STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365721	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overbrook Center	333 Page Street Middleport, OH 45760

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on review of facility schedule, and interview the facility failed to ensure a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. This had the potential to affect all 69 residents residing in the facility. Findings Include:Review of the facility schedules from 04/03/26 to 04/09/26 revealed on 04/05/26 the scheduled dayshift RN had called off and was not replaced with an RN. On 05/07/26 at 2:43 P.M., an interview with Licensed Practical Nurse (LPN) #528 verified the facility had not met required eight consecutive hours of RN coverage for 04/05/26. This deficiency represents noncompliance investigated under Complaint Number 3006363.

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, resident interview, review of resident rights, and staff interview, the facility failed to ensure each resident was treated with respect and dignity and was given care in an environment that promoted enhancement of quality of life. This affected one of 20 sampled residents (Resident #39). The facility census was 69.Review of the record for Resident #39 revealed an admission date of 04/24/26 and diagnoses including diabetes, bipolar disorder, anxiety disorder, hypertension, and depression. Review of an admission Minimum Data Set completed on 04/29/26 revealed a Brief Interview for Mental Status score of 15, indicating intact cognition. It stated the resident required partial/moderate assistance with showers. Interview with Resident #39 on 05/04/26 at 3:13 P.M. revealed there was a nursing assistant on evening/night shift (she only knew the first letter of her name who was later determined to be Nursing Assistant #555) who was loud and rude to her. She stated that last evening she had put her call light on because she needed a pain pill and Nursing Assistant #555 responded. She stated Nursing Assistant #555 said the nurse was on another hall and she would get it when she gets it. Resident #39 stated LPN #513 came and gave her the pain pill and said she was sorry for the way the nursing assistant talked to her and she had heard that the nursing assistant talked to other residents that way. Resident #39 stated she had reported this to LPN #519 around lunch time on 05/04/26. Resident #39 stated another incident had occurred on Friday 05/01/26 when she asked Nursing Assistant #555 for a shower since she was going out to a church function the next day and wanted her hair to look nice. She stated Nursing Assistant #555 told her she was not on the shower list, she had eight other showers to do, and she could not do it. Resident #39 stated she washed her own hair in her bathroom sink. Resident #39 stated the way Nursing Assistant #555 talked to her made her feel bad and downgraded. She stated that she felt she had Post Traumatic Stress Disorder (PTSD) due to her ex-husband being verbally and physically abusive to her. She stated that he had stabbed her and broke her nose and the PTSD caused her to have nightmares and panic attacks with anxiety. She stated she felt the treatment by Nursing Assistant #555 might cause her to have a trigger of her PTSD. She stated no one from the facility had followed up with her since reporting it to LPN #519. Interview with LPN #513 on 05/05/26 at 1:50 P.M. confirmed she worked the evening/night shift (7:00 P.M. to 7:00 A.M.) on 05/01/26, 05/02/26, and 05/03/26. She stated the Resident #39 does not get along with Nursing Assistant #555. She stated that Resident #39 told her she didn't think Nursing Assistant #555 liked her. LPN #513 said she did not pursue why Resident #39 felt that way. She stated she told Resident #39 that Nursing Assistant #555 was young and that is just her personality. She stated she was not aware of what Resident #39 reported about how Nursing Assistant #555 responded to her needing a pain pill or shower. She stated she was aware Resident #39 washed her own hair in the sink and another resident (Resident #5) also said Nursing Assistant #555 was cranky and did not smile. She stated she did not report any of this to Administration or anyone else. Interview with LPN #519 on 05/05/26 at 2:10 P.M. revealed Resident #39 reported to him on 05/04/26 that Nursing Assistant #555 was rude. He stated Resident #39 described her as a (expletive). Resident #39 said she asked for a pain pill and Nursing Assistant #555 was rude when saying the nurse would come. He stated he reported this to Unit Manager LPN #532 on 05/04/26. Interview with Unit Manager LPN #532 on 05/05/26 at 2:30 P.M. revealed she did not remember LPN #519 reporting anything to her about Resident #39 or Nursing Assistant #555. She stated Resident #39's showers are scheduled on Monday, Wednesday, and Friday on dayshift. She stated it was documented Resident #39 refused her shower on dayshift on Friday, 05/01/26. Interview with Nursing Assistant #537 on 05/06/26 at 9:00 A.M. revealed she documented on the shower sheet on dayshift on Friday 05/01/26 the resident refused her shower. She stated Resident #39 had asked for a shower on evening shift as she was going on an outing. A message was left on 05/05/26 at 2:15 