STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365779	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyant Woods Healthcare Center	200 Wyant Rd Akron, OH 44313

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews and facility policy review, the facility failed to ensure care plan meetings were offered timely to residents and guardians. This affected two residents (#117 and #134) out of three resident residents reviewed for care plan meetings. The facility census was 162. Findings include:1. Review of the medical record for Resident #117 revealed an admission date of 11/25/21. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, epilepsy, encephalopathy, impulse disorder and mood affective disorder. Resident #117 had a guardian since 2015. Review of the progress note dated 05/13/25, authored by Social Service Designee (SSD) #619 revealed a care conference was had last on 05/13/25. There was no documentation after 05/13/25 indicating a care conference for August 2025 or September 2025. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #117 had intact cognition. Resident #117 was dependent on staff for showers, lower body dressing, footwear and personal hygiene and required substantial assistance for toileting, upper body dressing, and oral hygiene and set up assistance for eating. Resident #117 was frequently incontinent of bladder and bowel. Interview on 09/29/25 at 11:05 A.M. via phone with Resident #117's guardian revealed she was not offered any care conferences in about four months. She reported the last care conference she had was about four months ago. Interview on 09/30/25 at 7:24 A.M. with Licensed Social Worker (LSW) #610 and SSD #619 confirmed Resident #117 did not have a care plan meeting timely. LSW #610 and SSD #619 reported last care plan meeting held for Resident #117 was 05/13/25, and he should have had one in August 2025 to be timely as required. LSW #610 and SSD #619 reported they were unable to state why the care plan meeting wasn't completed timely. Interview on 09/30/25 at 7:44 A.M., via phone with Licensed Practical Nurse (LPN) #605, confirmed care plan meetings were to be done quarterly. LPN #605 confirmed Resident #117 did not have a care plan meeting done timely and didn't know why. 2. Review of the medical record for Resident #134 revealed an admission date of 11/03/21. Diagnoses included fibromyalgia, type II diabetes mellitus with peripheral angiopathy, delusional disorders, bipolar disorder, panic disorder, phobic disorder and impulse disorder. Review of the progress note dated 05/29/25, authored by LSW #610 revealed a care conference was held last on 05/29/25. There was no documentation after 05/29/25 indicating a care conference for August 2025 or September 2025. Review of the quarterly MDS 3.0 assessment dated [DATE], revealed Resident #134 had intact cognition. Resident #134 required set up assistance for oral hygiene, personal hygiene and dressing and supervision for toileting and showers. Interview on 09/25/25 at 7:52 A.M. with Resident #134 denied having a care conference. She reported she couldn't remember when the last care conference was. Interview on 09/30/25 at 7:24 A.M. with LSW #610 and SSD #619 confirmed Resident #134's care plan meeting was not timely. LSW #610 and SSD #619 reported Resident #134's last care plan meeting was 05/29/25, and she was scheduled for her next care plan meeting 10/21/25. LSW #610 and SSD #619 unable to give a reason as to why the care plan meeting was late. Interview on 09/30/25 at 7:44 A.M., via phone with LPN #605 confirmed care plan meetings were to be done quarterly. LPN #605 confirmed Resident #134 did not have a care plan meeting done timely and didn't know why. Review of the undated facility policy titled Plan of Care Overview revealed attendees will sign and date care plan meeting agendas/documents. This deficiency is an incidental finding identified during the complaint investigation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, laboratory test reviews, hospital medical records review, pharmacy reviews and facility policy review, the facility failed to ensure the monthly pharmacy reviews recommended Resident #117's seizure medications were monitored with laboratory tests timely to prevent high/critical/toxic levels. This affected one resident (#117) out of three residents reviewed for medication monitoring. The facility census was 162. Findings include:Review of the medical record for Resident #117 revealed an admission date of 11/25/21. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, epilepsy, encephalopathy, impulse disorder and mood affective disorder. Resident #117 had a guardian since 2015. Review of the laboratory for Phenobarbital done at the facility for Resident #117 revealed a date of 01/24/25. The Phenobarbital level was 21 (normal range 10 to 40 micrograms per milliliter UG/ML). Review of the laboratory results dated [DATE] revealed the Levetiracetam (Keppra) (seizure medication) was high at 76, with normal range 6.00 to (-) 46.00 micrograms per milligram (ug/ml), Phenobarbital (seizure medication) was 23 ug/ml within normal limits (WNL) of 10-40 ug/ml, and Carbamazepine (Tegretol) (seizure medication) was 7.6 ug/ml WNL of 4-12 ug/ml. A repeat lab was done on 01/31/25 and revealed Levetiracetam (Keppra) was 30 ug/ml which was WNL, and Phenobarbital was 21 ug/ml which was WNL. There were no further laboratory tests done for seizure medication monitoring through the start of the investigation on 09/24/25. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #117 had intact cognition, with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Resident #117 was dependent on staff for showers, lower dressing, footwear and personal hygiene and required substantial assistance for toileting, upper dressing, and oral hygiene and set up assistance for eating. Review of the May and August 2025 Medication Administration Records (MARs) revealed an order Carbamazepine Extended Release (ER) (Tegretol) (anticonvulsant) 200 mg po BID for seizures (start date 12/28/23 and discontinue date of 07/28/25) on 07/28/25 the Tegretol 200 mg was re-ordered one tablet BID for seizures/epilepsy, an order for Levetiracetam (Keppra) (anticonvulsant) 1000 milligrams (mg) one tablet by mouth (po) two times daily (BID) for seizures (start date 12/28/23), Gabapentin 600 mg (anticonvulsant) one tablet po at bedtime (start date 08/06/24) and 600 mg two tablets po in the morning (start date 08/07/24), Dilantin (anticonvulsant) 100 mg one capsule po three times daily (TID) for seizures (start 01/27/25), Phenobarbital (anticonvulsant) 64.8 mg give 1 tablet po BID for convulsions (start date 04/07/25), and Divalproex Sodium capsule delayed release Sprinkle (Depakote) (anticonvulsant) 125 mg one capsule po TID (start 07/06/25). Review of the pharmacy recommendations from 06/01/25 to 08/25/25 revealed the pharmacist failed to identify the need for lab tests for levels for the anticonvulsants that Resident #117 was receiving. Review of the progress note dated 08/25/25 at 6:32 P.M. revealed a change in condition for Resident #117. Resident #117 had a decrease in food and fluid intake and a functional decline with worsening function and mobility. The resident's diet was downgraded to a puree diet with thickened liquids due to the concern of aspiration, and the resident was no longer able to assist with his personal care as he used to before and was now requiring total care. Review of the progress note dated 08/25/25 at 6:48 P. M. revealed Resident #117's guardian, unit manager, and physician were notified of the change in condition. Review of progress note dated 08/26/25 at 11:11 A.M. revealed Resident #117 was tested for Respiratory Syncytial Virus/Coronavirus Disease of 2019 (RSV/COVID) due to related symptoms, and the results were negative. Plan of care continued, and all parties notified per change in condition (CIC) form. Review of the progress note dated 08/26/25 at 1:30 P.M. revealed therapy notified the nurse that the resident was having a hard time eating. The nurse notified the physician, and he ordered to send the resident to the hospital for an evaluation. The Director of Nursing (DON) and guardian were notified. Review of the progress note dated 08/26/25 at 1:36 P.M. revealed Resident #117 was sent to hospital via 911 for altered mental status and poor intake of food and liquids. Resident #117 appeared to be lethargic and not swallowing well. Emergency Medical Services (EMS) arrived at 1:45 P.M. All notifications were made to include the physician, DON, unit manager, and guardian of the transfer to the hospital for evaluation. Review of the progress note dated 08/26/25 at 4:35 P.M. revealed Resident #117 was admitted to the hospital with diagnoses of altered mental status (AMS) and adult failure to thrive. All required parties were notified. Review of the progress noted dated 08/26/25 at 4:36 P.M. revealed Resident #117's guardian was notified of the hospital transfer. Review of the progress note dated 08/26/25 at 5:53 P.M. revealed Resident #117's guardian was updated on the resident's

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and facility policy review, the facility failed to ensure Resident #117's antibiotic medication was administered according to the physician orders. This affected one resident (#117) out of four residents reviewed for medications. The facility census was 162. Findings include:Review of the medical record for Resident #117 revealed an admission date of 11/25/21. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, epilepsy, encephalopathy, impulse disorder and mood affective disorder. Resident #117 had a guardian since 2015. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #117 had intact cognition, with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Resident #117 was dependent on staff for showers, lower body dressing, footwear and personal hygiene and required substantial assistance for toileting, upper body dressing, and oral hygiene and set up assistance for eating. Review of the chest x-ray report dated 08/18/25 at 10:14 P.M. revealed resident #117 had left lower lobe atelectasis/infiltrate. Review of the physician's order dated 08/20/25 revealed Resident #117 was ordered Levofloxacin (antibiotic) 250 milligram (mg) give three tablets, to total 750 mg, by mouth (PO) one time a day for infection for five days at 7:00 A.M. The order was discontinued on 08/20/25 after administering the dose. Review of the physician's order dated 08/21/25 revealed Resident #117 was ordered Levofloxacin 250 mg give three tablets, to total 750 mg, by mouth (PO) one time a day for pneumonia until 08/26/25 to start on 08/21/25 at 7:00 A.M. Review of the Medication Administrator Records (MAR) for August 2025 revealed Levofloxacin 250 mg, three tablets, totaling 750 mg was administered on 08/20/25 and 08/21/25 per the physician's order. On 08/22/25 and 08/23/25 the MAR had a number nine and the nurses initials. Review of the progress notes for 08/22/25 revealed the Levofloxacin 250 mg, three tablets, totaling 750 mg was on order. There was no documented evidence that the physician was notified. Review of the progress notes for 08/23/25 revealed the Levofloxacin 250 mg, three tablets, totaling 750 mg were not available. There was no documented evidence that the physician was notified. Interview on 10/07/25 at 3:45 P.M. with Corporate Nurse #800 confirmed Resident #117 did not receive his antibiotic medication as ordered on 08/22/25 and 08/23/25. Corporate Nurse #800 reported the medication was not available. Interview on 10/09/25 at 9:19 A.M. with Registered Nurse (RN)# 693 confirmed Levofloxacin for pneumonia was not administered on 08/22/25 and 08/23/25 due to the medication not available from pharmacy. RN #693 reported she checked in the Pixus machine, which usually had the medication, but it was out. RN #693 reported she contacted the pharmacy, and they were supposed to have it drop shipped, but it never came. RN #693 confirmed that there was no documented evidence that the physician was notified that the medication was not available to administer to Resident #117. Review of the facility policy titled Medication Administration, dated 2013, revealed to administer medications only as prescribed by the provider. This deficiency is an incidental finding identified during the complaint investigation.