STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 0550 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 interviews and record review the facility failed to ensure residents were treated with dignity and respect. This affected one Resident (Resident #19) out of three residents reviewed for dignity and respect. The facility census was 60.Findings include:Review of the medical record for Resident #19 revealed an admission date of 08/08/23 with diagnoses including type two diabetes, cellulitis, depression, morbid obesity, malignant neoplasm or endometrium, need for assistance with personal care, and muscle weakness.Review of Resident #19's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition, required setup to clean up assistance with eating, partial to moderate assistance with oral and personal hygiene, and substantial to maximal assistance with toileting and showering.Review of Resident #19's care plan, date initiated 08/21/23, revealed Resident #19 had a problem with psychosocial wellbeing related to a diagnosis of depression. Interventions included to increase communications between the resident/family/caregivers about care and living environment.Review of the personnel file for Certified Nursing Assistant (CNA) #155 revealed on 06/12/25 she was issued a verbal warning due to using inappropriate language towards a resident. Corrective action required the employee must improve language skills toward residents and maintain professional language when addressing residents. Also, on 06/25/25 CNA #155 was given an education due to an incident on 06/24/25 when CNA #155 was playfully calling a resident a heifer and the resident was playfully calling CNA #155 a heifer. The corrective action required for this incident was CNA #155 being educated on professionalism and resident rights by the Administrator. The disciplinary action report dated 06/25/25 was not signed by CNA #155.An interview on 07/08/25 at 1:15 P.M. with Ombudsman #191 revealed while visiting Resident #19 in her room, Certified Nursing Assistant (CNA) #155 entered the room and used an expletive word while talking with the resident, and Resident #19 told the CNA she was uncomfortable with CNA #155 talking like that in front of the Ombudsman and felt it was disrespectful. An interview on 07/09/25 at 9:45 A.M. with Resident #19 revealed CNA #155 came into her room, asked her how her coffee was and used an expletive word during the conversation. Resident #19 verified the Ombudsman was present at this time and Resident #19 stated she felt it was disrespectful for the CNA to talk like that in front of the Ombudsman. Resident #19 did not think it was abusive, but she did not think it was a respectful way for the CNA to talk and especially not in front of the Ombudsman. An interview on 07/14/25 at 4:00 P.M. with CNA #155 confirmed she used an expletive word while talking with Resident #19 with the Ombudsman in the room. CNA #155 stated the resident's cousin was in the room and she was actually talking with the cousin, not the resident. CNA #155 stated she always talked like that around the residents and other staff and did not think it was being disrespectful. CNA #155 denied ever being counseled/written up for unprofessional behavior.Review of the facility policy titled Resident Rights Policy and Procedure, last revised in 2025, revealed it was the facilities purpose to ensure the preservation of every resident's right to a dignified existence, self-determination, and communication with access to people and services inside and outside the facility. Section V for Respect and Dignity stated every resident has a right to be treated with respect and dignity.This deficiency represents non-compliance investigated under Complaint Number OH00167171.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure a comprehensive, person-centered care plan was developed to address individual needs and preferences related to insulin administration for Resident #19. This affected one resident (Resident #19) of 11 residents reviewed for care plans. The facility census was 60. Findings include:Review of the medical record for Resident #19 revealed an admission date of 08/08/23 and a pertinent diagnosis of type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 was cognitively intact and used insulin seven out of seven days. Review of the care plan, date initiated 08/21/23 and last revised on 05/01/25, revealed there was no care plan for the prescribed insulin, nor measurable goals or interventions pertaining to the use of insulin. There was nothing to indicate in the care plan that Resident #19 had preferences for certain nurses to not administer her insulin. Review of the physician orders for July 2025 for Resident #19 revealed an order for insulin glargine subcutaneous 100 units per milliliter (ml) 38 units at bedtime, and insulin lispro (Humalog) to be used on a sliding scale before meals.An interview on 07/09/25 at 9:45 A.M. with Resident #19 revealed when RN #142 was working another nurse needed to bring in her medications and insulin because Resident #19 did not trust RN #142. Resident #19 stated she kept a notebook where she marked down when she does not get her insulin and showed the notebook to the surveyor. On 06/02/25 and 06/24/25 the resident recorded that no one gave her the 38 units of glargine insulin. Resident #19 stated on 06/04/25 and 06/24/25 she did not receive her insulin and she did not refuse her insulin it was just not offered to her by nursing and no one came back later to try to give her it.An interview on 07/16/25 at 2:45 P.M. with Licensed Practical Nurse (LPN) #129 revealed Resident #19 would let LPN #129 give her insulin and there were other nurses Resident #19 trusted to give her medications. LPN #129 stated Resident #19 did not trust RN #142. LPN #129 stated on 06/04/25 and 06/24/25 she (LPN #129) did not administer insulin to Resident #19 on 06/04/25 or on 06/24/25 because she was busy taking care of their assigned residents and getting their own work done and could not cover for RN #142 so Resident #19 did not get the 38 units of glargine insulin on those days. LPN #129 verified it was not because Resident #19 refused her insulin on 06/04/25 and 06/24/25. An interview was conducted on 07/17/25 at approximately 3:10 P.M. with the Regional Director of Clinical Services (RDCS) and the DON. The RDCS stated Resident #19 was known to refuse her insulin at night because she was selective about which nurse gave it to her. The RDCS and the DON verified Resident #19 kept a notebook and recorded her insulin administration in that notebook. The DON verified no alternative approaches had been tried to ensure Resident #19 was consistently provided insulin as ordered, and confirmed there was no care plan developed to address insulin administration. This deficiency represents noncompliance investigated under Complaint Number OH00167171.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interviews, and policy review, the facility failed to provide basic life support (BLS), including Cardiopulmonary Resuscitation (CPR) to Resident #61 per the residents advanced directive for a full code status, when the resident was found unresponsive and absent of vital signs. This resulted in Immediate Jeopardy and serious life-threatening harm and the subsequent of death of Resident #61 beginning on [DATE] when Certified Nursing Assistant (CNA) #135 alerted Registered Nurse (RN) #142 Resident #61was absent of vital signs. Instead of providing immediate care (i.e. CPR) RN #142 assessed the resident to be absent of vital signs and contacted Licensed Practical Nurse (LPN) #136 who was working another unit to verify the resident ' s death. RN #142 pronounced the resident ' s time of death of 4:50 P.M. RN #142 notified the physician without indicating CPR was not initiated, and Physician #187 gave orders to release the resident to the funeral home. Resident #61 ' s family was notified of the resident's death but not of the fact CPR was never initiated. This affected one resident (#61) of 11 residents reviewed for death in the facility.On [DATE] at 3:54 P.M. the Administrator, Regional Director of Clinical Services (RDCS), Regional Director of Operations (DO) and the Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] at approximately 4:50 A.M. when staff failed to provide basic life saving measures/CPR to Resident #61. Upon entering the resident ' s room CNA #135 observed Resident #61 to be absent of vital signs and not breathing. CNA #135 alerted RN #142 who assessed Resident #61 and found the resident was absent of vital signs and asked LPN #136 who was working on another unit to come and verify time of the resident ' s death and absence of vital signs. RN #142 did not notify LPN #136 or CNA #135 Resident #61 was a full code not was CPR attempted/provided. RN #142 notified Physician #187 of time of death but did not notify Physician #187 that CPR was not initiated.The immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 8:15 A.M. the Director of Nursing (DON) notified the Medical Director of the incident involving Resident #61. On [DATE] at 11:00 A.M. the facility implemented a plan for the DON to perform CPR Mock Code Evaluations via hands on demonstration with verbal discussion on day shiftand night shift on [DATE], [DATE], [DATE]. Additional mock code scheduled for [DATE], [DATE] and [DATE]. The DON/ADON then would perform random mockcodes for one week to capture all facility staff nurses to evaluate effectiveness and ensure competency. Once the random mock codes for one week were conducted by or on[DATE] the facility DON will audit the Mock CPR codes comparing an all-facility nurse staff roster to confirm all staff nurses have participated in a Mock CPR drill. If anurse was on vacation or unable to attend the drills, additional Ad Hoc Mock CPR drills will be provided prior to their next shift. On [DATE] at 11:48 A.M., Human Resources Employee audited all 16 facility nurses (4 RNs, 12 LPNs) and 11 agency nurses (3 RNs and 8 LPNs) files to ensure a valid CPRcard was on file. For additional measure the facility had an American Heart Association (AHA) CPR class scheduled to be completed in house on [DATE]. The