STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365715	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary's Alzheimer's Center	1899 Garfield Rd Columbiana, OH 44408

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, interview, and facility policy review, the facility failed to ensure infection control practices were implemented correctly. This affected five Residents (#10, #12, #29, #56, and #82) of seven reviewed for infection control, and had the potential to affect 37 residents who resided on the south hall or who were observed for medication administration. The facility census was 75.Findings include:1.Review of the medical record for Resident #82 revealed an admission date of 03/20/26. Diagnoses included urinary tract infection (UTI), dementia, hypertension and heart failure. The comprehensive minimum data set (MDS) assessment was not yet completed at the time of the survey. Review of the physician's orders for March 2026 revealed an order for Levaquin (an antibiotic used to treat UTI's) 750 milligrams (mg) for five days. The order began on 03/21/26. There was also an order for contact isolation for a UTI which began on 03/20/26. Review of the baseline care plan dated 03/21/26 revealed Resident #82 was on contact isolation precautions for a UTI. Observation on 03/23/26 at 2:18 P.M. of Resident #82's room revealed no evidence contact precautions were identified. Interview at the time of the observation with the Director of Nursing (DON) confirmed Resident #82 was on contact precautions and should have a sign indicating such posted on his door. She confirmed there was no sign in place at the time of the observation. Review of the facility policy titled Procedure for Isolation: Initiation of Isolation dated February 2017 revealed contact precautions would be used for residents with a known infection which could be transmitted by direct or indirect contact and appropriate signage would be posted outside the door frame indicating the type of isolation or informing visitors to report to the nurses station before entering the room. 2. Observation on 03/25/26 from 8:22 A.M. to 9:05 A.M. of medication administration with Licensed Practical Nurse (LPN) #318 revealed the following: at 8:22 A.M., LPN #318 dispensed and administered oral medications for Resident #56. LPN #318 then put on gloves and administered the resident's eye drops. LPN #318 then removed his gloves and did not sanitize his hands afterwards. LPN #318 then immediately dispensed and administered medications to Resident #10 and did not sanitize his hands. LPN #318 then immediately put on a pair of gloves, administered different eyedrops to Resident #56, removed his gloves, and did not sanitize his hands. LPN #318 then proceeded to the medication room for breathing treatment supplies, prepared the breathing treatment (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Resident #10, applied the nebulizer mask to Resident #10 for the breathing treatment, started the breathing treatment, exited the room and did not sanitize his hands afterwards. LPN #318 then immediately dispensed and administered the medications for Resident #12 and did not sanitize his hands afterwards. LPN #318 then immediately dispensed medications for Resident #29, applied gloves, picked up a capsule to empty its contents into a medication cup, removed his gloves and did not sanitize his hands afterwards, and then administered the medications to Resident #29. LPN #318 did not sanitize his hands afterwards. LPN #318 then immediately went into Resident #10's room to remove the nebulizer mask due to the breathing treatment being completed and did not sanitize his hands afterwards. LPN #318 exited Resident #10's room without sanitizing his hands and started to document on the medication cart computer. An interview on 03/25/26 at 9:07 A.M. with LPN #318 verified the above findings. Review of the facility policy titled Handwashing/Hand Hygiene Policy, dated 11/2024 revealed personnel would follow established procedures, the policy is based on Center for Disease Control and Prevention (CDC), and hand hygiene was used to prevent the spread of infections or disease. According to the same facility policy, hand hygiene was to be completed before contact with residents, before preparing or handling medication, after contact with intact resident skin, after touching contaminated surfaces, after touching objects immediately around the resident, and after glove removal. Review of the facility policy titled Medication Administration, dated 03/2026 revealed employees would follow infection control guidelines and would use a sanitizing solution between residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to ensure insulin administration was accurately documented and that skin checks were accurately documented. This affected three residents (#4, #5, and #27) out of 21 residents reviewed for resident records. The facility census was 75. Findings include:1.Review of the medical record for Resident #27 revealed an admission date of 04/06/23 with diagnoses including dementia, diabetes mellitus type two, noncompliance with medication regimen, high blood pressure, and need for assistance with personal care.Review of the physician orders revealed an order for Novolog (a fast-acting insulin) Injection Solution 100 units per milliliter (ml) inject four units subcutaneously (sq) in the