STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365727	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pebble Creek Healthcare Center	670 Jarvis Rd Akron, OH 44319

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, resident and staff interview, medical record review, hospital documentation review, and policy review, the facility failed to ensure a resident received appropriate care and services to monitor for neurological changes and obtain laboratory values for a resident with know history of hepatic encephalopathy. Actual harm occurred to Resident #9 when the resident's ordered medication used to prevent hepatic encephalopathy was changed from being administered on a scheduled basis to only given as needed. Additionally, the facility did not implement monitoring for altered mental status changes as care planned and did not obtain ammonia laboratory values as ordered to determine the need for administering the as needed medication or additional interventions. This resulted in Resident #9 experiencing a change in mental status and elevated ammonia levels which necessitated hospitalization for treatment of the resident's condition. This affected one (#9) of three residents reviewed for quality of care. The facility census was 148. Findings include: Review of Resident #9's medical record revealed an admitted [DATE] and diagnoses included hepatic encephalopathy, type two diabetes mellitus, dysphagia, and congestive heart failure. Review of Resident #9's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had moderate cognitive impairment. Resident #9 was dependent for toileting hygiene, bathing, and lower body dressing. Resident #9 required partial to moderate assistance with personal hygiene. Resident #9 was always incontinent of urine and bowel. Resident #9 was at risk of developing a pressure ulcer but did not have a pressure ulcer or injury. Resident #9 did not reject care during the seven-day assessment look-back period. Review of Resident #9's physician orders dated 07/07/24 revealed the resident was ordered the laxative and ammonia reducing medication Lactulose oral solution 10 grams (g) per 15 milliliters (ml) with instructions to give 30 ml by mouth two times a day for constipation, abdominal bloating. The order was discontinued on 11/03/24. (continued on next page)

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #9's care plan dated 07/16/24 included Resident #9 had a neurologic disorder related to encephalopathy. Resident #9 would not have increased signs and symptoms of neurological complications through the target date of 04/26/25. Interventions included to monitor for signs and symptoms of altered neurological status such as pupils not equal and reactive to light, hand grasps are not equal, inappropriate response to pain, changes in level of consciousness; monitor vital signs as needed and report abnormal findings to the medical provider, resident, and resident representative; neurological consultation as needed, per medical providers orders; observe for changes in mental status and report abnormal findings to the medical provider, resident, resident representative; and obtain and monitor laboratory, diagnostic studies as ordered and report abnormal findings to the medical provider, resident, and resident representative. Review of Resident #9's progress notes dated 11/03/24 at 12:40 P.M. included Resident #9's Telehealth (a means to provide healthcare services via electronic means) provider was notified she refused her suppository and Lactulose today. An ammonia laboratory level was ordered and the Lactulose order was changed to as needed. Review of Resident #9's physician Telehealth progress notes dated 11/03/24 at 12:44 P.M. revealed Resident #9 was refusing a suppository and Lactulose. Resident #9 reported the Lactulose and suppository were making her bowels move too often and it was recommend to change the order to as needed. Review of Resident #9's physician orders dated 11/03/24 revealed an order for Lactulose oral solution 10 g per 15 ml with instructions to give 30 ml by mouth every 12 hours as needed for encephalopathy or constipation was given. Review of Resident #9's physician orders dated 11/03/24 revealed the facility was to obtain an ammonia level, one time only for one day. Review of Resident #9's medical record including progress notes did not reveal evidence an ammonia level was drawn. The order was discontinued on 11/05/24. Review of Resident #9's medical record including progress notes, physician orders, medication administration record (MAR), and treatment administration record (TAR) did not reveal monitoring for signs and symptoms of increased ammonia level. Review of