STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365771	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copley Health Center	155 Heritage Woods Drive Copley, OH 44321

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility policy, the facility failed to ensure consistent and accurate advanced directives were maintained throughout the electronic and physical medical records. This affected five residents (#9, #14, #18, #96, and #128) of five residents reviewed for advanced directives. The facility census was 124.Findings include:1.Review of Resident #9's electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder bipolar, moderate vascular dementia, delusional disorder, generalized anxiety disorder, cognitive communication deficit, uncomplicated hallucinogen abuse and chronic post-traumatic stress disorder.Review of Resident #9's physician orders in the EMR revealed her code status was for Cardiopulmonary Resuscitation (CPR) [full code]. Review of the advanced directive tab in the physical (paper) medical record revealed there was no documentation under the tab to indicate what the resident's advance directives were. Interview on [DATE] at 4:13 P.M. Registered Nurse (RN) #500 and Licensed Practical Nurse (LPN) #550 verified there was nothing under the advanced directives tab in Resident #9's paper chart and they did not have a separate code status book.2.Review of Resident #14's EMR revealed an original admission date of [DATE] and was re-admitted on [DATE]. Diagnoses included nonactive primary progressive multiple sclerosis, hypertensive heart and chronic kidney disease, chronic kidney disease stage two (mild), paraplegia and unspecified moderate dementia with mood disturbance. Review of Resident #14's orders in the EMR revealed her code status was Do Not Resuscitate-Comfort Care Arrest (DNR-CCA). Review of the advanced directive tab in the physical (paper) medical record revealed Resident #14 was Do Not Resuscitate-Comfort Care (DNR-CC).Interview on [DATE] at 4:13 P.M. with RN #500 and LPN #550 verified the advanced directives tab in the paper chart revealed Resident #14 was DNR-CC. They did not have a separate code status book. 3.Review of Resident #18's EMR revealed she was admitted to the facility on [DATE]. Diagnoses included schizoaffective disorder Bipolar, heart failure and essential hypertension. Review of Resident #18's orders in the EMR revealed a code status was CPR. Review of the advanced directive tab in the physical (paper) medical record revealed there was no documentation under that tab.Interview on [DATE] at 4:13 P.M. with RN #500 and LPN #550 verified the advanced directive tab in the paper medical record was empty of any documentation/paperwork. There was no separate code status book. 4.Review of Resident #96's EMR revealed he was admitted to the facility on [DATE] and re admitted on [DATE]. Diagnoses included unspecified intracranial injury with loss of consciousness of unspecified duration, aphasia and essential hypertension.Review of Residents #96's orders in the EMR revealed his code status was DNR-CCA. Review of the advanced directive tab in the physical (paper) medical record revealed there was no information regarding his code status.Interview on [DATE] at 4:13 P.M. with RN #500 and LPN #550 verified the advanced directive tab in the paper medical record was empty. There was no documentation under the advanced directive tab. There was no separate code status book.5.Review of Resident #128's EMR revealed an admission date to the facility on [DATE] and readmitted on [DATE]. Diagnoses included Alzheimer's disease, moderate dementia in other disease with mood disturbance, diabetes mellitus II (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with hyperglycemia and hypertensive heart disease with heart failure.Review of Resident #128's orders in the EMR revealed his code status was CPR. Review of the advanced directive tab in the physical (paper) medical record revealed the code status for Resident #128 was DNR-CC.Interview on [DATE] at 4:13 P.M. with RN #500 and LPN #550 verified the advanced directive tab in the paper chart stated Resident #128 was DNR-CC. There was no separate code status book. Review of the facility policy, Advance Directive (Resident's Right to Choose), with a revision date of [DATE] revealed should the resident have an Advance Directive, copies will be made and filed in the resident's electronic health record and in the resident's physical (paper) medical record as well as communicated to the staff.