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	04/20/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident representative was immediately notified about a leg injury and failed to ensure proper notification to the representative of an outside medical appointment for Resident #5. This effected one resident (Resident #5) of six residents (#3, #5, #30, #31, #41,and #58) reviewed for change in condition. The facility census was 67.Findings include:Review of the medical record for Resident #5 revealed an admission date of 07/18/22 with diagnoses including but not limited to cerebral infarction, hemiplegia (total loss of voluntary movement of affected muscle resulting in stiffness or spasticity) and hemiparesis (partial weakness) following cerebral infarction affecting right dominant side, unspecified psychosis, unspecified anxiety disorder, malignant neoplasm of colon, altered mental status, hypertension (high blood pressure), need for assistance for personal care, muscle atrophy, type two diabetes and aphasia (acquired language disorder affecting communication).Review of Resident #5's care plan, date initiated 08/04/22, revealed Resident #5 was dependent on staff for meeting his emotional, intellectual, physical, and social needs related to cognitive deficits and disease processes.Review of the Medication Administration Record (MAR) dated March 2026 revealed Resident #5 had an outside appointment at The Hope Center (a comprehensive cancer treatment center) on 03/13/26 at 1:00 P.M.Review of the document titled The Hope Center for Cancer Care, dated 03/13/26, revealed Resident #5 was referred to the center's hematology office for an initial visit due to anemia. Hope Center Physician (HCP) #980 wrote the resident had aphasia, chronic psychosis, was unable to give any history, was not able to answer questions, and was only able to state that his right leg hurt. HCP #980 indicated he is here with an aide from the facility, however the aide does not have any information regarding [name of resident stated] health history, status or complaints. The facility aid does not know why the patient is being seen today. All health history is obtained from medical records sent with referral. HCP #980 also noted unfortunately [Resident #5] is unable to answer any of my questions today. Labs to be drawn and sent out. If he is iron deficient, he will likely need IV repletion. Follow up in four weeks to develop a treatment plan. No questions presented by facility staff.Review of a Nurses Note dated 03/14/26 at 5:25 A.M. authored by Licensed Practical Nurse (LPN) #722 revealed STNA alerted this nurse that the resident has a large bruise and fluid filled sac on RLE [right lower extremity]. Upon assessment this nurse observed a bruise measuring approximately 11 cm [eleven centimeters] Wide and 16 cm long with a fluid filled sac measuring approximately 6 cm wide and 11cm long with a tear in the center measuring approximately 4 cm long and 1.5 cm wide with serosanguineous [clear, bloody] drainage. area drained, cleansed with NSS [normal saline solution], abd [a type of dressing] applied and covered with kerlix [gauze]. DON and R [resident] physician notified. There was no indication the resident's representative was notified. Review of the Nursing Note dated 03/14/26 at 6:10 A.M. written by the Director of Nursing (DON) revealed the DON came to the building to assess a bruise to the right lower extremity. The assistant director of nursing (ADON) stated Resident #5 had an incident on transport bus on 03/13/26. Resident #5 slid down in a chair and the left leg had pressed up against the footrest. The DON wrote this lines up with placement and injury. The DON wrote that the Nurse (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	04/20/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Practitioner was notified and a new order was obtained to cleanse right lower leg with normal saline solution, apply xeroform and DD (dry dressing) until healed. The DON wrote left message with family to notify.Review of the progress note entry dated 03/14/26 at 6:12 A.M. authored by LPN #722 revealed the entry was an SBAR (Situation, Background, Assessment and Recommendation) entry. LPN #722 documented the reported change of condition was fever (temperature 100.7 degrees Fahrenheit), relevant medical history was cancer, diabetes, the resident had pain, and the primary care provider was notified and started Resident #5 on Cephalexin 500 milligrams twice a day and Tylenol for temperature and pain. There was no indication the resident's representative was notified.Review of the progress note dated 03/14/26 at 9:31 A.M. authored by Nurse Practitioner (NP) #981 revealed the NP received a call from LPN #722 reporting bruise to RLE with fluid filled center. The blister opened and pus expressed. Nurse concerned it might be cellulitis. Temperature 100.7. There was no indication the resident's representative was notified.Review of a progress note dated 03/15/26 at 2:52 A.M. authored by LPN #722 revealed Resident #5 was sent out to the emergency room