P.M. for Nursing Assistant #539 (who worked with Nursing Assistant #555 on (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/01/26, 05/02/36, and 05/03/26) but she did not return the call. Interview with the Administrator and Director of Nursing on 05/05/26 at 2:40 P.M. revealed they had not received any reports of any staff being rude or any concerns related to Nursing Assistant #555. They stated they would begin an investigation at that time. Interview with the Administrator on 05/06/26 at 9:03 A.M. revealed the facility did not have a policy on Dignity and Respect. He stated the facility followed Resident Rights and he would provide a copy. Review of a Resident/Family/Staff Concern form dated 05/05/26 revealed Resident #39 reported to state that she has PTSD and that a nursing assistant was rude to her. Trauma informed care completed during social service admission assessment where resident denied experiencing any frightening, horrible, or traumatic event. However on 05/05/26 the resident reported to state she has PTSD. No diagnosis present. Social Services followed up with resident and resident reports her last husband physically abused her and triggers are loud noises and rude people. The resident was asked about the nursing assistant being rude to her and the resident reports when she asked for a shower the nursing assistant reported you're not getting one today because it's not your shower day. The resident also asked for her pain medication and the same nursing assistant reported you're going to have to wait because your nurse is on another hall right now. The concern form stated the nursing assistant was suspended at this time pending investigation. It stated that once the investigation was completed, if the facility retained the nursing assistant, she will be reassigned to the other wing of the facility and provided with disciplinary action. Interview with the Administrator and Director of Nursing on 05/06/26 at 12:30 P.M. confirmed Nursing Assistant #555 was suspended during the investigation. They stated other residents were interviewed with no other concerns except Resident #5. They stated they were starting staff education on customer service and if Nursing Assistant #555 returned, they would move her to a different hall and monitor her interactions. They stated they instructed Resident #39 to report any additional issues to Administration. Review of the undated Resident Rights provided revealed a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to document that quarterly care conferences were conducted and who attended the meetings. This affected three Residents (#2, #8, and #53) of three sampled for care conferences. The facility census was 69. 1. Review of Resident #2's medical record revealed an admission date of 04/08/19, a re-entry date of 05/20/2025 and diagnoses including chronic obstructive pulmonary disease, diabetes, chronic kidney disease stage 4, unspecified diastolic (congestive) heart failure, hypothyroidism, anemia, bipolar disorder, paroxysmal atrial fibrillation, peripheral vascular disease, schizoaffective disorder, unspecified mood disorder, major depressive disorder, and anxiety disorder. Review of Resident #2's annual Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of 15 indicating the resident was cognitively intact. Further review of Resident #2's MDS revealed the resident was dependent on facility staff for toileting hygiene, required substantial/maximal assistance for bed mobility, and was always incontinent of bladder and bowel. Review of Resident #2's social services quarterly/annual/significant change assessment dated [DATE] and completed by the Director of Social Services (DSS) #550 revealed a summary note that read the resident and resident' power of attorney were invited to a care conference and declined. Further review of Resident #2's medical record revealed no further mention of a care conference or who attended the care conference. In an interview on 05/05/2026 at 8:26 A.M. with Resident #2 revealed the resident didn't recall a recent care conference. In an interview on 05/05/2026 at 10:44 A.M. DSS #550 revealed social services quarterly/annual/significant change assessments are done quarterly and care conferences are offered to residents and families with notices sent to families by mail but most do not respond. In an interview on 05/05/2026 at 2:22 P.M. with the Director of Nursing (DON) revealed staff do have a care conference assessment and a quarterly assessment and it is documented if the resident and family decline to attend. He said the care conference is documented in the assessments by discipline and the care conference is an ongoing process and is discussed daily during morning meeting for updates and acute changes. However, there was no information about the care conference or who attended. 