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on resident interviews, observation of lunch meal, observation of test tray, review of resident council minutes, and review of facility policy, the facility failed to ensure meals were served at a palatable temperature. This had the potential to affect all residents who received meals from the kitchen. The facility identified eight residents (#4, #23, #94, #96, #127, #131 #144, and #149) who were on nothing by mouth (NPO) diet and did not receive food from the facility's kitchen. The facility census was 124.Findings include: Review of the resident council meeting minutes from 03/12/26 revealed residents complained of cold food.Interview on 03/16/26 at 11:09 A.M. with Resident #128 revealed the food was not palatable.Interview on 03/16/26 at 12:19 P.M. with family member of Resident #75 revealed the food was not always hot.Interview on 03/16/26 at 1:34 P.M. with Resident #2 revealed she voiced the food sucks. Interview on 03/17/26 at 8:55 A.M. with Resident #36 revealed the food was not always warm.A resident council meeting was held on 03/17/26 at 3:00 P.M. with Residents #31, #61, #64, #77, and #83. Residents reported food was frequently cold and the kitchen was not always using warming plates to keep food hot.Observation on 03/18/26 from 11:51 A.M. to 1:11 P.M. of the lunch meal service revealed the temperatures at the start of service were 190 degrees Fahrenheit (F) for hot dogs, 175 degrees F for baked beans, and 32 degrees F for coleslaw. At 1:11 P.M. the last cart for hallway trays was completed and contained a test tray. The cart arrived to the unit at 1:13 P.M. and staff completed passing trays at 1:17 P.M. Temperatures were obtained from the test tray by District Manager (DM) #913 using the facility's digital thermometer. Temperatures were 105 degrees F for the hot dog, 109 degrees F for the baked beans, and 36 degrees F for the coleslaw. Taste test of the hot dog and baked beans revealed the food was not a palatable temperature. DM #913 participated in tasting the test tray.Interview on 03/18/26 at 1:17 P.M. with DM #913 confirmed the hot dog and baked beans were not at an acceptable or palatable temperature.Review of the facility policy titled Food: Quality and Palatability dated September 2017 revealed food would be palatable, attractive, and served at a safe and appetizing temperature. This deficiency represents non-compliance investigated under Complaint Number 1273862 (OH00163626) and 1273861 (OH00163574).

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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. Based on observation, interview, record review, review of manufacturer information, and facility policy review, the facility failed to ensure strength of wound care solutions were specified in a physician order. This affected one Resident #15 of three residents observed for wound care. The facility census was 124. Findings include: Review of the medical record for Resident #15 revealed diagnosis of Alzheimer's, atrial fibrillation, malnutrition, depression and dysphagia.Review of Resident #15's physicians' order dated 03/05/26 for a wound dressing to the sacrum stated to cleanse with wound cleaner, pack with Dakin's solution moistened gauze and apply triad cream, zinc oxide based, around the outside of the wound. and cover with boarder foam dressing. The wound order to the sacrum did not identify a strength for Dakin's Solution.Review of the undated available Dakin's Solution products on the manufacturer's website revealed Dakin's solution is available in full strength (0.5 percent) (%), half strength (0.25%), quarter strength (0.125%) and as a Diluted Dakin's solution with the lowest strength of 0.0125%. Observation on 03/18/26 at 10:46 A.M. with Registered Nurse (RN) #544 providing wound care to Resident #15 revealed the nurse gathered supplies, including Dakin's 0.0125 % solution. RN #544 stated the Dakin's solution was quarter strength. RN #544 cleansed the wound with wound cleanser and packed the wound with gauze saturated with Dakin's 0.0125%, applied Triad cream around edges of the wound and applied a foam dressing. Interview on 03/18/26 at 11:00 A.M. with RN #544 verified the wound order did not have a specified strength to the Dakin's solution. RN #554 stated the order was not clarified to obtain the desired strength of the Dakin's solution. RN #544 thought Dakin's 0.0125% was quarter strength. RN #544 stated she would notify the resident's Nurse Practitioner (NP) to get a one-time order to use Dakin's 0.0125% for the wound dressing she had already completed. Review of the facility policy titled Medication Management undated policy stated to administer medication only as prescribed by the provider and observe the five rights in giving each medication. The right resident, the right time, the right medicine, the right dose, and the right route.