after being found with slurred speech, shaking and eyes rolling back in his head by a certified nursing assistant. Family notified. DON notified.An interview on 04/14/26 at 8:27 A.M. with LPN #722 revealed Resident #5's son was his representative and emergency contact and was very involved with Resident #5's care. LPN #722 stated she did not notify the son of the leg injury on 03/13/26, but did notify the son on 03/15/26 when Resident #5 was sent to the hospital and it was during that conversation the son told her that the DON had not called him at all nor left a voice mail to notify him about Resident #5's change of condition on 03/13/26. LPN #722 stated the son reported he was not told about Resident #5's appointment at the cancer center on 03/13/26 either because if he had known he would have gone to that appointment with Resident #5. LPN #722 confirmed the DON entered a note in the medical record stating she notified Resident #5's family on 03/14/26 of a bruise. An interview on 04/14/26 at 8:46 A.M. with Ombudsman #801 revealed their agency was investigating an incident involving Resident #5 and a staff member during transport to The Hope Center on 03/13/26 and during the investigation Resident #5's representative (son) stated to the Ombudsman he was not notified regarding any incident on the van during transportation to The Hope Center appointment or any appointment at The Hope Center.An interview on 04/14/26 at 12:35 P.M. with Resident #5's representative (son) confirmed that he was not notified of the bruise, fever or pus on his father's leg until he was hospitalized on [DATE], nor was he informed that his father had been sent out to an initial doctor's appointment at The Hope Center on 03/13/26. Resident #05's representative stated he was the primary contact and should be told when his dad was hurt or had to see the doctor. He stated he attended all of his dad's physician appointments and accompanied his dad on the ride to the facility. Resident #5's son stated the nursing home told me they must have dialed the wrong number.An interview on 04/15/26 at 9:54 A.M. with the DON confirmed that she did not notify Resident #5's representative when the bruise was found on 03/14/26 because it was early in the morning and stated she might have left a message, and did not remember speaking with Resident #5's representative on that occasion and verified Resident #5's representative was involved with Resident #5's care. The DON stated I must have called the wrong number Review of facility policy titled Change in a Resident's Condition or Status, revised February 2021, revealed the facility would promptly notify the resident, his or her attending physician, and the representative of changes in the resident's medical condition and/or status. The nurse will notify the resident representative when the resident is involved in any incident that results in injury including injuries of unknown source.This deficiency represents non-compliance investigated under Complaint Number 2978911.

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	04/20/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of witness statements, interviews and review of facility policy, the facility failed to ensure Resident #5 was free from verbal abuse by a staff member. This affected one resident (#5) out of three residents reviewed for abuse. The facility census was 67.Findings include:Review of Resident #5's medical records revealed an admission date of 07/18/22 with diagnoses including but not limited to cerebral infarction, hemiplegia (total loss of voluntary movement of affected muscle resulting in stiffness or spasticity) and hemiparesis (partial weakness) following cerebral infarction affecting right dominant side, unspecified psychosis, unspecified anxiety disorder, malignant neoplasm of colon, altered mental status, hypertension (high blood pressure), need for assistance for personal care, muscle atrophy, type two diabetes and aphasia (acquired language disorder affecting communication). Review of the care plan revised on 02/28/26 revealed Resident #5 was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. Interventions included staff to converse with Resident #5 during care. Resident #5 had a stoke with right sided weakness. Interventions included address emotional issues and teach families that stoke residents can have emotional liability and depression. Resident #5 had hemiplegia related to stoke. Interventions included reposition as tolerated every two hours. Resident #5 was dependent with bathing, toileting and extensive assistance with bed mobility and required a mechanical lift for transfers. Further review of the care plan revealed no hearing impairment or hearing appliance was noted on the plan of care up to the most recent revision date of 04/07/26. Review of the Medication Administration Record (MAR) dated March 2026 revealed Resident #5 had an outside appointment at The Hope Center (a comprehensive cancer treatment center) on 03/13/26 at 1:00 P.M. Review of a written statement provided by The Hope Center dated 03/17/26 