderate intellectual disabilities, abnormalities of gait and mobility, anxiety, and muscle weakness.</li> </ol> <p>Review of Resident #32's physician orders revealed the resident was to attend an outside adult day program Monday through Friday. An order dated 12/26/24 revealed the resident was to have skin sweeps performed twice daily, every day and night shift for monitoring for three days.</p> <p>Review of an email dated 12/19/24 at 2:03 P.M. from the adult day program to the Director of Nursing (DON) revealed Resident #32 was exposed to scabies at the adult day program. The local health department had recommended the day program reach out to potential exposures and close contacts. The email reported to contact the resident's provider to discuss the need for a cream to treat. The email communicated Resident #32 would not be able to return to the adult day program until 24 hours after the first treatment as a precaution.</p> <p>Review of the facility assessment dated [DATE] under Part 1 Our Residents Profile indicated infectious diseases/conditions that require complex medical care and management include skin and soft tissue infections, respiratory infections, tuberculosis, urinary tract infections, infections with multi-drug resistant organisms, septicemia, viral hepatitis, clostridium difficile, influenza, scabies, legionellosis.</p> <p>Review of Resident #32's plan of care revised on 01/13/25 revealed the resident had impaired cognitive function/dementia or impaired thought processes related to developmentally delayed and impaired decision making. Interventions included to keep the resident's routine consistent and to provide consistent caregivers as much as possible in order to decrease the resident's confusion.</p> <p>Interview on 02/10/25 at 12:12 P.M. with the guardian for Resident #32 revealed they had been notified that the resident had been exposed to scabies by a close contact at the resident's adult day program. The program manager reported the potential exposure to the facility DON on 12/19/24. The guardian stated the DON was not going to treat the Resident #32 and stated the physician had instead ordered skin assessments twice daily. The guardian confirmed the exposure letter, and recommended treatment, was provided to the DON. The guardian further stated the Resident #32 was unable to return to the day program for six weeks if not treated and a request was made to transfer the Resident #32 to a facility that would treat Resident #32 for scabies exposure.</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 - Many</p>	<p>Interview on 02/10/25 at 3:25 P.M., the DON verified she spoke with the legal guardian of Resident #32 and was notified of the Resident #32's close contact <i>Sarcoptes scabiei</i> (scabies) exposure at outside day program. The DON stated the guardian demanded the Resident #32 be treated for scabies. The DON stated she verbally reported the information to the Nurse Practitioner and an order was placed for skin checks twice daily for three days. The DON confirmed three out of six skin checks had not been completed per the physician order. The DON confirmed no documentation of a physician assessment or clinician progress notes were available regarding the scabies exposure. The DON further confirmed the reported scabies exposure was not reported to the infection control designee, staff, or Resident #32's roommate. The DON stated no additional investigation, follow up, or infection surveillance was performed. The DON stated, we are not going to treat what a resident does not have.</p> <p>Interview on 02/11/25 at 1:43 P.M. of the outside day Program Manager #860 revealed the program had sent recommendations to the facility, from the local health department, regarding direct contact exposure to scabies and treatment. The program manager stated the Resident #32's facility refused to treat her and Resident #32 was unable to return to the day program until treated or six weeks post-exposure.</p> <p>Interview on 02/11/25 at 2:02 P.M. with the outside day program Operations Manager #910 revealed on 12/19/24, Resident #32 was sent home with a letter stating the Resident #32 was in direct contact to another individual who was positive for scabies. The operations manager stated the local health department advised treatment based on close scabies exposure and the Resident #32 was not able to return to the day program until 24 hours after treatment. On 12/26/24, the guardian contacted the operations manager and stated the facility would not treat the Resident #32 or prescribe medication to treat exposure.</p> <p>Interview on 02/11/25 at 3:10 P.M. with Assistant Director of Nursing (ADON) #102 revealed the Resident #32's guardian had reported the scabies exposure to the nurse on duty. The ADON #102 verified she was the facility Infection Preventionist and stated a nurse had reported the exposure to her. The ADON #102 was unable to identify the nurse who reported the exposure and further verified no additional infection control or surveillance was initiated.</p> <p>Review of the Resident #32's discharge order revealed a discharge was initiated on 12/27/24 and the Resident #32 was discharged to another skilled nursing facility on 12/30/24.</p> <p>Review of the facility policy titled Scabies Identification, Treatment and Environmental Cleaning dated August 2016 revealed the purpose of the policy was to treat residents infected with and prevent the spread of scabies to other residents and staff. Scabies is an itching skin irritation caused by the microscopic human itch mite, which burrows into the skin's upper layers and eventually causes itching, tiny irregular red lines just above the skin, and an allergic rash. The incubation period can range between 2-6 weeks before onset of symptoms. Affected residents should remain on contact precautions until 24-hours after treatment. Family and friends of residents who have had close contact should be notified and given instructions regarding self-examination and treatment.