facility wantedto offer a hands-on CPR class to include return demonstration that adheres to the AHA guidelines for all in-house licensed personnel due to facility policy and procedureguidance promotes/notes the AHA guidelines. On [DATE] the DON audited the facilities two crash carts to ensure proper supplies and equipment were available. Crash cart audits would be monitored for completion five toseven days a week by DON/ADON for four weeks. On [DATE] the DON re-audited 60/60 in-house resident records for code status according to residents ' preference/physicians ' orders. The review included care plans,DNR forms, PCC demographic bar on every resident and compared the advanced directives to the physician order for accuracy. On [DATE] an Ad Hoc QAPI meeting was held with the IDT including medical director, DON, Infection Preventionist, Administrator, Activities, BOM, Maintenance Director,Housekeeping Supervisor, Admissions Director, and the Therapy Director. Topics discussed included the CPR policy titled Emergency Procedure CardiopulmonaryResuscitation and Basic Life Support. The DON and/or ADON would audit new admissions to verify the advanced directives were as preferred/ordered. On [DATE] at 6:10 P.M. the DON re-educated all 16 licensed staff nurses (4 RNs, 12 LPNs) and identified 11 frequent agency nurses (3 RNs and 8 LPNs) to educate.Education provided included the facility ' s CPR policy titled Emergency Procedure Cardiopulmonary Resuscitation and Basic Life Support and the procedure for initiatingCPR. Licensed nurses were not permitted to work a shift until education was completed. On [DATE] per facility CPR policy all licensed staff nurses in any given shift were identified as part of the CPR team per policy. Reminder postings were placed by the timeclock, in the break room, and at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, facility policy and procedure review and interviews, the facility failed to provide timely, necessary and adequate care and services following an acute change in condition involving Resident #61 that started on [DATE]. The facility failed to ensure changes in the residents ' medical condition were comprehensively assessed, the residents change in condition, including abnormal vital signs and extreme loss of balance, was communicated to the medical provider, and individualized interventions were implemented. This resulted in Immediate Jeopardy and Actual Harm with subsequent death beginning on [DATE] when Resident #61 experienced hypotension (low blood pressure defined as a systolic pressure or top number below 90 millimeters of mercury (mm/Hg) and/or diastolic pressure or bottom number below 60 mm/Hg), dizziness, extreme loss of balance with his body going limp and eyes rolling back in his head while in physical therapy, as identified by the Physical Therapy Director (PTD) #172 who reported the incident to Licensed Practical Nurse (LPN) #132. LPN #132 did not comprehensively assess Resident #61 or notify the physician or Nurse Practitioner (NP). On [DATE] Resident #61 again presented with hypotension during physical therapy with blood pressures taken by PTD #172 noted as 82/55 millimeters of mercury (mm/Hg) and 94/59 mm/Hg while sitting and 72/50 mm/Hg and 75/48 mm/Hg while standing which was reported to Physician #187 by PTD #172 face-to-face in the facility hallway. Physician #187 failed to do a comprehensive medical assessment on Resident #61 on [DATE]. Resident #61 expired in the facility on [DATE] due to cardiopulmonary arrest. This affected one resident (#61) of eleven residents reviewed for change of condition.On [DATE] at 3:54 P.M. the Administrator, Regional Director of Operations (RDO), Regional Director of Clinical Services (RDCS) and the Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] when therapy staff identified Resident #61 exhibited a change in condition which included abnormal vital signs, an extreme loss of balance caused by dizziness, body going limp and eyes rolling back in his head as recorded and reported by PTD #172. There was no evidence of timely or adequate interventions/medical treatment being provided. Resident #61 was not seen by Physician #187 nor by the Nurse Practitioner on [DATE]. Additionally, on [DATE] PTD #172 identified and documented Resident #61 again showed low blood pressures requiring therapy to be stopped. PTD #172 stopped Physician #187 in the hallway on [DATE] and notified him of low blood pressure. Physician #187 did not see Resident #61 on [DATE] or on [DATE]. On [DATE] Physician #187 gave verbal orders in the hallway to Registered Nurse (RN) #150 to decrease the residents Metoprolol (cardiac medication) from 25 milligrams (mg) daily to 12.5 mg daily and on [DATE] Physician #187 gave additional verbal orders to LPN #132 to discontinue the resident ' s Valsartan (cardiac medication) and to do orthostatic blood pressures every shift for three days. Resident #61 was subsequently found absent of all vital signs on [DATE] at 4:50 A.M. and pronounced deceased .The Immediate Jeopardy was removed on [DATE] when the facility implemented the followingactions: On [DATE] the Regional Director of Clinical Services (RDCS) notified the Medical Director of the Immediate Jeopardy involving quality of care for Resident #61. On [DATE] an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held and attended by the Administrator, Medical Director, Regional Director ofClinical Services (RDCS), Director of Nursing (DON), Therapy Director, Infection Preventionist, Activities Director, Business Office Manager (BOM), MaintenanceDirector, Housekeeping Supervisor, and Admissions Director (AD) to discuss the incident involving Resident #61. On [DATE] the DON, RDCS and LPNs interviewed/assessed 60 of 60 in house residents to identify any unreported changes in condition. Skin sweeps were done for 16 residentswho were unable to be interviewed due to cognitive deficits. 44 residents were interviewed related to unreported changes in their health status. On [DATE] the DON educated 16 of 16 licensed facility nurses, 11of 11 frequently used agency nurses, 14 of 14 therapy staff and 32 of 32 nurse aides on the facility ' s change incondition policy titled Change in a Resident ' s Condition or Status which included physician notification and documentation requirements. Staff members were notpermitted to work a shift until education was completed [DATE]. Newly hired (licensed nurses and nurse aides) would be educated on the change of condition policy includingphysician notification regulations during orientation by the DON/ADON. Beginning [DATE] the facility implemented a plan for the DON and Assistant Director of Nursing (ADON) to review the 24-hour report to identify documented changes inconditions to ensure any change of condition identified is properly reported to the resident, physician and the family/resident representative per policy/procedure. Thiswould occur for five to seven days a week for five weeks then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 0760 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, observation and interview, the facility failed to ensure one resident (Resident #19) received her insulin as ordered. This affected one resident (Resident #19) of three residents reviewed for medication administration. The facility census was 60. Findings include:Review of the medical record for Resident #19 revealed an admission date of 08/08/23 and a pertinent diagnosis of type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 was cognitively intact and used insulin seven out of seven days. Review of the care plan, date initiated 08/21/23 and last revised on 05/01/25, revealed there was no care plan for insulin administration. On 02/29/24 a care plan was initiated for Resident #19 regarding resistance to care including refusing medications and insulin. The interventions included allow resident to make decisions about treatment, educate on possible outcomes of not complying, if possible negotiate a time for treatments so that the resident participates in the decision making process and return at the agreed upon time, if resident resists treatment, leave and return five to 10 minutes later to try again, provide resident with choice during care provisions and give a clear explanation of all care. Review of the physician orders for July 2025 for Resident #19 revealed an order for insulin glargine subcutaneous 100 units per milliliter (ml) 38 units at bedtime, and insulin lispro (Humalog) to be used on a sliding scale before meals. Review of the Medication Administration Record (MAR) for June 2025 revealed no evidence insulin glargine 100ML 38 units at bedtime was administered to Resident #19 on 06/04/25 or 06/24/25, as the MAR on these dates for this medication was left blank and void of nurse initials and/or chart code. Resident #19's blood sugars ranged from 235 milligrams per deciliter (mg/dL) to 299 mg/dL on 06/04/24 (normal blood sugars for a type two diabetic using insulin ranges between 80 to 130 mg/dL before meals and less than 180 mg/dL two hours after meals). Resident #19's blood sugars ranged from 227 mg/dL to 299 mg/dL on 06/24/25. This MAR was obtained from the electronic medical record on 07/14/25 at 3:21 P.M.Review of a modified MAR obtained from the medical record on 07/17/25 at 11:17 A.M. revealed on 06/24/25 an entry was made by Registered Nurse (RN) #142 to indicate the insulin was refused (chart code number two) by Resident #19. There was no change made to the 06/04/25 date. An interview on 07/09/25 at 9:45 A.M. with Resident #19 revealed when RN #142 was working another nurse needed to bring in her medications and insulin because Resident #19 did not trust RN #142. Resident #19 stated she kept a notebook where she marked down when she does not get her insulin and showed the notebook to the surveyor. On 06/02/25 and 06/24/25 the resident recorded that no one gave her the 38 units of glargine insulin. Resident #19 stated on 06/04/25 and 06/24/25 she did not receive her insulin and she did not refuse her insulin it was just not offered to her by nursing and no one came back later to try to give her it. An interview on 07/15/25 at 2:06 P.M. with the Director of Nursing (DON) revealed she had no evidence Resident #19 had been administered her insulin as ordered on 06/04/25 or 06/24/25. An interview on 07/16/25 at 2:45 P.M. with Licensed Practical Nurse (LPN) #129 revealed Resident #19 would let LPN #129 give her insulin and there were other nurses Resident #19 trusted to give her medications. LPN #129 stated Resident #19 did not trust RN #142. LPN #129 stated on 06/04/25 and 06/24/25 she (LPN #129) did not administer insulin to Resident #19 on 06/04/25 or on 06/24/25 because she was busy taking care of their assigned residents and getting their own work done and could not cover for RN #142 so Resident #19 did not get the 38 units of glargine insulin on those days. LPN #129 verified it was not because Resident #19 refused her insulin on 06/04/25 and 06/24/25.An interview was conducted on 07/17/25 at approximately 3:10 P.M. with the Regional Director of Clinical Services (RDCS) and the DON. The RDCS stated Resident #19 was known to refuse her insulin at night because she was selective about which nurse gave it to her. The RDCS and the DON verified Resident #19 kept a notebook and recorded her insulin administration in that notebook. The DON verified no alternative approaches had been tried to ensure Resident #19 was consistently provided insulin as ordered, and confirmed the was no care plan developed to address insulin administration. Review of the facility policy titled Diabetes, Clinical Protocol dated 2001 revealed the physician would order appropriate interventions to address diabetic care including insulin as appropriate. Review of the facility policy titled Administering Medications dated 2001 revealed medications would be administered per the prescriber's orders, including any required time frame. Medications would be administered within one hour of their prescribed time, unless otherwise specified. This deficiency represents noncompliance investigated under Complaint Number OH00167171.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 record review and interview the facility did not ensure lab results were timely reported to the physician. This affected one resident (#19) out of three residents reviewed for lab services. The facility census was 60. Findings include:Review of the medical record for Resident #19 revealed an admission date of 08/08/23. Diagnoses included diabetes, morbid obesity, anemia, depression, kidney disease and muscle weakness. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 was cognitively intact and used insulin seven out of seven days.Review of the physicians orders for July 2025 revealed an order for Resident #19 to have her A1C (a blood test that provides an estimate of a person's average blood sugar levels over the past two to three months) drawn on admission then every six months. Review of the care plan dated 05/09/25 revealed resident #19 had a nutritional problem of morbid obesity. Interventions included administering medications as ordered, explaining and reinforcing the importance of maintaining her diet, offering healthy alternatives and obtaining lab work as ordered.Review of the lab results dated 02/12/25 revealed Resident #19's A1C was 7.3 percent.An interview on 07/15/25 at 10:43 A.M. with the Director of Nursing (DON) revealed she kept a binder with all resident lab work which was reviewed and signed by the physician.An interview on 07/15/25 at 2:06 P.M. with the DON revealed she had no evidence Resident #19's lab work dated 02/12/25 had been reviewed by the physician. Review of the facility policy titled Diabetes, Clinical Protocol dated 2001 revealed the physician would order appropriate interventions to address diabetic care including insulin as appropriate and the physician would order lab tests such as an A1C and adjust treatments based on the results.Review of the facility policy titled Lab and Diagnostic Test Results, Clinical Protocol dated 2001 revealed when test results were reported to the facility, a nurse would review the results and contact the physician based on the immediacy of the results.This deficiency represents noncompliance investigated under complaint #OH00167171.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility did not ensure a complete and accurate medical record for Resident #19. This affected one resident (Resident #19) out of 11 residents reviewed for complete and accurate medical record. The facility census was 60.Findings include:Review of the medical record for Resident #19 revealed an admission date of 08/08/23 and a pertinent diagnosis of type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 was cognitively intact and used insulin seven out of seven days. Review of the physician orders for July 2025 for Resident #19 revealed an order for insulin glargine subcutaneous 100 units per milliliter (ml) 38 units at bedtime. Review of the Medication Administration Record (MAR) for June 2025 revealed no evidence insulin glargine 100ML 38 units at bedtime was administered to Resident #19 on 06/04/25 or 06/24/25, as the MAR on these dates for this medication was left blank and void of nurse initials and/or chart code. This