Resident #9's MAR and TAR dated 11/03/24 through 02/05/25 did not reveal evidence Lactulose 30 ml was administered. Review of Resident #9's physician and nurse practitioner notes, written by Medical Director (MD) #413 and Nurse Practitioner (NP) #414, dated 11/03/24 through 02/05/25 did not reveal documentation related to monitoring for signs and symptoms of increased ammonia levels. Review of Resident #9's progress notes dated 02/04/25 at 1:52 P.M. through 02/04/25 at 3:15 P.M. included Resident #9 was complaining of nausea. The resident received the anti-nausea medication Zofran with little relief. NP #414 was notified and gave orders for a polymerase chain reaction (PCR) test for respiratory syncytial virus (RSV), influenza, and COVID-19. All tests came back negative. A stat (immediately) laboratory draw was ordered for a comprehensive metabolic panel and complete blood count with differential and monitor for changes. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #9's progress notes dated 02/04/25 at 6:00 P.M. revealed Resident #9's son was notified of her change of condition. Review of Resident #9's progress notes dated 02/05/25 at 1:13 A.M. revealed NP #414 was notified of Resident #9's laboratory values and altered mental status, and orders were given to transport Resident #9 to the hospital due to elevated laboratory values and mental status change. Review of Resident #9's hospital admission progress notes dated 02/05/25 through 02/10/25 included Resident #9 was admitted to the hospital on 02/05/25 for altered mental status (AMS). All information was obtained from the resident's chart as Resident #9 was a poor historian. Per paperwork from the facility, Resident #9 had a history of metabolic encephalopathy and chronic communication deficit. Resident #9 also had a known history of hepatic encephalopathy. The facility stated Resident #9 had and episode of vomiting yesterday (02/04/25) and was sent to the emergency department (ED) due to confusion and increased bilirubin (a substance produced when red blood cells break down and are processed by the liver and converted into a substance called bile) levels. In the ED Resident #9 was noted to have elevated ammonia levels and was given a Lactulose enema. Resident #9's problem list included hyperammonemia, altered mental status, urinary tract infection (UTI) and elevated bilirubin. Resident #9's altered mental status was likely due to her UTI and hepatic encephalopathy and was improved with Lactulose and Rocephin (antibiotic). Resident #9 had hyperammonemia and was on scheduled Lactulose now (Lactulose 30 gram twice a day). The elevated bilirubin was suspected to be due to UTI and cholelithiasis (gallstones) on ultrasound. Resident #9 was admitted to the hospital and the plan included to repeat her ammonia level post Lactulose enema. Review of Resident #9's ammonia level dated 02/05/25 at 3:22 A.M. revealed a normal ammonia level was 11 to 51 micromoles per liter (umol/L) and Resident #9's ammonia level was greater than 61 umol/L. Review of Resident #9's ammonia level dated 02/06/25 at 6:17 A.M., after the Lactulose enema revealed Resident #9's ammonia level was 48 umol/L. Review of Resident #9's progress notes dated 02/14/25 at 10:41 A.M. revealed new orders were given by the nurse practitioner for bi-weekly laboratory values and Lactulose 30 ml twice a day. Resident #9 and her son were aware of all new and existing orders. Interview on 03/26/25 at 10:29 A.M. with Family Member (FM) #411 revealed Resident #9 was diagnosed with liver disease in April 2024 and was ordered Lactulose because she had high ammonia levels, and the Lactulose would bring the ammonia level down. Resident #9 had diarrhea in November 2024 and the Lactulose order was changed to as needed. FM #411 stated if the Lactulose was supposed to be taken to lower Resident #9's ammonia level then it would need to be taken to keep the levels from going up. FM #411 indicated Resident #9 was in the hospital for five days in February 2025 with part of the problem being high ammonia levels and the hospital was able to stabilized the resident. FM #411 stated he was upset Resident #9's Lactulose was discontinued, and the facility staff did not listen to him when he called. (continued on next page)

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	365727	A. Building B. Wing	03/27/2025