</p> <p>2. Review of the medical record for the Resident #33 revealed an admitted [DATE]. Diagnosis included Alzheimer's Disease, abnormalities of gait/mobility, depressive disorder, hearing loss, and falls.</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 - Many</p>	<p>Review of the physician orders dated 01/29/25 revealed to cleanse Resident #33's wound to right buttocks with Normal Saline and apply a wet-to-dry dressing every shift until healed. Resident #33 also had an order to empty Foley (urinary drainage) bag every shift and as needed.</p> <p>Observation of wound care on 2/12/25 at 2:58 P.M. with ADON #102 revealed she gathered wound supplies and placed them directly on Resident #33's side table next to a styrofoam cup with straw without disinfecting the side table or creating a barrier for aseptic technique.</p> <p>Observation of urinary catheter care on 2/12/25 at 3:00 P.M. with ADON #102 revealed after draining the urine from the drainage bag, the ADON #102 did not wipe the drain with an antiseptic wipe per protocol.</p> <p>Interview on 02/12/25 directly following the observations, the ADON #102 confirmed the above findings.</p> <p>Review of the facility policy titled Wound Care revealed a disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached.</p> <p>Review of the Certified Nurse Aide (CNA) training on emptying urinary catheters included after draining urine into the graduated cylinder until bag is empty, close the drain, and wipe the drain with an antiseptic wipe after the drainage bag is empty.</p> <p>Review of the facility policy titled Introduction: Infection Prevention and Control in Long-Term Care, revised on 12/2023 revealed the purpose of Infection prevention and control programs (IPCP) should fulfill essential functions and also be flexible enough to fit a facility's specific environment, pertinent to residents' potential and actual problems, and able to accommodate new issues or requirements. The elements of the IPCP should include the following:</p> <ul style="list-style-type: none"> <li>o Coordination and Oversight</li> <li>o Policies and Procedures</li> <li>o Surveillance and Data Analysis</li> <li>o Antibiotic Stewardship</li> <li>o Prevention of Healthcare Associated Infections</li> <li>o Outbreak Management</li> <li>o Influenza and Pneumococcal Immunization</li> <li>o Employee Health and Safety</li> </ul> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00161888.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>45753</p> <p>Based on record review, interview, and review of facility policy, the facility failed to designate a certified infection preventionist responsible for the infection control and prevention program. This affected one resident (Resident #32) of four residents sampled and had the potential to affect all facility residents. Facility census was 73.</p> <p>Findings include:</p> <p>Review of the Infection Preventionist certification from The Centers for Disease Control and Prevention (CDC) revealed the Assistant Director of Nursing (ADON) #102 completed the Nursing Home Infection Preventionist Training Course, (#WB4448R) on 02/10/25.</p> <p>Review of the facility staffing records during the annual survey revealed a part-time qualified infection control preventionist was not present in the building as required.</p> <p>Review of the quarterly Quality Assurance and Performance Improvement (QAPI) committee meeting documentation revealed an Infection Preventionist was not in attendance on 10/23/24, 11/6/24, 01/16/25. No other documentation was provided.</p> <p>Interview on 02/20/25 at 12:09 P.M., the VP of Clinical Operations #202 confirmed no additional documentation of a qualified infection control preventionist working part-time at the facility was available from date of last annual survey, 04/24/23 until 02/10/25.</p> <p>Interview on 02/20/25 during the annual survey, Regional Administrator #203 confirmed the infection preventionist was not documented at the QAPI committee meetings as required.</p> <p>Review of the facility policy titled Introduction: Infection Prevention and Control in Long-Term Care, revised on 12/2023 revealed the purpose of Infection prevention and control programs (IPCP) should fulfill essential functions and also be flexible enough to fit a facility's specific environment, pertinent to residents' potential and actual problems, and able to accommodate new issues or requirements.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>51518</p> <p>Based on observation and interview, the facility failed to ensure residents had a functional call light. This affected one (Resident #46) of 25 sampled residents. The facility census was 75.</p> <p>Findings include:</p> <p>Observation and interview on 02/09/25 at 10:25 A.M. with Resident #46 revealed that it can take hours for her call light to be answered. Resident #46 pressed her call light at 10:37 A.M. the visual light outside Resident #46's room indicating Resident #46 call light was activated was not illuminated to alert staff she required assistance.</p> <p>Observation and interview on 02/09/25 at 10:46 A.M. with Certified Nursing Assistant (CNA) #192 confirmed that Resident #46's call light outside her door was not working.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35768</p> <p>Based on record review, observations and interview, the facility failed to maintain a safe and sanitary resident environment. This affected one (Resident #23) of 18 residents observed for environment.