authored by Office Manager #812 revealed Resident #5 had arrived at the center on 03/13/26 in a van and was put into a wheelchair. The transporter [Transporter #719] was observed yelling at patient and was not very patient with him per the secretary. This information was noted as reported to the Ombudsman via telephone. Review of staff statement dated 03/17/26 authored by the Hope Center Secretary #813 revealed Resident #5 had arrived at the facility with transportation driver (Transporter #719) who had appeared upset and stated, he was having a bad day with the patient. Transport driver had gone out the van to get Resident #5 and he had got into the patients face and was yelling at him. Resident #5's legs were not in the feet rest at any time during his visit and driver was very rough with patient. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 required max assistance with eating, was dependent with toileting and bathing and personal hygiene. Resident #5 was dependent with bed mobility and transfers and was non ambulatory. Observation on 04/14/26 at 9:28 A.M. revealed Resident #5 was alert while resting in bed but demonstrated impaired verbal communication and was unable to answer questions. Telephone interview on 04/14/26 at 1:18 P.M. with the Hope Center Office Manager (OM) #812 (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	04/20/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	revealed Resident #5 had an appointment on 03/13/26 at approximately 1:00 P.M. at The Hope Center (a comprehensive cancer treatment center) where Office Manager #812 worked. OM #812 stated she had been made aware by the center's Secretary #813 that Transporter #719 had arrived at the Hope Center with Resident #5 and Transporter #719 was observed to have been yelling at Resident #5 who had an upset look on his face after being yelled at by Transporter #719. OM #812 verified this was reported to the Ombudsman. Interview on 04/14/26 at 10:54 A.M. with Transporter #719 revealed he had transported Resident #5 to an outside appointment on 03/13/26. Transporter #719 denied he had yelled at Resident #5 and provided no further comments. Telephone interview on 04/15/26 at 1:37 P.M. with the Hope Center Secretary #813 revealed on 03/13/26 Transporter #719 had arrived at the facility in the afternoon and had appeared to be upset and he had stated I have had the worst day and I need to check this resident in. Secretary #813 stated Transporter #719 had then exited the facility, and walked back to the resident. When asked to describe what she saw next, Secretary #813 stated Transporter #719 was within an inch of the residents' face, flailing his arms up and down and yelling at him. I had my hand on the phone ready to call the police. Secretary #813 stated she had reported the incident to the office manager (OM #812). Interview on 04/16/26 at 11:11 A.M. with the Administrator, Director of Nursing (DON) the Regional Director of Operations (RDO) #805 and [NAME] President of Operations (VPO) #901, revealed they had not received any communication directly from the Hope Center regarding concerns with Transporter #719 and Resident #5. VPO #901 confirmed a meeting with the Ombudsman occurred and the Ombudsman said Transporter #719 appeared to be frustrated with Resident #5 and nothing was reported about Transporter #719 yelling at the resident. Telephone interview on 04/16/26 at 12:05 P.M. with Ombudsman #814 revealed she had been made aware by the Hope Center staff having witnessed Transporter #719 yelling at Resident #5 and they were concerned for the resident so reported it to the Ombudsman. Ombudsman #814 stated she had a video conference with RDO #805 and VPO #901 as well as Ombudsman #801 on 04/09/26 at 11:00 A.M. and had informed them of the allegations made by the Hope Center staff concerning the treatment of Resident #5 by the transporter from the facility and she told them the resident was observed being yelled at by Transporter #719. Ombudsman stated she had received digital confirmation from RDO #805 and VPO #901 confirming attendance at the video conference on 04/09/26 at 11:00 A.M. Review of facility policy titled Abuse, Neglect and Exploitation undated, revealed the definition of abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse. Mental abuse includes, but is not limited to, humiliation, harassment, threats of deprivation or punishment. Mistreatment means inappropriate treatment or exploitation of a resident. An immediate investigation is warranted when suspicions of abuse or neglect occur. The facility will make efforts to ensure all residents are protected from physical and psychological harm during and after the investigation. Examples included but were not limited to responding immediately to protect the alleged victim and protection from retaliation. Reporting of all alleged violations to the state agency no later than 24 hours if the event did not involve abuse and did not result in serious bodily injury. This deficiency represents noncompliance as an incidental finding investigated under Complaint 2978911.

