

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365759	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/06/2025
NAME OF PROVIDER OR SUPPLIER  Health Center at the Renaissance		STREET ADDRESS, CITY, STATE, ZIP CODE 26376 John Rd Olmsted Twp, OH 44138	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on resident record review, staff interviews, review of Self-Reported Incidents (SRIs), and review of facility concern logs, a soft file investigation and facility policy review, the facility failed to ensure Residents #33 and #48 were free from verbal and physical abuse. This affected two residents (#33 and #48) of two residents reviewed for abuse. The facility census was 82. Findings include: 1. Review of the medical record for Resident #33 revealed an admission date of 08/23/20 and diagnoses including dementia, hypertension, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 had short- and long-term cognition impairment, was severely impaired regarding tasks of daily life, had a history of physical and verbally aggressive behaviors, was resistant to care, and was dependent on staff for toileting, lower body dressing and mobility. Review of the care plan last updated on 08/22/25 revealed Resident #33 had a diagnosis of dementia with a history of behaviors during care that included kicking, grabbing, pushing, pinching, scratching, spitting, biting, abusive language, threatening behaviors and attempts to grab and hit staff members. Interventions included staff were to anticipate Resident #33's needs, approach in a calm and friendly manner, and/or stop care and reapproach later. Resident #33 was also resistive to allowing staff to provide care with interventions including to leave and return five to ten minutes later and try again. The resident had an electronic monitoring device in the room in accordance with the provisions of Esther's Law. Review of the progress note dated 03/06/25 at 12:10 P.M. revealed Resident #33 was combative with hygiene care and with routine medication. Review of the progress note dated 03/22/25 at 4:34 A.M. revealed Resident #33 was combative during care and punched an unknown nurse in the mouth and lips. Review of the progress note dated 03/30/25 at 9:39 P.M. revealed Resident #33 moved away an unknown nurse's hand during medication administration. Review of the SRI tracking system located within the Ohio Department of Health (ODH) for certification and licensing website revealed an SRI dated 03/24/25 of an allegation of alleged abuse. Resident #33's son contacted the facility and complained of staff being too rough during care, which resulted in Registered Nurse (RN) #717 being immediately suspended pending investigation. Resident #33's son provided video footage, reviewed by the Administrator, which revealed RN #717 assisting Certified Nurse Aide (CNA) #720 with Resident #33's incontinence care. Resident #33 was then observed punching RN #717 in the face. RN #717 was heard stating You will NOT do that as she then grabbed Resident #33's hands and held them while rolling Resident #33 over to continue with incontinence care. RN #717 revealed she and CNA #720 struggled to provide care for Resident #33, so she held Resident #33's hands as a result. Further review of the SRI revealed Resident #33's son informed the Administrator of another incident regarding CNA #720 while providing care to Resident #33 and as she turned Resident #33, she hit the resident's head on the enabler bar. CNA #720 did not stop providing care and did not report the incident to the nurse on duty which resulted in CNA #720's termination. The Administrator stated CNA #720's haste in providing care resulted in Resident #33 hitting her head. Review of the progress notes in Resident #33's medical record revealed no progress note related to the alleged incident. Review of the mandatory training for all staff revealed the facility educated staff on sensitivity and dementia care dated 06/16/25, 07/14/25, and 08/11/25. Subsequently implemented approximately three months after the alleged incident, which occurred in March 2025. Review of the facility document titled New Hire Orientation dated 09/25/25 revealed the staff were educated on abuse policy and protocols and dementia care related to trauma, behaviors, and substance. Review of the staff education revealed staff were educated on trauma-informed care 02/01/25, challenging behaviors for dementia residents 03/02/25, and abuse, neglect, and exploitation 09/01/25. Review of the personnel file for RN #717 revealed a hire date of 08/06/21 and education received for the abuse, neglect and misappropriation policy on 08/06/21 and 08/09/21. Review of the job termination notice dated 03/25/25 revealed RN #717 was terminated after the incident on 03/23/25 because of violating the facility's conduct and behavior policy. Review of the termination notice revealed RN #717 was observed on video footage reacting firmly and abruptly to Resident #33, who struck her during care. Review of the notice revealed RN #717 actions were loud, reactive, and lacked the calm, professional demeanor expected of quality resident care. RN #717, rather than deescalating the situation was observed on video raising her voice and holding Resident #33 hands in a manner to prevent striking, but it did not align with best practices for dealing with combative behaviors. An interview with RN #717 and CNA #720 was attempted throughout the survey period. However, attempts were unsuccessful as their employment was terminated with the facility.