2. Review of the record for Resident #53 revealed an admission date of 10/24/25 and diagnoses including cerebral infarction, diabetes, chronic obstructive pulmonary disorder, seizures, and migraines. Review of a Minimum Data Set assessment completed 03/27/26 revealed a Brief Interview for Mental Status score of 15, indicating intact cognition. Review of a care conference summary dated 10/30/25 revealed- met with resident and sister this date. Goal to return home with sister and home health care. It was not documented what staff were part of the care conference at that time. Review of a Social Service Quarterly/Annual/Significant change assessment dated [DATE] revealed resident and POA invited to care conference but declined. Resident encouraged to reach out to Social Service if any concerns and/or questions arise. It did not indicate that a care conference was still (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	held and what staff attended to review the plan of care. Interview with Resident #53 and her sister on 05/04/26 at 11:00 A.M. revealed there had been one care conference since she was admitted (in October 2025). She stated there had been none since and she would like to have one. Interview with Director of Social Services #550 on 05/05/26 at 10:47 A.M. revealed that letters are sent out quarterly regarding care conferences. She stated a letter is sent to Resident #53's sister. She stated when quarterly assessments are done, they ask the resident if they want to meet. She stated Resident #53's sister is here frequently and stops up at the front desk and speaks with her. Interview with Resident #53's sister on 05/05/26 at 10:55 A.M. revealed she had not received any letters pertaining to care conferences. She stated she brings in any mail that she gets pertaining to Resident #53 and lets her look at it also. Resident #53 confirmed she had not seen any letters related to a quarterly care conference. Interview with the Director of Nursing on 05/05/26 at 2:22 P.M. confirmed there was no evidence or documentation to indicate that a care conference was held quarterly to review the quarterly assessment and plan of care or who attended the care conference. He confirmed there was no evidence a care conference was held with the interdisciplinary team even if the resident/family declined to attend. 3. Review of the medical record for Resident #8 revealed an admission date of 05/17/25. Diagnoses included chronic obstructive pulmonary disease, cirrhosis of liver, bipolar disorder, current manic severe with psychotic features, schizoaffective disorder, post-traumatic stress disorder, pain in left hip, Raynaud's syndrome, hypertension, hyperlipidemia, intervertebral disc degeneration, lumbar region, chronic viral hepatitis C, anxiety disorder, osteoarthritis, gastro-esophageal reflux disease, obesity, nonrheumatic tricuspid valve insufficiency, mood disorder, congestive heart failure, cervical disc degeneration, chronic gastric ulcer, peripheral vascular disease, anemia and chronic kidney disease. Review of the medical record revealed a care conference was held on 05/20/25 with Social Services, the resident and her son via phone. Further review revealed the only discipline in attendance was social services. Review of the care conference letter dated 03/01/26 and sent to the resident's guardian (son) revealed a care conference was scheduled for 03/17/26 between 10:00 A.M. and 1:00 P.M. and to call to confirm reservation for care conference. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the medical record revealed no documented evidence a care conference had been held quarterly since the initial care conference of 05/20/25. On 05/05/26 at 10:41 A.M., an interview with Social Service Designee (SSD) #550 verified she does not document quarterly care conferences in the medical record and not all disciplines attend all the care conferences.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review the facility failed to ensure routine shaving, nail care, and/or showers were provided for Resident #4 and #6. This affected two residents (#4 and #6) of three residents reviewed for activities of daily living (ADL). The facility census was 69. Findings Include:1. Review of the medical record for Resident #6 revealed an initial admission date of 08/17/22 with the latest readmission of 06/18/24. Diagnoses included congestive heart failure, chronic kidney disease, diabetes mellitus, benign prostatic hyperplasia, protein calorie malnutrition, major depressive disorder, acquired absence of right foot, anemia, cirrhosis of liver, ascites, hypertension, ischemic cardiomyopathy, retention of urine, chronic obstructive pulmonary disease, dysphagia, insomnia, and atrial fibrillation. Review of the care plan dated 08/18/22 revealed the resident had an activity of daily living (ADL) self-care performance deficit and potential for fluctuations in ADL related to congestive heart failure, weakness, reduced mobility, depression, physical debility, difficulty walking and need for assistance with personal care. Interventions included resident requires maximum assistance with personal hygiene and shower twice weekly with hair and nail care per resident's preference. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident had no indicators of depression and displayed no behaviors including rejection of care. The resident required substantial/maximal assistance with personal hygiene and bed mobility. On 05/04/26 at 1:26 P.M., observation of Resident #6 revealed the resident had several days of facial hair growth. The resident stated, not purposely, when as if he was growing a beard. Further observation revealed the resident's fingernails were long, jagged and dirty with a brown substance under the nail. The resident stated, they need cut, when asked if the liked his nails long. On 05/05/26 at 10:08 A.M., observation of the resident revealed the resident's facial hair remained long and his fingernails remained long, jagged and dirty with a brown substance under the nail. On 05/06/26 at 11:20 A.M., observation of the resident revealed the resident's facial hair remained long and his fingernails remained long, jagged and dirty with a brown substance under the nail. On 05/06/26 at 11:30 A.M., an interview with Licensed Practical Nurse (LPN) #523 verified the resident had several days of facial hair growth and his fingernails were long, jagged and dirty with a brown substance under the nail. 2. Review of the medical record for Resident #4 revealed an admission date of 08/25/25 with the latest readmission date of 10/10/25. Diagnoses included Parkinson's disease, obstructive sleep apnea, dementia, atrial fibrillation, anemia, chronic pulmonary embolism, hypertension, dysphagia, retention of urine, cervical disc degeneration, benign prostatic hyperplasia, chronic kidney disease, gout, osteoarthritis, fatty liver, chronic pain, insomnia, malignant neoplasm of prostate, cerebral aneurysm, depression and diabetic mellitus. Review of the care plan dated 08/31/25 the resident had an ADL self-care performance deficit and potential for fluctuations in ADLs related to muscle wasting and atrophy, weakness, lack of coordination, difficulty walking, need for assistance with personal care, unsteadiness on feet, reduced mobility, age related physical debility and will refuse showers when offered at times. Interventions included Assist with bathing body parts that resident cannot do, requires partial assistance with bathing and honor resident's choices and preferences whenever possible. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident had no indicators of depression and displayed no behaviors including rejection of care. The resident required partial/moderate assistance with bathing. On 05/04/26 at 9:53 A.M., an interview with Resident #4 revealed he was upset because he did not receive his shower on Saturday 05/02/26 and he stated, I stink. The resident stated, The aide said they were too busy to do showers. Review of the shower documentation for 05/02/26 by Certified Nursing Assistant (CNA) #537 revealed the resident's shower was documented as the resident refused the shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes revealed no documented evidence the resident had refused his scheduled shower on 05/02/26. Review of the requested shower sheet for 05/02/26 revealed CNA #562 had filled out a shower sheet for 05/04/26 and the provided shower sheet had a two heavily marked over the four indicating the resident had received a shower on 05/02/26. On 05/07/26 at 11:17 A.M., an interview with CNA #537 revealed the resident had not refused the shower on 05/02/26 and she had not provided the resident with his scheduled shower on 05/02/26. CNA #537 revealed she must have marked the refusal on accident due to being in a hurry. On 05/07/26 at 1:04 P.M., interview with CNA #562 revealed she did not work at the facility on 05/02/26. She revealed she worked 05/04/26 and the resident was upset he had not received his scheduled shower on 05/02/26 so she ensured he had a shower on 05/04/26.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Resident #55's peripheral inserted central catheter (PICC) dressing was changed as ordered. This affected one (Resident #55) of one resident reviewed for PICC dressings. The census was 69.Findings include:Record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses that include but are not limited to localization-related idiopathic epilepsy and epileptic syndromes with seizures of localized onset, paroxysmal fibrillation, and atherosclerosis atrial fibrillation. Review of the physician's orders for Resident #55 revealed an order dated 04/25/2026 to change the dressing to the midline weekly and as needed every night shift every Thursday until 05/05/2026 at 11:59 P.M.Review of the Medication Administration Record (MAR) revealed that the dressing change was signed off as completed by the LPN on 04/30/2026.On 05/05/2026 at 9:40 A.M. during medication observation Resident #55 was observed with a PICC line dressing dated 04/24/2026 on the right arm.Interview on 05/05/2026 at 10:30 A.M. with the LPN revealed that the date on the right arm PICC line dressing was dated 04/24/2026 and is to be changed per the order every Thursday during night Shift. During this interview, Resident #55 confirmed the dressing had not been since it was applied on 04/24/2026.Interview on 05/06/2026 at 6:45 A.M. with the LPN revealed the PICC line dressing change for Resident #55 was signed off on 04/30/2026 but did not get completed as ordered. The LPN stated she was going to do it in the evening, but the resident asked her to wait until morning, and she forgot to do the dressing as requested but should not have signed off until the treatment was completed.The facility did not have a policy specific to dressing changes for PICC lines.