STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365774	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medina Bsd Opco LLC	550 Miner Dr Medina, OH 44256

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with staff, the facility failed to ensure laboratory tests were obtained as ordered for Resident #2. This affected one resident (Resident #2) of three residents who were reviewed for physician orders. Findings Include: Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, bronchiectasis, gastroparesis, dependent on a respirator, neuromuscular dysfunction of the bladder, obstructive sleep apnea, hypertension, osteomyelitis, Acinetobacter Baumannii, pseudomonas, resistant to antibiotics, anxiety disorder, pressure ulcers, acquired absence of right and left legs above the knee, diverticulitis, gastric ulcer, suprapubic catheter, and major depressive disorder. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #2 had intact cognition, she was dependent for toileting hygiene, required moderate assistance for personal hygiene, and she did not transfer to the toilet. Resident #2 was always incontinent of bowel. Review of the Progress Note dated 05/13/26 at 2:05 A.M. revealed Resident #2 had complained of gastrointestinal (GI) upset, she was having constant belching, loose watery stools, she was given Zofran for nausea with some effect. It also noted her dressing kept coming off due to frequent stool, the physician updated. Review of the Progress Note dated 05/13/26 at 6:08 A.M. Resident #2 continued with complaints of nausea and loose stools, stool was less watery this morning. Resident did not want to go to the emergency department. The physician was given another update. Review of the Progress Note dated 05/13/26 at 4:07 P.M. revealed Resident #2 was seen by the Nurse Practitioner for a routine visit, and due to GI symptoms and continuation of loose stool. New orders were received to recheck stool for Closterium difficile (C-Diff), continue vancomycin 125 milligrams every six hours for 10 days, and start house fiber capsule once daily. The resident was updated with new orders. Review of the Nurse Practitioner Progress Note dated 05/13/26 revealed Resident #2 was seen and examined for episodic visit while the resident received skilled care. The resident continued with loose stools over the last three days she was recently treated for watery stools/diarrhea/C-Diff. Per the resident, they had started to improve but had worsened over the last three days. The plan was to restart the 10-day course of vancomycin, get another stool sample, and start a fiber supplement to bulk up her stools. Review of the physician's orders revealed Resident #2 had orders to check her stool for C-Diff due to loose stools on 05/14/26 and to discontinue the order once stool was sent to the pharmacy, and vancomycin 125 milligrams every six hours for 10 days dated 05/13/26. Review of the May 2026 Bowel Movement (BM) Record for Resident #2 revealed documentation on 05/13/26 that she had a large loose BM, on 05/14/26 she had one formed medium and one loose medium BM, on 05/15/26 she had two medium loose BM's, on 05/16/26 she had one large formed BM, on 05/17/26 she had one small loose and one medium loose BM, on 05/18/26 she had one medium loose BM, on 05/19/26 she had one medium loose BM, and on 05/20/26 she had one small loose and one medium loose BM. Resident #2 was documented as incontinent for all BM's from 05/13/26 through 05/20/26. Review of Resident #2's medical record revealed no documented evidence of a C-Diff stool sample related to the new order for it on 05/13/26. Review of the Nurse (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practitioner Progress Note dated 05/20/26 revealed Resident #2 was restarted on oral antibiotics last week and the second stool to confirm the diagnosis, was not obtained. However, the resident reported her stools had formed up and improved. She was recently seen by Infectious Disease and antibiotics were discontinued. She was to follow up with Infectious Disease in three months. On 06/02/26 at 10:25 A.M. an interview with the Director of Nursing (DON) revealed the Nurse Practitioner came in on 05/20/26 and discontinued the order for a stool for C-diff due to the resident having formed stools and she was on an antibiotic. The DON verified at this time the documentation on the BM records indicated Resident #2 was still having loose stools. On 06/02/26 at 11:30 A.M. an interview with the Administrator verified the nurse did not obtain the stool for the C-Diff even though the resident was documented as still having loose stools.