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	02/26/2026

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

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on interview, record reviews, review of the facility self-reported incident (SRI), Board of Pharmacy documentation review, observation and facility policy review, the facility failed to protect Residents #101, #108, #111, #114, #115, #127, #219, #265, #400, and #401 from misappropriation of medications. This affected 10 (Residents #101, #108, #111, #114, #115, #127, #219, #265, #400, and #401) of 10 residents reviewed for misappropriation of medications. The facility census was 170. Findings include: 1. Review of the medical record revealed Resident #101's was admitted on [DATE] with diagnoses including paranoid schizophrenia, unspecified dementia and delusional disorders.Review of Resident #101's physician's order revealed an order dated 07/08/23 for Ibuprofen (nonsteroidal anti-inflammatory) 600 milligrams (mg) by mouth three times a day for arthritis or pain (prescription number 10481545). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #101's Brief Interview of Mental Status (BIMS) score was 12, indicating Resident #101 had moderate cognitive impairment. Resident #101 required supervision for bathing, bed to chair to transfers and walking ten feet. Resident #101 was on antipsychotic medication, antianxiety medication, antidepressant medication, antiplatelet medication, and anticonvulsant medication. 2. Review of the medical record revealed Resident #108's was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including Alzheimer's disease, paranoid schizophrenia, and chronic obstructive pulmonary disease (COPD).Review of Resident #108's physician orders revealed an order dated 06/19/24 with a stop date of 11/24/24 for quetiapine (antipsychotic) 100 mg by mouth at bedtime for paranoid schizophrenia (prescription number 9867530).Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #108 exhibited severe cognitive impairment. Resident #108 was dependent on staff for bathing, transfers from bed to chair and did not attempt to walk ten feet. Resident #108 received antipsychotic medication. 3. Review of the medical record revealed Resident #111's was admitted on [DATE] with diagnoses including COPD, bipolar disorder and schizoaffective disorder bipolar type.Review of Resident #111's physician orders revealed an order dated 12/15/24 for ondansetron (antinausea) 4 mg give one tablet every six hours as needed for nausea and vomiting and before Trulicity injection (prescription number 20049187).Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #111 exhibited intact cognition and required set up assistance for bathing, transfers from bed to chair and to walking ten feet. Resident #111 received antipsychotic medication, antianxiety medication, antidepressant medication, diuretic medication, antiplatelet medication, and hypoglycemic medication. 4. Review of the medical record revealed Resident #114 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including bipolar disorder, schizoaffective disorder and diabetes.Review of Resident #114's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Moderate assistance was needed for bathing. Supervision was needed to transfer from bed to chair and to (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	walk ten feet. Resident #114 received antipsychotic medication, antianxiety medication, antidepressant medication, diuretic medication, antiplatelet medication, hypoglycemic medication, and anticonvulsant. Review of Resident #114's pharmacy documentation revealed an order dated 08/07/25 for Ibuprofen 800 mg give one tablet by mouth every eight hours as needed for pain at a level of one to three (prescription number 9332723), an order dated 11/15/21 for hydroxyzine 25 mg (antihistamine) give one tablet every four hours as needed for anxiety for fourteen days (prescription number 10338019), and an order dated 04/12/25 for ondansetron 4 mg (antinausea) give one tablet by mouth every six hours as needed for nausea and vomiting (prescription number 20018721) . 5. Review of the medical record revealed Resident #115 was admitted on [DATE] with diagnoses including Alzheimer's disease, primary generalized osteoarthritis and paranoid schizophrenia.Review of Resident #115's physician orders revealed an order dated 10/05/24 for olanzapine 10 mg (antipsychotic) give one tablet by mouth one time a day for schizophrenia (prescription number 10501858).Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #115 exhibited moderate cognitive impairment and required supervision for bathing, transfers from bed to chair and to walking ten feet. Resident #115 received antipsychotic medication. 6. Review of the medical record revealed Resident #127 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including borderline personality disorder, paranoid schizophrenia and generalized anxiety disorder. Review of Resident #127's physician orders revealed an order dated 05/10/24 for cyproheptadine 4 mg (midodrine) give one tablet by mouth every morning and at bedtime for an appetite stimulant (prescription number 9867527).Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #127 exhibited moderate cognitive impairment and required supervision for bathing, set up assistance to transfers from bed to chair and to walking ten feet. Resident #127 received antipsychotic medication, antidepressant medication, antiplatelet, and anticonvulsant medication. 7. Review of the medical record revealed Resident #219 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including diabetes, essential hypertension and major depressive disorder.Review of Resident #219's physician orders revealed an order dated 11/01/24 for ampicillin (antibiotic) give one capsule by mouth every six hours for a skin infection for ten days (prescription number 9787296).Review of the discharge return anticipated MDS 3.0 assessment dated [DATE] revealed Resident #219 exhibited intact cognition and required moderate assistance for bathing, did not attempt to transfer from bed to chair or walk ten feet. Resident #219 received antidepressant, anticoagulant, and opioid medication. 8. Review of the medical record revealed Resident #265 was admitted on [DATE] with diagnoses including paranoid schizophrenia, Alzheimer's disease and anxiety disorder.Review of Resident #265's physician orders revealed an order dated 05/22/25 for gabapentin (antiseizure and nerve pain) give one capsule by mouth every morning and at bedtime for pain (prescription number 20084636).Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #265 exhibited moderate cognitive impairment and was dependent on staff for bathing, transfers from bed to chair, and did not attempt to walk ten feet. Resident #265 received antipsychotic and antianxiety medications. 9. Review of the medical record revealed Resident #400 was initially admitted on [DATE], readmitted on [DATE] and discharged on 08/15/25 with diagnoses including paraplegia, end stage renal disease and anxiety disorder. Review of Resident #400's physician orders revealed an order dated 12/23/24 for metronidazole 500 mg (antibiotic) by mouth three times per day for a wound infection until 01/23/25 (prescription number 10069527).Review of the discharge MDS 3.0 assessment dated [DATE] revealed Resident #400 exhibited intact cognition and required set up assistance to transfer from bed to chair. Resident #400 received antianxiety, antidepression, diuretic, opioid and anticonvulsant medication. 10. Review of the medical record revealed Resident #401 was admitted on [DATE] and (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discharged on 01/02/26 with diagnoses including bilateral primary osteoarthritis of the knee, schizoaffective disorder bipolar type and COPD.Review of Resident #401's physician orders revealed an order dated 04/17/25 for baclofen 10 mg (muscle relaxant) give one tablet every six hours as needed for spasms for 10 days (prescription number 20025599), an order dated 06/07/24 baclofen 10 mg by mouth every eight hours as needed with a discontinue date of 04/17/25, and an order dated 06/07/24 for baclofen 10 mg by mouth twice a day for muscle spasms.Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #401 exhibited intact cognition and required set up assistance for bathing, supervision for transfers from bed to chair, and set up assistance to walk ten feet. Resident #401 received antipsychotic, antianxiety, antidepressant, diuretic, opioid, and anticonvulsant medication. Review of SRI tracking number 266132 dated 10/07/25 revealed on 10/06/25 the Board of Pharmacy visited the facility and reported there was medication found at an outside location at a previous employee's house. The Board of Pharmacy released the names of the residents related to the medication that were found. The medication listed by the Board of Pharmacy were found to been removed from the facility after the medications were discontinued. All medications were from discharged or transferred residents and were discontinued after 24-hour discharge timeframe. Zero residents had adverse effected. The facility notified all required parties including the physician, psych physician, the medical director, and pharmacies, residents, residents' guardians/responsible parties and police department were notified. Staff education was started and completed on 10/07/25. Education included Medication Controlled Drugs and Security Policy, Pathway to narcotic management: Shift to Shift Count, Storage of Medications, Controlled Substance Storage, Medication Administration, Liberalized Medication Pass Times, Stock Medications, Clinical Documentation Standards, Missed Medication/Medication Error, Nurse Shift Change and Walking Rounds, Blood Glucose Quality Checks, Refrigerator Maintenance and Temperature, Abuse, Neglect, and Misappropriation. Review of the Board of Pharmacy letter dated 12/01/25 revealed a Case Cover Sheet Investigation #502-6239 revealed a probable drug diversion from long term facilities by Licensed Practical Nurse (LPN) #901. LPN #901 was reported to work in the facility and was believed to have diverted the prescription medication from the facility. An inspection was completed of the facility. On 07/21/25 the Regional Agent in Charge (RAC) with the Ohio Board of Pharmacy received