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	04/20/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the facility Self-Reported Incident (SRI) and review of facility policy, the facility failed to report allegations of abuse to the state agency as required. This affected one (Resident #5) of three residents reviewed for abuse. The facility census was 67.Findings include:Review of Resident #5's medical records revealed an admission date of 07/18/22 with diagnoses including but not limited to cerebral infarction, hemiplegia (total loss of voluntary movement of affected muscle resulting in stiffness or spasticity) and hemiparesis (partial weakness) following cerebral infarction affecting right dominant side, unspecified psychosis, unspecified anxiety disorder, malignant neoplasm of colon, altered mental status, hypertension (high blood pressure), need for assistance for personal care, muscle atrophy, type two diabetes and aphasia (acquired language disorder affecting communication).Review of the care plan revised on 02/28/26 revealed Resident #5 was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. Interventions included staff to converse with Resident #5 during care. Resident #5 had a stoke with right sided weakness. Interventions included address emotional issues and teach families that stoke residents can have emotional liability and depression. Resident #5 had hemiplegia related to stoke. Interventions included reposition as tolerated every two hours. Resident #5 was dependent with bathing, toileting and extensive assistance with bed mobility and required a mechanical lift for transfers. Further review of the care plan revealed no hearing impairment or hearing appliance was noted on the plan of care up to the most recent revision date of 04/07/26. Review of the Medication Administration Record (MAR) dated March 2026 revealed Resident #5 had an outside appointment at The Hope Center (a comprehensive cancer treatment center) on 03/13/26 at 1:00 P.M.Review of a written statement provided by The Hope Center dated 03/17/26 authored by Office Manager #812 revealed Resident #5 had arrived at the center on 03/13/26 in a van and was put into a wheelchair. The transporter [Transporter #719] was observed yelling at patient and was not very patient with him per the secretary. This information was noted as reported to the Ombudsman via telephone. Review of staff statement dated 03/17/26 authored by the Hope Center Secretary #813 revealed Resident #5 had arrived at the facility with transportation driver (Transporter #719) who had appeared upset and stated, he was having a bad day with the patient. Transport driver had gone out the van to get Resident #5 and he had got into the patients face and was yelling at him. Resident #5's legs were not in the feet rest at any time during his visit and driver was very rough with patient. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 required max assistance with eating, was dependent with toileting and bathing and personal hygiene. Resident #5 was dependent with bed mobility and transfers and was non ambulatory. Observation on 04/14/26 at 9:28 A.M. revealed Resident #5 was alert while resting in bed but demonstrated impaired verbal communication and was unable to answer questions. Telephone interview on 04/14/26 at 1:18 P.M. with the Hope Center Office Manager (OM) #812 revealed Resident #5 had an appointment on 03/13/26 at approximately 1:00 P.M. at The Hope Center (a comprehensive cancer treatment center) where Office Manager #812 worked. OM #812 stated she had been made aware by the center's Secretary #813 that Transporter #719 had arrived at the Hope Center with Resident #5 and Transporter #719 was observed to have been yelling at Resident #5 who had an upset look on his face after being yelled at by Transporter #719. OM #812 verified this was reported to the Ombudsman. Interview on 04/14/26 at 10:54 A.M. with Transporter #719 revealed he had transported Resident #5 to an outside appointment on 03/13/26. Transporter #719 denied he had yelled at Resident #5 and provided no further comments. Telephone interview on 04/15/26 at 1:37 P.M. with the Hope Center Secretary #813 revealed on 03/13/26 Transporter #719 had arrived at the facility in the afternoon and had appeared to be upset and he had stated I have had the worst day and I need to check this resident (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	04/20/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	in. Secretary #813 stated Transporter #719 had then exited the facility, and walked back to the resident. When asked to describe what she saw next, Secretary #813 stated Transporter #719 was within an inch of the residents' face, flailing his arms up and down and yelling at him. I had my hand on the phone ready to call the police. Secretary #813 stated she had reported the incident to the office manager (OM #812). Interview on 04/16/26 at 11:11 A.M. with the Administrator, Director of Nursing (DON) the Regional Director of Operations (RDO) #805 and [NAME] President of Operations (VPO) #901, revealed they had not received any communication directly from the Hope Center regarding concerns with Transporter #719 and Resident #5. VPO #901 confirmed a meeting with the