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 03/26/25 at 12:36 P.M. with the Director of Nursing (DON) revealed Resident #9 and her family requested her Lactulose be discontinued because she was having diarrhea. The DON confirmed she talked to Resident #9's son and he mentioned something about the resident's liver, and she told him he requested her Lactulose to be discontinued because he did not like the side effects of the medication. The DON stated she was not sure if Resident #9 received Lactulose and it should be documented in the progress notes if she did. Interview on 03/27/25 at 7:42 A.M. with the DON revealed the facility did not do ammonia levels for Resident #9 because an ammonia level was a time sensitive test and had to be at the laboratory in a certain timeframe. The DON stated MD #413 indicated to monitor Resident #9's symptoms, check for elevated liver enzymes, and change in mental status. The DON stated Resident #9 would receive Lactulose if it was ordered by the physician. The DON confirmed Resident #9 did not have an ammonia level drawn from 11/03/24 through 02/05/25. Interview on 03/27/25 at 9:25 A.M. with Laboratory Representative (LR) #415 revealed the laboratory had a contract with the local hospital and there was a 15 minute timeframe from the time the ammonia level was drawn until it was processed, and the laboratory could not meet the timeframe due to things like drive time etcetera. Interview on 03/27/25 at 8:28 A.M. with Licensed Practical Nurse (LPN) #370 revealed Resident #9 received daily scheduled Lactulose and she did not like it but she took it without a problem when she was told it was important for her health. LPN #370 stated Resident #9 was compliant and did not refuse to take the Lactulose. Observation and interview on 03/27/25 at 8:43 A.M. revealed Resident #9 was lying in bed, was pleasant, and answered questions without issues. Resident #9 was confused and did not remember what Lactulose was or if she refused to take it. Interview on 03/27/25 at 11:54 A.M. with the DON revealed NP #414 told her Resident #9 did not like her Lactulose and to make a huge difference she would need to tolerate it twice a day. NP #414 felt like her dementia was progressing and every day she was assessed for a change in condition. The DON confirmed there was no documentation in Resident #9's medical record related to monitoring for signs and symptoms of increased ammonia levels. The DON stated if Resident #9 had a change of condition and NP #414 was notified he might say to give Lactulose. The DON stated NP #414 watched liver function and that was his gauge. The DON confirmed Lactulose was not administered to Resident #9 from 11/03/25 through 02/05/25. Review of the facility policy titled, Medication Administration, revised 12/14/17, revealed it was the policy of the facility to provide resident centered care that met the psychosocial, physical, and emotional needs and concerns of the residents. Further review revealed safety of residents, visitors, and employees was a top priority of care. This deficiency represents non-compliance investigated under Complaint Number OH00162412.

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	365727	A. Building B. Wing	03/27/2025

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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 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** 42013 Based on observation, medical record review, resident and staff interview, review of shower sheets, and policy review, the facility failed to ensure pressure ulcer treatments were implemented as ordered and failed to ensure pressure ulcers were properly identified and addressed in a timely manner. This affected two (#9 and #108) of four residents reviewed for pressure ulcers. The facility census was 148. Findings included: 1. Review of Resident #9's medical record revealed an admitted [DATE]. Diagnoses included hepatic encephalopathy, type two diabetes mellitus, dysphagia, and congestive heart failure. Review of Resident #9's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had moderate cognitive impairment. Resident #9 was dependent for toileting hygiene, bathing, and lower body dressing. Resident #9 required partial to moderate assistance with personal hygiene. Resident #9 was always incontinent of urine and bowel. Resident #9 was at risk of developing a pressure ulcer but did not have a pressure ulcer or injury. Resident #9 did not reject care during the seven-day assessment look-back period. Review of Resident #9's Braden scale observation tool dated 03/11/25 revealed Resident #9 was at low risk for developing a pressure ulcer. Review of Resident #9's progress notes dated 02/05/25 at 1:40 A.M. revealed Resident #9 was transported to the local hospital. Review of Resident #9's progress notes dated 02/10/25 at 4:03 P.M. revealed Resident #9 was readmitted to the facility and had three pressure ulcers with treatments ordered. Resident #9 was placed on a low air loss mattress and Resident #9's son was notified. Review of Resident #9's wound assessment report dated 02/12/25 revealed Resident #9 had a stage two pressure ulcer (partial-thickness skin loss with exposed dermis) to the sacrum present on admission with measurements of 2.0 centimeters (cm) long by 1.0 cm wide by 0.2 cm deep. Treatment initiated to cleanse the wound with normal saline, apply Triad cream (a zinc oxide-based paste used for managing wounds), and a bordered foam dressing daily and as needed. Resident #9 had a stage one pressure ulcer (non-blanchable erythema of intact skin) to the mid-back on admission with measurements of 1.0 cm long by 1.5 cm wide with no measurable depth. Treatment was initiated to cleanse the wound with wound cleanser, apply skin prep and a bordered foam dressing three times a week and as needed. Resident #9 also had a stage one pressure ulcer to the right lateral ankle present on admission with measurements of 1.0 cm long by 1.0 cm wide with no measurable depth. Treatment was initiated to cleanse the wound with normal saline, apply skin prep and a bordered foam dressing three times per week and as needed. Review of Resident #9's wound assessment report dated 02/19/25 included Resident #9's right lateral ankle stage one pressure injury was resolved. (continued on next page)

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	365727	A. Building B. Wing	03/27/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9's wound assessment report dated 02/26/25 included Resident #9's sacral stage two pressure ulcer was resolved. Review of Resident #9's wound assessment report dated 03/05/25 included Resident #9's stage one pressure ulcer to the mid-back was resolved. Review of Resident #9's progress notes and assessments dated 03/05/25 through 03/25/25 did not reveal evidence Resident #9 had reddened or open areas on her back and coccyx. Review of Resident #9's medication administration record and treatment administration record dated 03/05/25 through 03/26/25 did not reveal treatment orders were provided for Resident #9's back, buttocks, or coccyx areas. Review of Resident #9's nurse aide assignment sheets dated 03/20/25, 03/21/25, and 03/25/25 revealed Certified Nurse Aide (CAN) #253 was assigned to care for Resident #9. Review of Resident #9's shower sheet revealed the documented month was March 2025, but the specific date was unable to be determined. Further review revealed there was an area of concern over Resident #9's right buttock. Review of Resident #9's shower sheet dated 03/20/25 and 03/22/25 revealed there was a mark placed over the drawing of a back on the shower sheet indicating there was an area of concern. Observation and interview during incontinence care on 03/26/25 at 8:30 A.M. with CNA #215 revealed Resident #9 had three areas of injury on the skin including one to her mid-back which was red, non-blanchable, and the size of a deck of cards; one to her coccyx which was reddened, open, approximately 0.1 cm deep, and the size of a dime; and the third area was over slightly to the right of the coccyx wound on the right buttock which was the size of a pencil eraser, and was reddened and non-blanchable. Further observation by the surveyor determined the areas identified were pressure- related. CNA #215 verified the three areas of injury on the resident's skin at the time of the observation. Interview on 03/26/25 at 1:22 P.M. with Nurse Practitioner (NP) #412 revealed she evaluated Resident #9 today on 03/26/25 and Resident #9 had two areas of MASD on her coccyx. Interview on 03/26/25 at 12:00 P.M. with CNA #253 revealed Resident #9 had red areas on her back and coccyx for a while. CNA #253 stated she told the nurse a couple days ago about Resident #9's red areas on her back and coccyx, but she did not remember what day it was or which nurse she told. CNA #253 stated the areas were reddened and were not open the last time she cared for Resident #9. 35765 2. Review of the medical record revealed Resident #108 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, chronic pain, metabolic encephalopathy, peripheral vascular disease, adult failure to thrive, dementia, dysphagia, insomnia, hypertensive heart disease, anxiety disorder, bullous pemphigoid, protein-calorie malnutrition, vitamin D deficiency, major depressive disorder, syncope and collapse, and hyperlipidemia. (continued on next page)