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on resident record review, staff interviews, review of Self-Reported Incidents (SRIs), review of facility soft file investigation, and facility policy review, the facility failed to report an incident of alleged abuse to the State Agency. This affected one (Resident #48) of two residents reviewed for abuse. The facility census was 82. Findings include: Review of the medical record for Resident #48 revealed an admission date of 03/03/25 with diagnoses including Alzheimer's disease, hypertension, osteoarthritis of the left knee, and right artificial hip joint. Review of the MDS assessment dated [DATE] revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment and the resident was dependent on staff for toileting, lower body dressing and hygiene. Review of the physician orders dated 03/03/25 revealed an order to assist Resident #48 with turning and repositioning during routine rounds and as needed. Review of the progress note dated 03/04/25 at 4:44 P.M. revealed Resident #48 was admitted to the facility after a fall which resulted in a right hip fracture with repair. Review of the concern log for March 2025 revealed Resident #48's son contacted the Administrator on 03/24/25 to express concerns regarding the conduct of an agency aide, CNA #718, who was assigned to Resident #48. Out of abundance of caution, CNA #718 was immediately removed from duty pending a full investigation, and after a thorough review of the incident, it was determined CNA #718 would not return to the facility. Review of the facility folder titled Soft File for Resident #48 dated 03/23/25 revealed an incident timeline and analysis. Review of the timeline revealed on 03/23/25 at 8:36 P.M., the Administrator missed a call from an unknown number and at 8:37 P.M. Resident #48's son sent a text message to the Administrator requesting a callback regarding the situation. The Administrator returned the call at 8:38 P.M. and was informed the aide on duty (CNA #718) was unprofessional during care as observed via the room camera. Resident #48's son stated CNA #718 mocked Resident #48 and sent a video clip to the Administrator. At 8:46 P.M. Assistant Director of Nursing (ADON) #862 notified the Director of Nursing (DON) and the Administrator that she had also received a call to report Resident #48's family was upset. ADON #862 revealed Resident #48's family alleged CNA #718 was rough while turning Resident #48 during care and mocked him. ADON #862 confirmed Licensed Practical Nurse (LPN) #894 was present at the time of care being provided. At 8:52 P.M. the Administrator instructed ADON #862 to send CNA #718 home. At 9:12 P.M. the Administrator contacted Resident #48's son and daughter and informed them CNA #718 was sent home due to the family's concern and for failing to uphold the professionalism expected at the facility. As a result, the facility initiated a Do-Not-Return (DNR) order for CNA #718. Further review of the soft file revealed the provided video of the alleged incident was reviewed by the Administrator and DON which showed CNA #718 assisted Resident #48 with changing clothes and transferred him to bed using a Hoyer lift with the assistance of LPN #894. As Resident #48 was transferred, he made moaning noises, in which CNA #718 paused and asked if she was doing something wrong or if Resident #48 was in pain. CNA #718 was then heard mimicking the noise Resident #48 made. As CNA #718 walked toward the bathroom, she then repeated the mimicked noise from Resident #48's indication of pain. Interview on 09/24/25 at 3:21 P.M. with LPN #894 was attempted via phone. However, contact was unsuccessful as the number was disconnected. Interview on 09/24/25 at 4:12 P.M. with the Administrator revealed Resident #48's son contacted her on a weekend in March of the current year regarding an agency aide's (CNA #718) conduct, in which she had a soft file pertaining to the incident. Interview on 09/25/25 at 8:01 A.M. with the Administrator and the DON revealed Resident #48 had a fall prior to being admitted to the facility, and the family wanted a camera installed in the room. Resident #48's son reported CNA #718 was unprofessional and mocked the resident and sent a video clip of the incident in question. The Administrator revealed prior to reviewing the video clip, CNA #718 was sent home, and subsequently, after watching the video clip, CNA #718 was placed on the DNR list. The video clip revealed Resident #48 was in process of being transferred into bed by CNA #718 and LPN #894 via Hoyer lift when Resident #48 made a moaning noise indicating pain. CNA #718 asked Resident #48 if she was doing something wrong and mimicked the noise made by Resident #48. Once Resident #48 was in bed, CNA #718 walked towards the bathroom while mimicking Resident #48's moaning noise. Review of additional video clips with the Administrator and DON present, revealed CNA #718 provided incontinence care to Resident #48 while in bed. The resident was heard yelling out in pain and CNA #718 stated, You have to help me and stop resisting. CNA #718 was then observed with both hands placed on Resident #48's right hip and pushed him onto his left