information regarding a probable drug diversion by LPN #901. The information came from Summit County Sheriff's Office (SCSO). SCSO reported that LPN 901 worked at two long term care facilities and believed there could be systemic drug security failures at one or both facilities. On 09/04/25 the SCSO reported LPN #901's cause of death was an overdose of prescription drugs. Photos on the scene of LPN #901's residence revealed the following medications were found: Resident #114 Ibuprofen 800 mg 21 tablets Resident #219 Ampicillin 500 mg 25 tablets/capsules Resident #101 Ibuprofen 600 mg 30 tablets/capsules Resident #400 Metronidazole 500 mg eight tablets/capsules Resident #108 Quetiapine 100 mg 30 tablets/capsules Resident #265 Gabapentin 300 mg empty blister pack Resident #401 Baclofen 10 mg 14 tablets/capsules Resident #115 Olanzapine 10 mg 29 tablets/capsules Resident #111 had Ondansetron 4 mg five tablets/capsules *Resident #127 Cyproheptadine 4 mg 60 tablets/capsules On 10/06/25 the Ohio Board of Pharmacy conducted an inspection of the facility. The inspection was explained to the Administrator and Former Director of Nursing (DON) #596. Former DON #596 identified multiple residents on the list of prescription medication found at LPN's #901 residence. The Ohio Board of Pharmacy inspection noted the following: Signatures of documentation were inconsistent varying from initials, full names, and first initial with last name. Shift to shift counts were found to be pre-signed by the off going nurse. Documentation of cards/sheet did not match the actual count. Shift to shift counts were missing documentation, including dates, signatures and counts. On 11/03/26 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Board of Pharmacy reviewed Former DON #569's resident to resident interviews conducted on 10/07/25. A medication cart audit and medication administration record (MAR) audit was conducted on applicable residents. On 10/07/25 Former DON #569 completed assessments and interviews for concerns related to missing medication, and on 10/07/25, Former DON #569 educated all nursing staff and nursing managers and will educate all new nursing staff and nursing managers during orientation on the following: Medication Controlled Drugs and Security Policy, Pathway to Narcotic Management: Shift to Shift Count, Storage of Medications, Controlled Substances Storage, Stock Medications, Missed Medications and Medication Error, Nurse Shift Change and Walking Rounds, Refrigerator Maintenance and Temperature, Abuse, Neglect, and Misappropriation. Interview on 02/23/26 at 11:22 A.M. with the Administrator and Regional Director of Clinical Operations #686 revealed LPN #901 was hired on 07/11/22 and worked in the facility part time. LPN #901's last day working in the facility was 07/11/25. Regional Director of Clinical Operations #686 stated that if a non-narcotic medication was discontinued, the medication was to be removed by the nurse from the medication cart and placed in a Pharmacy Return Bag for disposal by the pharmacy. Regional Director of Clinical Operations #686 verified the investigation result of the Ohio Board of Pharmacy inspection. Interview on 02/24/26 at 9:44 A.M. with LPN #652 revealed if a medication was discontinued the medication was to be taken out of the medication cart and placed in a Pharmacy Return Bag. LPN #652 stated there was no way others would know if a nurse put the discontinued medication in the bag or not. Observation on 02/24/26 at 9:49 A.M. of the [NAME] unit revealed three filled white bags labeled Pharmacy Return Bags were in a locked medication room.Interview on 02/24/26 at 4:10 P.M. with Regional Clinical Director of Operations #686 stated there was no feasible method the facility had to track whether a non-narcotic medication had been placed in the Pharmacy Return Bag when the medication was discontinued. Review of the undated facility policy titled Ohio Abuse, Neglect, and Misappropriation revealed misappropriation was defined at the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings without the resident consent. The deficient practice was corrected on 10/08/25 when the facility implemented the following corrective action: On 10/07/25 Former DON #596 educated 26 of 26 LPNs and 11 of 11 Registered Nurses (RNs) regarding Medication Controlled Drugs and Security Policy, Pathway to Narcotic Management: Shift to Shift Count, Storage of Medications, Controlled Substance Storage, Medication Administration, Liberalized Medication Pass Times, Stock Medications, Clinical Documentation Standards, Missed Medication/ Medication Error, Nurse shift change and Walking Rounds, Blood Glucose Quality Checks, Refrigerator Maintenance and Temperature, Abuse/neglect/Misappropriation. On 10/07/25 Former DON #596 interviewed all applicable residents listed. On 10/07/25 Former DON #596 and designee reviewed and assessed all applicable residents listed. No residents experienced any adverse effects. On 10/07/25 Former DON #596 and designee initiated began daily medication cart audits which were completed on 10/30/25. No concerns noted. On 10/07/25 Former DON #596 and designee initiated and completed staff interviews