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review and interviews, the facility failed to ensure pressure relieving interventions were implemented as ordered. This affected one resident (#6) of three residents reviewed for pressure ulcer. The facility census was 69. Findings Include: Review of the medical record for Resident #6 revealed an initial admission date of 08/17/22 with the latest readmission of 06/18/24. Diagnoses included congestive heart failure, chronic kidney disease, diabetes mellitus, benign prostatic hyperplasia, protein calorie malnutrition, major depressive disorder, acquired absence of right foot, anemia, cirrhosis of liver, ascites, hypertension, ischemic cardiomyopathy, retention of urine, chronic obstructive pulmonary disease, dysphagia, insomnia, and atrial fibrillation. Review of the care plan dated 03/30/26 revealed the resident had the potential for pressure ulcer development related to decreased mobility and incontinence. Interventions included air mattress to bed, administer treatments as ordered, encourage/assist resident as needed to elevate heels off the mattress as tolerated, heel protector boot to bilateral feet and preventative treatments as ordered. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident had no indicators of depression and displayed no behaviors including rejection of care. The resident required substantial/maximal assistance with personal hygiene and bed mobility. The resident was assessed to be at risk for skin breakdown and had no skin issues. Review of the resident's physician orders for May 2026 identified orders dated 09/03/24 to apply skin prep to right heel for skin breakdown for prevention, encourage/assist to elevate heels when in bed, use two or more pillows to assist with elevating and 04/24/25 soft boots while in bed, check placement every shift and document any noncompliance. Review of the resident's progress notes from 05/04/26 to 05/05/26 revealed no documented evidence the resident refused the soft boots while in bed. On 05/04/26 at 1:39 P.M., observation of Resident #6 revealed the resident was in bed and the soft boots while in bed were not in place as physician ordered. On 05/05/26 at 3:25 P.M., observation of the resident revealed he was in bed and the soft boots while in bed were not in place as physician ordered. On 05/05/26 at 3:30 P.M., an interview with the Director of Nursing (DON) verified the soft boots while in bed were not in place as physician ordered.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and medical record review, the facility failed to ensure contracture maintenance devices were in place as physician ordered. This affected one resident (#5) of one resident reviewed for range of motion (ROM). The facility census was 69. Findings Include:Review of the medical record for Resident #5 revealed an initial admission date of 07/30/16 with the latest readmission of 01/12/26. Diagnoses included cerebrovascular accident with left sided hemiplegia, chronic respiratory failure, diabetes mellitus, bipolar disorder, anemia, benign prostatic hyperplasia, hypertension, chronic obstructive pulmonary disease, anxiety disorder, diverticulosis of intestine, insomnia, hyperlipidemia, dysphagia, mood disorder, contracture of left foot, pseudobulbar affect, major depressive disorder and contracture of left hand. Review of the care plan dated 02/13/25 revealed the resident had an alteration in musculoskeletal status related to contracture left foot and left hand. Interventions included apply ankle foot orthosis (AFO) to left lower extremity every morning for transfers, remove every night, perform skin inspection every shift, hand roll left hand apply during bedtime care, remove with morning care, perform range of motion (ROM) and skin care prior to applying hand roll for 15 minutes, resting hand splint to left upper extremity apply with morning care remove after four hours, perform gentle passive range of motion prior to applying for 15 minutes, check skin after removal. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident had indicators of depression and displayed verbal behaviors directed towards others and had not rejected care. The resident had impaired functional limitation in range of motion on one side to both upper and lower extremities. Review of the resident's monthly physician orders for May 2026 identified an order dated 01/12/26 to encourage resting hand splint to left upper extremity, applied with morning care and remove in four hours, perform gentle passive range of motion prior to applying resting hand splint daily for 15 minutes, check skin after removal everyday shift for maintenance. On 05/04/26 at 1:15 P.M., observation and interview of Resident #5 revealed he was supposed to wear a hand brace and leg brace, but the aides never put it on. The blue brace was observed laying in a bucket on the resident's nightstand. On 05/05/26 at 10:14 A.M., observation of the resident revealed the resting hand splint was not in place. On 05/06/26 at 8:26 A.M., observation of the resident revealed the resting hand splint was not in place. On 05/06/26 at 10:05 A.M., observation of the resident revealed the resting hand splint was not in place. On 05/06/26 at 3:15 P.M. an interview with Certified Nursing Assistant (CNA) #537 verified the resting hand splint had not been in place for the physician ordered four hours. The CNA revealed she thought nightshift applied the splint.