morning, hold for blood sugar less than 80 milligrams (mg) per deciliter (dl).Review of the care plan revealed Resident #27 had diabetes mellitus dated 04/19/23 with a goal the resident would not have diabetic related complications. Interventions included to administer diabetic medications as ordered and to document effectiveness.Review of the medication administration record (MAR) from 02/01/26 to 02/28/26 revealed the absence of documentation for the administration Novolog Injection Solution 100 units/ml inject four units sq in the morning, hold for blood sugar less than 80 mg/dl on 02/25/26.Review of the MAR from 03/01/26 to 03/25/26 revealed the absence of documentation for the administration Novolog Injection Solution 100 units/ml inject four units sq in the morning, hold for blood sugar less than 80 mg/dl on 03/05/26, 03/15/26, 03/19/26, 03/20/26, 03/21/26, and 03/24/26.Review of the progress notes from 02/24/26 to 03/26/26 revealed the absence of documentation related to insulin administration on 02/25/26, 03/05/36, 03/15/26, 03/19/26, 03/20/26, 03/21/26, and 03/24/26.An interview on 03/26/26 at 12:09 P.M. with Licensed Practical Nurse (LPN) #314 revealed medication administration would be documented in the MAR, if the medication was not administered it would be documented as not administered on the MAR, and the medical team would be notified if a medication was not administered.An interview on 03/26/26 at 12:48 P.M. with the Director of Nursing (DON) verified the missing insulin documentation.Review of the facility policy titled Medication Administration, dated 03/2026 revealed all communication with the physician would be documented and medications would be charted on the MAR.2. Review of the medical record for Resident #5 revealed they were admitted to the facility on [DATE] with diagnoses that included dementia, muscle weakness, colon cancer, anxiety, and high blood pressure.Review of the care plan revealed the resident would have a person-centered care plan dated 05/18/21 with interventions that included the resident would have skin checks every Friday and any abnormal findings would be documented.Review of the physician orders revealed an order dated 01/10/25 for a weekly skin check by a nurse every week.Review of the Evaluations screen in the electronic medical record (EMR) from 01/01/26 to 03/25/26 for weekly skin check documentation revealed skin evaluations were documented on 01/09/26, 01/16/26, 01/23/26, 02/13/26, 03/07/26, 03/13/26, and 03/20/26.Review of the treatment administration record (TAR) from 01/01/26 to 01/31/26 revealed the absence of documentation for a skin check on 01/02/26.Review of the TAR from 02/01/26 to 02/28/26 revealed the absence of documentation for a skin check on 02/06/26.Review of the progress notes 01/01/26 to 03/24/26 revealed the absence of documentation for the missing skin checks and skin evaluations.An interview on 03/26/26 at 11:47 A.M. with Registered Nurse (RN) #306 revealed skin checks were to be completed weekly, skin checks were to be documented in the TAR which is an attestation the skin check was completed. The actual condition of the resident's skin was to be documented as a skin evaluation in the EMR evaluation tab, and all skin documentation occurred in the EMR.An interview on 03/26/26 at 12:09 P.M. with Licensed Practical Nurse (LPN) #314 revealed skin checks were to be completed weekly, documented in the TAR, and the skin evaluation completed in the EMR evaluations tab.An interview on 03/26/26 at 12:48 P.M. with the DON verified the missing skin checks.3) Review of the medical record (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident #4 revealed they were admitted to the facility on [DATE] with diagnoses that included dementia, schizoaffective disorder, depression, altered mental status, heart surgery, and disorientation.Review of the care plan revealed the resident was at risk for pressure ulcer development dated 08/30/23 with the goal to have intact skin. Interventions included follow facility policies for the prevention of skin breakdown.Review of the physician orders revealed an order dated 01/07/26 for a skin check to be completed by a nurse weekly.Review of the TAR from 02/01/26 to 02/28/26 revealed the absence of documentation for a skin check on 02/25/26.Review of the TAR from 03/01/26 to 03/25/26 revealed the absence of documentation for a skin check on 03/04/26 and 03/11/26.Review of progress notes from 02/01/26 to 03/25/26 revealed the absence of documentation for the missing skin checks.An interview on 03/26/26 at 11:47 A.M. with RN #306 revealed skin checks were to be completed weekly, skin checks were to be documented in the TAR which is an attestation the skin check was completed, the actual condition of the resident's skin was to be documented as a skin evaluation in the EMR evaluation tab, and all skin documentation occurred in the EMR.An interview on 03/26/26 at 12:09 P.M. with Licensed Practical Nurse (LPN) #314 revealed skin checks were to be completed weekly, documented in the TAR, and the skin evaluation completed in the EMR evaluations tab.An interview on 03/26/26 at 12:48 P.M. with the DON verified the missing skin checks.Review of the facility policy titled Skin Evaluations, Weekly, dated 09/2025 revealed weekly skin evaluations were to be completed by the nurse and documented in the EMR in the evaluation tab.