related to the Board of Pharmacy Survey. No concerns were noted. On 10/07/25 Former DON #596 and designee initiated and completed assessments and or interviews for missing medications or concerns related to missing medications. All residents were interviewed and assessed. No concerns were noted. On 10/08/25 the Administrator contacted the local police department after the facility was contacted by the Ohio Board Of Pharmacy regarding residents medication that were found in a home of a former employee of the facility. The police report stated there were 263 pills belonging to 10 different residents in the facility and none of the medications were narcotics. On 10/08/25 the facility completed an Ad Hoc QAPI meeting. The Medical Director was in attendance by phone. On 10/08/25 Former DON #596 and designee completed skin sweeps and interviews on all 90 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	non-interviewable residents. No concerns were noted. Review of facility resident interviews revealed 73 of 73 residents were able to be interviewed, BIMS score was documented. No concerns were noted. Review of the facility pharmacy audits beginning on 10/08/25 revealed daily audits were completed until 10/30/25 regarding two full signatures on narcotic logs, documentation cards matched actual count, administration time of medication matched, medication including narcotics were destroyed or returned, documentation strike outs are completed per policy. Audits were done on Hickory, Buckeye, Willow, Maple, Oak, Walnut, Elm, Birch, This deficiency represents non-compliance under Complaint Number 2692620 and Complaint Number 2735853 .

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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** Based on record review, observation and interview, the facility failed to ensure adequate supervision and implement appropriate safety interventions for Resident #138, who continued to operate a power wheelchair at excessive speeds inside the facility despite multiple Occupational Therapy (OT) assessments identifying the resident as unsafe and recommending restriction of power wheelchair use to outdoor areas only. This affected one (Resident #138) of four residents reviewed for accidents. The facility census was 170.Findings include:Review of the medical record revealed Resident #138's was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertension and muscle weakness.Review of Resident #138's OT progress note dated 10/28/25 revealed the resident hit the door and ran over someone's foot while driving his scooter. The resident needed safety education and training. The resident was very impulsive and showed aggressive behavior very quickly.Review of the Social Services note dated 10/30/25 noted staff including Social Services staff, Therapy Director and the Nurse Unit Manager met with Resident #138 to discuss recent safety concerns with his wheelchair scooter in the facility. The Therapy Director offered a new, more appropriate wheelchair, but Resident #138 declined. Staff informed Resident #138 any more incidents involving the scooter would result in the scooter being taken away. Staff stated this information was provided in writing.Review of Resident #138's OT progress note dated 11/03/25 revealed the resident was provided safety education for the power scooter regarding use in the facility provided again on this date. Despite all the education and demonstration, Resident #138 continued to demonstrate poor maneuverability skills and refused to adhere to appropriate facility speed settings to improve safety of the resident as well as other residents and staff in the building. It was the therapy recommendation that the resident did not utilize the power scooter safely in the facility. The manual wheelchair was provided with safety/mobility education. The resident returned the ability to utilize the manual wheelchair in the facility with good safety and good mobility. It is recommended that the power scooter is utilized only outside of the facility in the community.Review of the OT progress note dated 11/05/25 revealed Resident#138 was observed outside the facility. Staff provided safety sequence education concerning wheelchair use in the and out of doorways and various entryways. Resident #138 was reluctant to participate in the education and demonstrated poor safety despite verbal cues.Review of Resident #138's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #138 had intact cognition.Telephone interview on 02/23/26 at 2:23 P.M. with Certified Nurse Assistant (CNA) #615 revealed Resident #138 was upset at some point in 10/2025 and ran full speed into her leg with a mobility scooter fracturing her leg. CNA #615 indicated she had observed Resident #138 run into other people on the mobility scooter, but she could not name those people. She also indicated there was a lack of staffing including on 02/08/26 on the 6:00 A.M. to 6:00 P.M. shift.Review of Resident #138's OT progress note dated 02/25/26 revealed Resident#138 had poor safety awareness with the wheelchair scooter trying to fit through doorways that were too narrow.Observation on 02/25/26 at 8:07 A.M., Resident #138 was