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	365721	A. Building B. Wing	05/07/2026

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Overbrook Center	333 Page Street Middleport, OH 45760

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure adequate staffing levels to meet the total care needs of residents. This affected five residents (Resident #6, #39, #43, #44 and one anonymous resident) of 69 residents residing in the facility. Findings Include:1. On 05/04/26 at 9:53 A.M., an interview with Resident #4 revealed he was upset because he did not receive his shower on Saturday 05/02/26 and he stated, I stink. The resident stated, The aide said they were too busy to do showers. On 05/07/26 at 1:04 P.M., interview with Certified Nursing Assistant (CNA) #562 revealed she did not work at the facility on 05/02/26. She revealed she worked 05/04/26 and the resident was upset he had not received his scheduled shower on 05/02/26 so she ensured he had a shower on 05/04/26. 2. On 05/06/26 at 2:35 P.M.Resident #43 asked for assistance to get out of bed. The resident was informed the surveyor could not assist her out of bed but would alert someone to assist her and the resident's call light was activated. Licensed Practical Nurse (LPN) #528 was notified the resident was requesting to get up and she stated, The aides are in rooms so she will have to wait. On 05/06/26 at 3:15 P.M. Resident #43 remained in bed. Interview with CNA #537 revealed residents that require two person assistance, they have to wait until the other aides are available to help. On 05/06/26 at 3:46 P.M. Resident #43 remained in bed. 3.On 05/06/26 at 2:42 P.M., and observation of Resident #6 revealed he was sitting in his wheelchair at the nurse's station and asked the CNA #537 to be put to bed. The CNA stated he would have to wait because the other two aides on the unit were doing showers. On 05/06/26 at 3:15 P.M., observation of Resident #6 revealed he remained up in his chair. Interview with CNA #537 revealed residents that require two person assistance, they have to wait until the other aides are available to help. On 05/06/26 at 3:46 P.M., observation of Resident #6 revealed staff were now assisting the resident to bed more than an hour after requesting to go to bed. 4.Review of the record for Resident #39 revealed an admission date of 04/24/26 and diagnoses including diabetes, bipolar disorder, anxiety disorder, hypertension, and depression. Review of an admission Minimum Data Set completed on 04/29/26 revealed a Brief Interview for Mental Status score of 15, indicating intact cognition. It stated the resident required partial/moderate assistance with showers. Interview with Resident #39 on 05/04/26 at 3:13 P.M. revealed on Friday 05/01/26 she asked Nursing Assistant #555 for a shower since she was going out to a church function the next day and wanted her hair to look nice. She stated Nursing Assistant #555 told her she was not on the shower list, she had eight other showers to do, and she could not do it. Resident #39 stated she washed her own hair in her bathroom sink. Interview with Unit Manager LPN #532 on 05/05/26 at 2:30 P.M. revealed Resident #39's showers are scheduled on Monday, Wednesday, and Friday on dayshift. She stated it was documented that (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39 refused her shower on dayshift on Friday, 05/01/26. Interview with Nursing Assistant #537 on 05/06/26 at 9:00 A.M. revealed she documented on the shower sheet on dayshift on Friday 05/01/26 that the resident refused her shower. She stated Resident #39 had asked for a shower on evening shift as she was going out on an outing. Interview with LPN #513 on 05/05/26 at 1:50 P.M. revealed she was aware that Resident #39 washed her own hair in her sink. She stated there was not enough staff to meet resident needs in the area of showers. She stated Resident #4 went two days past his regular scheduled shower day because of this. She stated they normally have two nurses and four aides on the evening/night shift for the building. She stated ideally they would have five aides. 5.Interview with LPN #511 on 05/06/26 at 6:45 A.M. revealed she normally works the evening/night shift (7:00 P.M. to 7:00 A.M.) She stated they usually have two nurses and four aides in the building on that shift. She stated with only two aides per side of the building, they can't always do showers when the residents want them, so the residents will refuse. She stated that if a resident takes two for a shower, that leaves just the nurse on the floor and if the nurse is passing medications, it makes it difficult to do that and answer call lights. She stated it gets very hectic with only two aides per side of the building. (four total). She stated that when there is a fifth aide to work as a float between sides, it makes it much better. She stated that does not happen very often. 