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	365727	A. Building B. Wing	03/27/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the March 2025 medication administration record revealed Resident #108 had an order for the nurse to use adhesive removal when changing the dressing to the sacrum every shift dated 01/27/25 and was signed off as completed twice daily. Review of the March 2025 physician orders revealed Resident #108 had an order to cleanse the sacral wound with Hibiclens, pat dry, apply iodoform, and cover with bordered foam dressings every shift and as needed dated 03/17/25 and a nurse to use adhesive removal when changing dressing to sacrum dated 01/27/25. Observation of wound care on 03/26/25 at 8:00 A.M. revealed LPN #280 provided wound care to Resident #108. LPN #280 started to remove the border foam from the sacrum of Resident #108 and the resident voiced expressions of pain numerous times while LPN #280 removed the treatment. On 03/26/25 at 12:30 P.M. an interview with the Director of Nursing (DON) stated she does not know why Resident #108 still had an order for adhesive remover because she thought it was discontinued. The DON stated at one time Resident #108 had a dressing that was irritating the skin around her sacrum so they got an order of adhesive remover so it would be easier on her. On 03/26/25 at 11:21 A.M. an interview with LPN #280 confirmed she did not use the adhesive remover prior to removing the border foam dressing from the sacrum of Resident #108. LPN #280 stated she did not know Resident #108 had an order for adhesive remover. Review of the undated facility policy titled, Skin Care and Wound Management Overview, revealed the facility strives to prevent resident skin impairment and to promote the healing of exiting wounds. The interdisciplinary team works with the resident and for family to identify and implement interventions to prevent and treat potential skin integrity issues. This deficiency represents non-compliance investigated under Complaint Number OH00162412.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, staff interview, medical record review, and review of the facility policy, the facility failed to ensure fall interventions were in place as care planned to prevent falls. This affected one (#111) of three residents reviewed for falls. The facility census was 148. Findings include: Review of Resident #111's medical record revealed an admitted [DATE] and diagnoses included hemiplegia affecting the right dominant side, acute respiratory failure with hypoxia, and vascular dementia. Review of Resident #111's annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #111 did not have a Brief Interview for Mental Status (BIMS) completed due to Resident #111 being rarely or never understood. Resident #111 was dependent for toileting hygiene, bathing, personal hygiene, and lower body dressing. Resident #111 required partial to moderate assistance for the ability to roll from lying on her back to the left and right side and return to lying on her back on the bed. Resident #111 was always incontinent of urine and bowel. Review of Resident #111's fall risk observation tool dated 11/02/24 revealed Resident #111 was at risk for falls. Review of Resident #111's care plan revised 04/22/24 included Resident #111 was at risk for falls related to diagnoses with a goal Resident #111 would not sustain a major injury related to falls through the review date. Interventions included Dycem (non-slip pad) to chair as ordered; move Resident #111 closer to the nurses station when available; and an intervention initiated 11/12/24 revealed to place Dycem between Resident #111 and the Hoyer (mechanical lift) pad. Review of Resident #111's progress notes dated 02/01/25 at 12:30 P.M. revealed the nurse heard Resident #111 start yelling, when she checked on her she was found in the common area on the floor in front of her chair. A head-to-toe assessment was completed and no injuries or pain was noted. Resident #111 was assisted back to her chair using a mechanical lift with the assistance of three staff. Neurological checks were started and an intervention was documented for extra Dycem in the resident's chair to prevent future falls. Review of Resident #111's fall risk observation tool dated 02/02/25 revealed Resident #111 was at risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/25/25 at 2:07 P.M. with Licensed Practical Nurse (LPN) #221 revealed when Resident #111 fell on [DATE] she was sitting in her padded tilt-in-space wheelchair and had recently been checked and changed for incontinence. LPN #221 stated she did not see the fall, she heard yelling, and ran to where the yelling was. LPN #221 stated Resident #111 slid out of her chair and she did not know how it happened. LPN #221 stated she saw Resident #111 about five minutes before she experienced the fall and she was fine. LPN #221 stated she could not remember the position of Resident #111's tilt-in-space wheelchair when she had the fall. There was