observed speeding down the hallway, wheelchair scooter was set on high (rabbit) mode.Interview on 02/25/26 at 8:07 A.M., Licensed Practical Nurse (LPN) #584 stated Resident #138 always sped down the hall, but it wasn't intentional. Interview on 02/25/26 at 11:38 A.M., CNA #592 stated Resident #138 flies down the hall all the time, staff educate the resident, but he refuses to cooperate.Observations and interview on 02/25/26 at 2:56 P.M., Resident #138's wheelchair scooter was observed to be heavily damaged in the front missing half of the front panel and one headlight, Resident #138 was asked about the condition of the scooter and stated he ran into (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	something but could not remember what. Resident #138 further stated his hand got stuck in the space where the trigger was to engage/disengage the scooter. Resident #138 was asked about the speed settings on the scooter, Resident #138 stated he always had the scooter set between the turtle (slow) and the rabbit (fast) mode. Observations at time of interview noted the scooter was set at the fastest speed. Resident #138 denied hitting a staff member stating, she ran into me.Interview on 02/25/26 at 3:00 P.M., the OT #543 stated Resident #138 was assessed and educated several times; however, Resident #138 was stubborn and would not give up the scooter.Observation on 02/26/26 at 1:00 P.M. and at 4:00 P.M. was observed speeding down the hallway, and the wheelchair scooter was set on high (rabbit) mode.This deficiency represents non-compliance investigated under Complaint Number 2736364 and Complaint Number 2736364.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, manufactures guidelines and policy review, the facility failed to ensure Resident #218 rinsed his mouth after using a steroid inhaler. This affected one (Resident #218) of five residents observed for medication administration. The facility census was 170.Findings include:Review of the medical record for Resident #218 noted an admission date of 07/28/25. Diagnoses included schizoaffective disorder, depressive type and chronic obstructive pulmonary disease.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #218 had intact cognition. Observation on 02/26/26 at 8:44 A.M. of medication administration noted Licensed Practical Nurse (LPN) #584 administering medications to Resident #218. LPN #584 handed Resident #218 a BREO steroid inhaler, Resident #218 took one breath and gave the inhaler back to LPN #584. LPN #584 did not encourage or prompt Resident #218 to rinse his mouth after inhaling the steroid.During an interview with LPN #584 immediately after the observation, LPN #584 stated Resident #218 refused to rinse his mouth in the past, so I did not say anything. LPN #584 agreed that she should have prompted Resident #218 to rinse his mouth.During an interview on 02/26/26 at 3:50 P.M., Regional Director of Clinical Operations #686 verified staff should be encouraging residents to rinse their mouths after using a steroid inhaler.Review of the BREO inhaler guidelines from accessdata.fda.gov, noted after inhalation, the resident should rinse his/her mouth with water without swallowing to help reduce the risk of overgrowth of yeast in the mouth (oropharyngeal candidiasis).Review of the undated facility policy titled Medication Administration noted residents were to rinse their mouths after using a steroid inhaler.This deficiency was an incidental finding identified during the complaint investigation.

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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, interview and policy review, the facility failed to administer Resident #402's medications within appropriate timeframes. This affected one (Resident #402) of five residents observed for medication administration. The facility census was 170.Findings include:Review of the closed medical record for Resident #402 noted an admission date of 06/27/25. Resident #402 was discharged on 11/11/25. Diagnoses included hemiplegia and hemiparesis, major depressive disorder and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #402 had intact cognition. Review of the medication administration record (MAR) noted Resident #402 was receiving acetaminophen (analgesic) 1000 milligrams (mg) dated 06/27/25 twice a day for pain, hydroxyzine (antianxiety) 50 mg 09/20/25 twice a day for anxiety, Rabeprazole (acid reducer) 20 mg dated 10/11/25 twice a day for heartburn.Review of medication administration audit report which the facility utilizes to track medications that were administered late noted Resident #402' s medications as follows:10/01/25- acetaminophen 1000 mg scheduled at 7:00 A.M., was administered at 4:20 P.M. acetaminophen 1000 mg scheduled at 7:30 P.M., was administered at 12:46 A.M. on 10/02/25.10/29/25-hydroxyzine 50 mg and Rabeprazole 20 mg scheduled for 7:00 A.M. were administered at 1:24 P.M.10/31/25- acetaminophen 1000 mg, hydroxyzine 50 mg and Rabeprazole 20 mg scheduled for 7:00 A.M. were administered at 12:51 P.M.11/01/15- Rabeprazole 20 mg scheduled for 7:00 A.M. was administered at 12:08 P.M.11/04/25- acetaminophen 1000 mg, hydroxyzine 50 mg and Rabeprazole 