5.Interview with a resident who wished to remain anonymous on 05/04/26 at 10:55 A.M. revealed he/she routinely has to wait for hours for his/her call light to be answered. He/she stated at these times he/she needs to be changed after being incontinent. He/she stated there is usually only two aides for the evening/night shift on each side of the building (four total). He/she stated if a resident needs two staff for care, they have to wait until both staff are available. He/she stated staff will say put your call light on but it may be awhile before they can assist them. This deficiency demonstrates noncompliance investigated under Complaint Number 3006363. 3. Record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses that include but are not limited to localization-related idiopathic epilepsy and epileptic syndromes with seizures of localized onset, paroxysmal fibrillation, and atherosclerosis atrial fibrillation. Interview with Resident #55 on 05/04/2026 at 1:31 P.M. revealed that there is not enough staff to provide all needs, especially nurses aides. Call lights are not answered in a timely manner and the care received is lacking because they are all in a hurry. Resident #55 stated that there is a need for more nurses aids and that they are provided with more training.

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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 observation, record review and interview, the facility failed to accurately document resident care in the medical record. This affected two residents (Resident #4 and #55) of 20 residents reviewed for accurate medical records.The facility census was 69. Findings include:1.On 05/05/2026 at 9:40 A.M. during medication observation Resident #55 was observed with a PICC line dressing date 04/24/2026 on the right arm. Review of the Medication Administration Record (MAR) on 05/05/2026 revealed that the dressing change was signed off as completed by LPN on 04/30/2026. Interview on 05/05/2026 at 10:30 A.M. with LPN revealed the date on the right arm PICC line dressing was dated 04/24/2026 and is to be changed per the order every Thursday during night Shift. During this interview, Resident #55 confirmed that the dressing had not been since it was applied on 04/24/2026. Interview on 05/06/2026 at 6:45 A.M. with the LPN revealed that the PICC line dressing change for Resident #55 was signed off on 04/30/2026 but did not get completed as ordered. LPN stated that she was going to do it in the evening, but the resident asked her to wait until morning, and she forgot to do the dressing as requested but should not have signed off until the treatment was completed. The facility did not have a policy related to documentation. 2. Review of the medical record for Resident #4 revealed an admission date of 08/25/25 with the latest readmission date of 10/10/25. Diagnoses included Parkinson's disease, obstructive sleep apnea, dementia, atrial fibrillation, anemia, chronic pulmonary embolism, hypertension, dysphagia, retention of urine, cervical disc degeneration, benign prostatic hyperplasia, chronic kidney disease, gout, osteoarthritis, fatty liver, chronic pain, insomnia, malignant neoplasm of prostate, cerebral aneurysm, depression and diabetic mellitus. Review of the care plan dated 08/31/25 the resident had an ADL self-care performance deficit and potential for fluctuations in ADLs related to muscle wasting and atrophy, weakness, lack of coordination, difficulty walking, need for assistance with personal care, unsteadiness on feet, reduced mobility, age related physical debility and will refuse showers when offered at times. Interventions included Assist with bathing body parts that resident cannot do, requires partial assistance with bathing and honor resident's choices and preferences whenever possible. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident had no indicators of depression and displayed no behaviors including rejection of care. The resident required partial/moderate assistance with bathing. On 05/04/26 at 9:53 A.M., an interview with Resident #4 revealed he was upset because he did not receive his shower on Saturday 05/02/26 and he stated, I stink. The resident stated, The aide said they were too busy to do showers. Review of the shower documentation for 05/02/26 by Certified Nursing Assistant (CNA) #537 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the resident's shower was documented as the resident refused the shower. Review of the resident's progress notes revealed no documented evidence that the resident had refused his scheduled shower on 05/02/26. Review of the requested shower sheet for 05/02/26 revealed CNA #562 had filled out a shower sheet for 05/04/26 and the provided shower sheet had a two heavily marked over the four indicating the resident had received a shower on 05/02/26. On 05/07/26 at 11:17 A.M., an interview with CNA #537 revealed the resident had not refused the shower on 05/02/26 and she had not provided the resident with his scheduled shower on 05/02/26. CNA #537 revealed she must have marked the refusal on accident due to being in a hurry. On 05/07/26 at 1:04 P.M., interview with CAN #562 revealed she did not work at the facility on 05/02/26. She revealed she worked 05/04/26 and the resident was upset he had not received his scheduled shower on 05/02/26 so she ensured he had a shower on 05/04/26. On 05/07/26 at 3:49 P.M., an interview with the Director of Nursing (DON) verified Resident #4's shower sheet had been altered from 05/04/26 to 05/02/26.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interview, and policy review, the facility failed to implement infection control procedures related to maintaining enhanced barrier precautions and glove use. This affected three of 20 sampled residents (Residents #6, #39, and #55). The facility census was 69.1. Record review revealed a physician's order for Resident #39 to receive insulin (Lispro) 15 units subcutaneous. Observations on 05/04/26 at 4:00 P.M. revealed LPN #519 to administer an insulin injection to Resident #39's abdomen. LPN #519 did not wear gloves to administer the injection. Interview with LPN #519 on 05/04/26 at 4:05 P.M. revealed he was supposed to wear gloves to give an injection but did not. Interview with the Director of Nursing on 05/05/26 at 1:25 P.M. confirmed staff were to wear gloves when administering insulin. Review of the facility policy titled Medication Administration : Subcutaneous insulin dated 01/23 revealed staff were to put on gloves prior to giving the injection. 2. Observations on 05/05/26 at 9:40 A.M. revealed LPN #526 to prepare IV antibiotics (Meropenem 2 grams) for Resident #55. She applied gloves. Then, after priming the IV tubing, she used hand sanitizer on the gloves she was wearing and proceeded to connect the IV tubing to the IV in the resident's arm. Interview with the Director of Nursing on 05/05/26 at 1:25 P.M. revealed LPN #526 should have changed her gloves, not used hand sanitizer on the gloves. He stated using hand sanitizer on gloves was not part of the facility policy. 3. Review of the medical record for Resident #6 revealed an initial admission date of 08/17/22 with the latest readmission of 06/18/24. Diagnoses included congestive heart failure, chronic kidney disease, diabetes mellitus, benign prostatic hyperplasia, protein calorie malnutrition, major depressive disorder, acquired absence of right foot, anemia, cirrhosis of liver, ascites, hypertension, ischemic cardiomyopathy, retention of urine, chronic obstructive pulmonary disease, dysphagia, insomnia, and atrial fibrillation. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the resident's physician orders for May 2026 identified orders dated 08/14/24 enhanced barrier precautions due to history of extended-spectrum beta-lactamases (ESBL), check placement of sign and cart, stock every shift. On 05/04/26 at 1:31 P.M., observation of the resident being assisted into bed revealed a sign on the door alerting staff the resident was in enhanced barrier precautions (EBP). Further observation revealed the Certified Nursing Assistants (CNA) had not donned gowns while providing the resident care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/04/26 at 1:35 P.M., an interview with CNA #562 verified the CNA had not donned the appropriate personal protective equipment (PPE) while providing care to Resident #6 as required for EBP. Review of the facility policy titled, Enhanced Barrier Precautions, last revised 04/15/24 revealed the facility will implement enhanced barrier precautions for the prevention of multidrug-resistant organisms (MDRO). PPE for EBP is only needed when performing high-contact activities and may not be needed prior to entering a resident's room. Facility will ensure that gowns, gloves and hand hygiene are available. High contact activities include transferring, personal hygiene, change briefs, linens and assisting on commode.