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #23 noted an admitted [DATE]. Diagnoses included unspecified dementia, without behavioral disturbance, type two diabetes mellitus, cognitive communication deficit.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] noted Resident #23 had intact cognition.</p> <p>Observation on 02/09/25 at 10:30 A.M. of Resident #23's room noted two large holes in the wall measuring approximately six inches in width by seven inches in length behind the headboard and miscellaneous debris including dust, food wrappers, and crumbs. Interview during observations, Resident #23 stated the holes in the wall were there since he moved in.</p> <p>Interview on 02/09/25 at 10:49 A.M., Housekeeper #117 verified the observations.</p> <p>Observations and interview on 02/12/25 8:56 A.M., [NAME] President of Operations #202 verified the holes in the wall and debris and stated she would have that fixed immediately.</p> <p>Review of the facility policy titled Quality of Life-Homelike Environment, not dated noted the facility shall maximize, to the extent possible, the characteristics that reflect a clean sanitary and orderly environment.</p>

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35768</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff approved to drive the facility bus were appropriately trained on safety mechanisms in the facility bus upon hire and annually. This affected one resident (#24) of three residents reviewed for accidents. The facility census was 73.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, unspecified, muscle wasting and atrophy, major depressive disorder, and other lack of coordination.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] noted Resident #24 had intact cognition. The assessment revealed Resident #24 required maximum (staff) assistance for activities of daily living and utilized an electric wheelchair for mobility.</p> <p>Review of the undated plan of care revealed Resident #24 was at risk for falls and had an activity of daily living self-care deficit.</p> <p>Review of nurse progress notes dated 12/06/24 through 01/01/25 revealed no documentation indicating Resident #24 had experienced a change in condition.</p> <p>Review of a progress note dated 12/12/24 indicated Resident #24 returned to the facility wearing a brace on her right arm. No additional progress notes were provided that indicated Resident #24 had sustained a significant injury, a fracture of the right humerus, on 12/12/24.</p> <p>Review of emergency room documentation dated 12/12/24 noted Resident #24 sustained a shoulder, leg, and head injury. Resident #24 received a computed tomography scan (CT) of the brain, cervical, right elbow and shoulder. The results of the CT's noted a fracture to Resident #24's right humerus.</p> <p>Review of the statement from Resident #24 dated 12/12/24 revealed BD #118 had to stop abruptly causing her to fall out of her wheelchair. Resident #24 stated she needed to be secured facing 90 degrees from the front of the bus (facing sideways) because it allowed her to have her leg rest on the electric wheelchair fully extended as her leg was in a brace and the electric wheelchair did not fit facing forward.</p> <p>Review of the written statement from BD #118 dated 12/12/24 revealed he had slammed on the brakes to prevent hitting a vehicle who was in front of him. BD #118 stated Resident #24 came out of her chair, he called emergency services who then transported Resident #24 to the hospital.</p> <p>(continued on next page)</p>

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an undated folder provided by the Administrator for bus training and information noted a training packet titled Sure-Lok, Safe and Secure. The training consisted of pre-trip assessment, sensitivity training, securing the wheelchair, securing the occupant, system care and maintenance, and hands-on training. The Securing the Wheelchair, section of the training indicated correctly securing the wheelchair is extremely important for the safety and comfort of the passenger as well as for your peace of mind. Injury or death may result from improper securement. The section indicated residents should be facing the front of the vehicle.</p> <p>Review of the Securing the Occupant, section of the training indicated to attach the lap belt around the passenger by threading the belt through the opening between the side panel or the seat back and the seat cushion. Position the lap belt around the occupant's pelvis zone near the hip, with the buckle of the lap belt placed opposite to the side where the shoulder belt is attached to the wall.</p> <p>Review of a facility investigation file following the 12/12/24 incident, provided by the Administrator, contained a certificate for Bus Driver (BD) #118 titled Defensive Driving Training, dated 04/15/22, an electronic receipt indicating the facility purchased an online course titled Passenger Assistance Safety and Sensitivity, (PASS), dated 12/16/24 for BD #118 and #119, a certificate of completion for the PASS program dated 01/15/25 for BD #118, and a written statement from Resident #24. The investigative file contained no additional staff interviews, interviews with residents who used a wheelchair and were transported on the facility bus, and no additional staff training records. There was no evidence the bus had been audited or inspected for proper harness functioning following the 12/12/24 incident.</p> <p>Review of personnel file revealed BD #118 was hired on 05/01/21. Further review noted no evidence BD #118 received training related to resident safety when transporting residents. A document titled Risk Management, policy, Driving/Vehicle Fleet Safety Program consisting of driver responsibilities indicated BD #118 reviewed and signed the training 04/15/22 and again on 02/11/25. No documentation was provided to indicate BD #118 received the Sure-Lok, Safe and Secure training.