side as he yelled</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, hospital record review and interview, the facility failed to develop and implement a comprehensive and individualized fall prevention program/fall interventions to decrease Resident #2's risk of falls including falls with injury. This affected one resident (#2) of one resident reviewed for falls. The facility census was 82. Actual Harm occurred on 12/09/24 when Resident #2, who was at risk for falls and had a history of falls, sustained a left hip fracture without evidence the facility had implemented individualized and effective interventions to prevent the fall with fracture. The resident had sustained falls on 11/29/24 and 12/08/24 with the only intervention listed post fall was to remind the resident to call for assistance. Actual Harm continued on 02/10/25 when Resident #2, who remained at risk for falls and continued to sustain falls, was assessed to have a right hip fracture as a result of a fall when Certified Nursing Assistant (CNA) #899 failed to maintain hands-on contact assistance during a resident transfer which resulted in the fall. Resident #2 had severe pain and decreased range of motion to the right hip, was transported to the hospital and subsequently diagnosed with a closed fracture of the right hip (superior and inferior pubic rami). Findings include: Review of the medical record for Resident #2 revealed an admission date of 11/22/24 and diagnoses including diabetes mellitus, abnormalities of gait and mobility, osteopenia, osteoarthritis, anemia, lymphedema, repeated falls, and generalized muscle weakness. Review of the hospital paperwork for admission dated 11/19/24 revealed Resident #2 had previously fallen at home and sustained a nondisplaced periprosthetic fracture of the femoral component and a chronic subdural hematoma. Review of the Fall Risk Evaluation dated 11/22/24 revealed Resident #2 was at risk for falls. Review of the care plan initiated 11/23/24 revealed Resident #2 was at risk for falls. Initial interventions included for staff assistance with ambulation and transfers, and to utilize therapy recommendations. Review of a Brief Interview for Mental Status (BIMS) score dated 11/29/24 revealed a score of 13 (out of 15) indicating Resident #2 had intact cognition. Review of a fall investigation report dated 11/29/24 revealed Resident #2 had an unwitnessed fall in the bedroom due to an attempted self-transfer but had no injury. Staff intervention included educating Resident #2 to call for assistance. Review of a fall investigation report dated 12/08/24 revealed Resident #2 had an unwitnessed fall in the bedroom due to an attempted self-transfer but had no injury. Staff intervention was educating Resident #2 to call for assistance (the same intervention initiated after the unwitnessed fall on 11/29/24). Review of a fall investigation report dated 12/09/24 revealed Resident #2 had an unwitnessed fall in the doorway into the hall, and the resident was unable to report what happened. Blood was observed on multiple areas of both legs and was then transferred to the hospital. A staff intervention following the incident was to bring Resident #2 into the common area for increased supervision. Review of hospital paperwork dated 12/09/24 revealed Resident #2 had fallen and complained of left hip pain. Resident #2's left leg was shortened and externally rotated. There was a left hip (peri trochanteric femur) fracture. No surgical interventions were taken. Review of admission summary note dated 12/13/24 revealed Resident #2 returned from the hospital with a left hip fracture and was non-weight bearing to the left side. Review of the Fall Risk Evaluation dated 12/13/24 revealed Resident #2 was at risk for falls. Review of the daily note dated 01/07/25 revealed Resident #2 was transferring unassisted and required education on waiting for assistance. Review of an order note dated 01/10/25 revealed Resident #2 received new therapy orders for transfers to graduate from a mechanical lift to transfer with a slide board. Review of the Medicare Minimum Data Set (MDS) five-day assessment dated [DATE] revealed Resident #2 had a (BIMS) score of 12 (out of 15) which indicated the resident had moderate cognitive impairment. The assessment revealed the resident required partial/moderate (staff) assistance for transfers and was independent for bed mobility and wheelchair use. Review of the physician's orders dated 02/10/25 revealed Resident #2 required one staff assistance with transfers, bilateral enabler bars for turning and repositioning, and weight bearing as tolerated. Review of a fall investigation report dated 02/10/25 revealed Resident #2 had a witnessed fall while being assisted by CNA #899 to transfer from the chair scale to the wheelchair. During the transfer while Resident #2 was standing, CNA #899 swapped the two chairs while not holding on to the resident. Resident #2 lost balance and fell backwards, then complained of pain to the right hip and had decreased range of motion. The resident was sent to the hospital. Following the incident, CNA #899 received education on safe transfers and was reminded of Resident #2 requiring hands-on assistance for standing and transfers. Review of the incident note dated 02/10/25 revealed Resident #2 was yelling out in pain and complained of severe pain to</p>		