no evidence she had a seizure, and sometimes Resident #111 moved around a bit in the chair. Observation on 03/25/25 at 2:32 P.M. of Resident #111 with Unit Manager (UM) #230 revealed she was lying in bed with her eyes open. A fall mat was observed on the floor next to her bed and the bed was in the lowest position. Resident #111 told UM #230 she wanted to get out of bed. UM #230 instructed Certified Nurse Aide (CNA) #292 and CNA #293 to assist Resident #111 out of her bed into her padded tilt-in-space wheelchair. CNA #292 and CNA #293 assisted Resident #111 to her padded wheelchair using a mechanical lift. Observation on 03/25/25 at 4:40 P.M. of UM #230 and LPN #270 revealed they assisted Resident #111 to her bed using a mechanical lift to check her for incontinence. Observation revealed there was Dycem located on the wheelchair cushion, but there was no Dycem between Resident #111 and the mechanical lift pad. The Dycem that was supposed to be between Resident #111 and the mechanical lift pad was observed laying on Resident #111's bedside table. UM #230 and LPN #270 confirmed the Dycem was not placed between Resident #111 and the mechanical lift pad and should have been. Review of the undated facility policy titled, Fall Prevention and Management, revealed fall prevention and management was the process of identifying risk factors that could minimize the potential for falls and also a process to manage a resident's care if a fall occurred. If the resident was identified to be at risk for falls, a care plan should be initiated that included a plan to potentially diminish the risk for falls. The care plan should be reviewed and updated as needed with each change of condition.

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	365727	A. Building B. Wing	03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, resident and staff interview, medical record review, and review of the facility policy, the facility failed to ensure incontinence care was completed timely. This affected one (#15) of three residents reviewed for incontinence. The facility census was 148. Findings include: Review of Resident #15's medical record revealed an admitted [DATE] and diagnoses included congestive heart failure, type two diabetes mellitus with diabetic peripheral angiopathy without gangrene, and chronic kidney disease. Review of Resident #15's care plan revised 03/18/25 revealed Resident #15 had impaired skin integrity or was at risk for altered skin integrity. Resident #15 would have improved or maintain current skin status through the next review date. Interventions included to provide peri-care as needed to avoid skin breakdown due to incontinence. Review of Resident #15's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was cognitively intact. Resident #15 was dependent for toileting hygiene and lower body dressing. Resident #15 was dependent for the ability to transfer to and from a bed to a chair or wheelchair. Resident #15 was always incontinent of urine and frequently incontinent of bowel. Observation and interview on 03/24/25 at 2:48 P.M. of Certified Nurse Aide (CNA) #289 and CNA #417 revealed they transferred Resident #15 back to her bed. Resident #15 stated she was put in her chair around 10:00 A.M. and she was unable to be put back to bed until now because there is no care during meals and you might as well forget it if you need something. Resident #15 stated she had to wait until the lunch meal was finished. Observation of Resident #15's incontinence care revealed her left and right buttocks had large red areas on them. Resident #15's left buttock was more reddened than her right buttock. Resident #15 stated she had a huge bowel movement that morning that was not diarrhea, and it took at least two hours for her to be changed because it happened during the breakfast meal. CNA #289 confirmed Resident #15 had reddened areas on the right and left buttocks. CNA #289 stated she was not working at the time of the lunch meal and just came to work. CNA #417 confirmed residents often had to wait for care during meal times because the staff was passing out meal trays and feeding residents. Review of the undated facility policy titled, Perineal Care Male or Female, revealed the purpose of the procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. It was the policy of the facility to provide resident care that met the psychosocial, physical, emotional needs and concerns of the the residents. Providing personal care services promoted a sense of well-being and met hygiene standards of care. Perineal care was performed on residents who were unable or unwilling to maintain body cleanliness and, or who were incontinent of bowel and bladder.