</p> <p>Review of personnel file noted BD #119 was hired on 09/17/24 in housekeeping. BD #119 stated started driving the facility bus in November 2024. Further review noted no evidence BD#119 received training related to resident safety when transporting residents. A document titled Risk Management, policy, Driving/Vehicle Fleet Safety Program consisting of driver responsibilities indicated BD #119 reviewed and signed the initial training 02/11/25. No documentation was provided to indicate BD#118 and #119 received the Sure-Lok, Safe and Secure training.</p> <p>An interview on 02/09/25 at 10:35 A.M. with Resident #24 revealed (on 12/12/24) she was on the facility bus heading for a pre-operative appointment. The bus driver slammed on the brakes, she flew out of her wheelchair, and fractured her right arm. Resident #24 reported BD #118 did not secure her wheelchair correctly in the bus causing it to fall on its side allowing her to fall out during the transport. Following the incident, Resident #24 stated her right arm fracture was deemed non-surgical. She received occupational therapy to treat and utilized oral pain medication to control the right arm pain.</p> <p>(continued on next page)</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 02/10/25 at 8:54 A.M. with BD #118 revealed (on 12/12/24) he was taking Resident #24 to an appointment when he had to slam on the brakes to prevent hitting a vehicle in front of him due to icy road conditions. BD #118 stated Resident #24 fell out of her wheelchair and he called emergency services who transported Resident #24 to the hospital. BD #118 stated Resident #118 was facing sideways in the facility bus. BD #118 reported the wheelchair was difficult to secure due to the width and he had to figure out a way to secure the harness because the harness would not tighten. BD #118 stated in a joking manner that he could have jimmed out of the harness.</p> <p>An interview on 02/10/25 at 11:21 A.M. with the Administrator revealed she was notified of the incident (on 12/12/24) with Resident #24 and the facility bus after being alerted by the [NAME] President of the company, who was driving down the road and observed the facility bus pulled over on the side of the road. The Administrator stated the bus driver called emergency services to transport Resident #24 to the hospital. Following the incident, the facility interviewed the bus driver and Resident #24. The Administrator reported she arranged online driver safety training for BD #118 and the one other facility bus driver, BD #119.</p> <p>An interview on 02/10/25 at 3:28 P.M. with BD #119 revealed she started driving (the facility bus) in November 2024 and she always positioned residents facing forward. A follow-up interview on 02/11/25 at 9:17 A.M. revealed BD #119 stated she was unsure if she received formal training related to driving the facility bus. BD #119 stated she did receive hands-on training from BD #118, who showed her how to secure residents in wheelchairs in a perpendicular position (facing the side of the bus). BD #119 stated she placed residents forward-facing as she did not feel comfortable positioning residents in the perpendicular position. BD #119 confirmed she had not yet completed the online PASS training yet.</p> <p>An interview on 02/11/25 at 10:35 A.M. with the Administrator revealed she did not think the bus drivers received formal training, rather the new staff were just trained by other staff. The Administrator stated the Risk Management policy should be reviewed and signed yearly by the bus drivers, and verified BD #118 did not review and sign an acknowledgement of the policy in 2024. The Administrator also verified BD #119 did not review and sign acknowledgement of the policy before moving into a bus driver role.</p> <p>During an interview on 02/11/25 at 4:04 P.M., the Regional Director of Operations (RDOO) #206, [NAME] President of Clinical Operations (VPCO) #202, and [NAME] President of Operations (VPO) #116, were informed of the survey team's concerns related to the fall incident, lack of fall investigation, lack of training, failure to report the incident to the State Agency, and the lack of documentation in Resident #24's medical record related to the 12/12/24 incident. VPO #116 verified the findings and shared the facility had begun to implement corrective action.</p> <p>Observation of the facility bus and interview on 02/12/25 at 8:22 A.M. with Regional Maintenance Director (RMD) #205 revealed there is no safe way to secure a wheelchair or the resident when it is placed perpendicular to the front of the bus. I would never transport a resident placed perpendicular to the front of the bus.</p> <p>(continued on next page)</p>		

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  02/25/2025
NAME OF PROVIDER OR SUPPLIER  Medina Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  555 Springbrook Dr Medina, OH 44256	

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the facility bus and interview on 02/12/25 at 9:35 A.M. with BD #118, who was called into the facility to complete driver training, revealed he was learning a lot with the training. BD #118 stated he never knew he was not supposed to transport residents facing sideways. BD #118 demonstrated the hands-on steps he took to secure Resident #24 in a perpendicular position. BD #118 stated he used the shoulder straps and noted they were difficult to use due to the resident's size, wheelchair, and position of the wheelchair. BD #118 proceeded to illustrate where Resident #24 fell and slid. Further observations of the bus indicated Resident #24 fell forward approximately three feet before hitting the floor and then slid an additional four feet, landing in the aisle on her right side.</p>