20 mg scheduled for 7:00 A.M. was administered at 12:50 P.M.11/06/25- acetaminophen 1000 mg scheduled for 7:30 P.M. was administered at 12:25 A.M. on 11/07/25.11/07/25- acetaminophen 1000 mg scheduled for 7:30 P.M. was administered at 12:19 A.M. on 11/08/25.11/10/25- acetaminophen 1000 mg, hydroxyzine 50 mg and Rabeprazole 20 mg scheduled for 7:00 A.M. were administered at 12:09 P.M., hydroxyzine 50 mg and Rabeprazole 20 mg scheduled for 9:00 P.M. were administered at 5:42 A.M. on 11/11/25.Interview on 02/26/26 at 3:50 P.M., Regional Director of Clinical Operations #686 reviewed the audit and verified the medications were administered out of the timeframe scheduled.Resident #402 was not available for interview.Review of the undated facility policy titled Medication Administration noted medications would be administered within the times frame of one hour before and one hour after the time ordered.Review of the facility Liberalized Medication Pass Times, noted medications listed as early morning were from 4:00 A.M. to 7:00 A.M., medications listed as A.M. were from 6:00 A.M. to 11:00 A.M., medications listed as afternoon were from 12:00 P.M. to 3:00 P.M., medications listed as P.M. were from 4:00 P.M. to 7:00 P.M., and medications listed as HS were from 8:00 P.M. to 11:00 P.M.This deficiency represents non-compliance investigated under Complaint Number 2667132.

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	02/26/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, interview, manufacturers guidelines and policy review, the facility failed to sanitize blood glucose monitors appropriately. This affected one (Resident #243) of five residents who required blood glucose monitoring. The facility also failed to ensure infection control standards were followed when administering medications. This affected three (Residents #131, #199 and #218) of five residents observed for medication administration. This had the potential to affect all residents residing in the facility. The facility census was 170.Findings include:Review of medical record for Resident #131 noted an admission date of 04/17/24. Diagnoses included Alzheimer's disease, heart failure and diabetes mellitus.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #131 had impaired cognition. Review of medical record for Resident #199 noted an admission date of 08/09/22. Diagnoses included Alzheimer's disease and chronic obstructive pulmonary disease.Review of the annual MDS assessment dated [DATE] revealed Resident #199 had intact cognition. Review of medical record for Resident #218 noted an admission date of 07/28/25. Diagnoses included schizoaffective disorder, depressive type and chronic obstructive pulmonary disease.Review of the quarterly MDS assessment dated [DATE] revealed Resident #218 had intact cognition. Review of medical record for Resident #243 noted an admission date of 11/11/24. Diagnoses included diabetes and peripheral vascular disease. Review of the quarterly MDS assessment dated [DATE] revealed Resident #243 had intact cognition. Observation on 02/26/26 at 8:44 A.M., LPN #652 was administering a medication to Resident #131. LPN #652 placed 11 medications into her hand without sanitizing or wearing a glove. LPN #652 was also observed carrying a blood glucose meter in her hand after checking the glucose level for Resident #243. LPN #652 placed the meter in the top drawer of the medication cart without sanitizing it. Interview immediately following the observation, LPN #652 verified the findings stating, I don't sanitize my hands between residents, I worked at other places, and no one has said anything to me. LPN #652 was also asked about the policy and procedure for disinfecting blood glucose meters. LPN #652 stated I don't clean the meters between residents, how would I clean them anyway, with alcohol? LPN #652 stated she had worked at the facility for three weeks and never cleaned the meters. Observation on 02/26/26 at 8:44 A.M., LPN #584 was administering medication to Resident #218. LPN #584 placed one medication into her hand without sanitizing or wearing a glove. Observation on 02/26/26 at 8:44 A.M., LPN #584 was administering a medication to Resident #199. LPN #584 placed three medications into her hand without sanitizing or wearing a glove. Interview immediately after the observation LPN #584 verified the findings and stated she should have put on a glove before touching medications.Interview on 02/26/26 at 3:50 P.M., Regional Director of Clinical Operations (RDCO) #686 verified staff should not be popping medications into their hands and blood glucose meters should be sanitized between each resident. Review of the manufactures guidelines for maintaining the meter stated cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe.Review of the undated facility policy titled Medication Administration noted staff are not touch the medication, either when opening a liquid or dose pack.Review of the undated facility policy titled Cleaning and Disinfection of Glucose Meter noted glucose meters should be disinfected with a high-level antimicrobial wipe.This deficiency was an incidental finding identified during the complaint investigation.