MAR was obtained from the electronic medical record on 07/14/25 at 3:21 P.M. Review of a modified MAR for June 2025 obtained from the medical record on 07/17/25 at 11:17 A.M. revealed on 06/24/25 an entry was made by Registered Nurse (RN) #142 to indicate the insulin was refused (chart code number two) by Resident #19. There was no change made to the 06/04/25 date. An interview on 07/09/25 at 9:45 A.M. with Resident #19 revealed when RN #142 was working another nurse needed to bring in her medications and insulin because Resident #19 did not trust RN #142. Resident #19 stated she kept a notebook where she marked down when she does not get her insulin and showed the notebook to the surveyor. On 06/02/25 and 06/24/25 the resident recorded that no one gave her the 38 units of glargine insulin. Resident #19 stated on 06/04/25 and 06/24/25 she did not receive her insulin and she did not refuse her insulin it was just not offered to her by nursing and no one came back later to try to give her it.An interview on 07/15/25 at 2:06 P.M. with the Director of Nursing (DON) revealed she had no evidence Resident #19 had been administered her insulin as ordered on 06/04/25 or 06/24/25.An interview on 07/16/25 at 2:45 P.M. with Licensed Practical Nurse (LPN) #129 revealed LPN #129 stated on 06/04/25 and 06/24/25 she (LPN #129) did not administer insulin to Resident #19 on 06/04/25 or on 06/24/25 because she was busy taking care of their assigned residents and getting their own work done and could not cover for RN #142 so Resident #19 did not get the 38 units of glargine insulin on those days. LPN #129 verified it was not because Resident #19 refused her insulin on 06/04/25 and 06/24/25. LPN #129 confirmed medication refusals should be documented in the MAR at the time the medication was refused. An interview was conducted on 07/17/25 at approximately 3:10 P.M. with the Regional Director of Clinical Services (RDCS) and the DON who verified the June 2025 MAR had been altered in July 2025 from it's original form and this occurred after the surveyor brought it to the DON's attention that on 06/04/25 and 06/24/25 the MAR was left blank and void of nurse initials and/or chart code. This deficiency represents noncompliance investigated under Complaint Number OH00167171.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to ensure a safe, functional and comfortable environment for residents, staff and the public. This had the potential to affect 14 residents (Residents #2, #5, #12, #15, #21, #25, #27, #32, #42, #47, #48, #49, #53 and #57) who resided on the [NAME] unit, out of 60 residents observed for physical environment. The facility census was 60.Findings include:An interview on 07/08/25 at 1:15 P.M. with Ombudsman #190 and Ombudsman #191 revealed Ombudsman #191 was present in the facility on 06/18/25 when there was a heavy rain storm and rain water was coming in under the exit door on the [NAME] unit in the hallway by Resident #21 and #27's room. Ombudsman #191 brought it to the attention of the Maintenance Director who verified that during heavy rain water flowed in under the exit door on that unit. Ombudsman #190 and Ombudsman #191 both confirmed they notified the Administrator and had a phone conversation with the Regional Director of Operations (RDO) regarding the water issue and email records of correspondence related to this issue and not getting a clear answer on what the facility would be doing to fix this issue because it was affecting the residents on that unit.An observation on 07/10/25 at 3:00 P.M. on the [NAME] unit revealed there was rainwater puddling in the hallway covering a surface area of three feet and this water steadily kept getting larger in the hall way, as it was a heavy rain outside at the time of the observation. The rain water was flowing in under the exit door at the end of the [NAME] hallway by Resident #21 and #27's room. The amount of water presented as a safety concern, as there was enough water to splash in and soak shoes. During the observation Resident #27 was heard yelling from inside their room saying the water comes in every time it rains and nothing is ever done about it. An interview on 07/10/25 at 3:03 P.M. with the Administrator and Maintenance Director (MD) #119 verified when there was heavy rain, water does come in under the exit door at the end of the [NAME] hallway by Resident #21 and #27's room. Both verified the observed amount of water in the hallway, it was still flowing in under the exit door so they put down a bath blanket to soak up the water. There was no wet floor sign placed in the hallway.An observation made on 07/10/25 at 4:37 P.M. of the [NAME] hallway exit door revealed there was still rainwater coming in under the doorframe with bath blankets on the floor soaking up the water. There were no wet floor signs observed in the hallway.Review of the facility policy titled Resident Rights Policy and Procedure, dated 2025, revealed each resident had the right to a safe, clean, comfortable and homelike environment.This deficiency represents non compliance investigated under complaint #OH00167171.