Ombudsman occurred and the Ombudsman said Transporter #719 appeared to be frustrated with Resident #5 and nothing was reported about Transporter #719 yelling at the resident. Telephone interview on 04/16/26 at 12:05 P.M. with Ombudsman #814 revealed she had been made aware by the Hope Center staff having witnessed Transporter #719 yelling at Resident #5 and they were concerned for the resident so reported it to the Ombudsman. Ombudsman #814 stated she had a video conference with RDO #805 and VPO #901 as well as Ombudsman #801 on 04/09/26 at 11:00 A.M. and had informed them of the allegations made by the Hope Center staff concerning the treatment of Resident #5 by the transporter from the facility and she told them the resident was observed being yelled at by Transporter #719. Ombudsman stated she had received digital confirmation from RDO #805 and VPO #901 confirming attendance at the video conference on 04/09/26 at 11:00 A.M.Review of Self-Reported Incident (SRI) #273384 dated 04/16/26 revealed an investigation had been started related to allegations of staff to resident verbal abuse of Resident #5.Review of facility policy titled Abuse, Neglect and Exploitation undated, revealed the definition of abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse. Mental abuse includes, but is not limited to, humiliation, harassment, threats of deprivation or punishment. Mistreatment means inappropriate treatment or exploitation of a resident. An immediate investigation is warranted when suspicions of abuse or neglect occur. The facility will make efforts to ensure all residents are protected from physical and psychological harm during and after the investigation. Examples included but were not limited to responding immediately to protect the alleged victim and protection from retaliation. Reporting of all alleged violations to the state agency no later than 24 hours if the event did not involve abuse and did not result in serious bodily injury. This deficiency represents noncompliance as an incidental finding investigated under Complaint 2978911.

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	04/20/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and review of facility policy the facility failed to coordinate transportation services that were resident centered following a surgical procedure for the highest practicable well-being for Resident #41, and failed to adequately monitor Resident #5 following a change in health status resulting in hospitalization. This affected two residents (Resident #5 and #41) of five residents reviewed for quality of care . The facility census was 67.Findings include:Findings include: 1.Review of Resident #5's medical records revealed an admission date of 07/18/22. Diagnoses included hemiplegia with right side weakness, muscle weakness and need for personal care assistance. Review of the care plan revised 02/28/26 revealed Resident #5 had hemiplegia related to a stroke. Interventions included reposition as tolerated every two hours. Resident #5 had self-care deficits that included dressing, personal hygiene, eating, toileting and bathing. Resident #5 required extensive assistance of one to two staff for bed mobility and was dependent with bathing and toileting and required a Hoyer (mechanical lift) for transfers. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 required max assistance with eating, was dependent with toileting and bathing and personal hygiene. Resident #5 was dependent with bed mobility and transfers and was non ambulatory. Review of a progress note dated 03/14/26 timed 5:26 A.M. authored by Licensed Practical Nurse (LPN) #722 revealed an aide had alerted her of a large bruise and a fluid filled sac on Resident #5's right lower extremity. Bruise measured 11 centimeters (cm) wide and 16 cm long with a fluid filled sac measuring 6 cm wide and 11 cm long with a tear in the center that measured 4 cm long and 1.5 cm wide with serosanguinous (blood tinged) drainage. Area was cleansed with normal saline and covered with absorbent dressing and kerlex and the Director of Nursing (DON) and physician were notified. Review of a progress note dated 03/14/26 timed 6:10 A.M. authored by the DON revealed she had arrived at the facility to assess Resident #5's right leg. Upon speaking with the Assistant Director of Nursing (ADON) she had been advised Resident #5 had an incident on the transport bus on 03/13/26 and had slid down in chair and leg had had pressed against the footrest which lined up with the placement and injury on Resident #5's leg. ADON stated she and staff had assisted Resident #5 with repositioning and Resident #5 had minimal pain which had been controlled with Tylenol. Nurse Practitioner had been notified and new orders to cleanse the area with normal saline, apply xeroform (wound dressing) and dry dressing. Review of a progress note dated 03/14/26 timed 6:12 A.M. authored by LPN #722 revealed vital signs were within a normal range with the exception of an elevated temperature of 100.7 degrees. Review of a progress note dated 03/14/26 timed 6:43 A.M. authored by LPN #722 revealed Tylenol 325 mg two tablets was given for pain and temperature. Review of on call physician progress note dated 03/14/26 (untimed) revealed staff reported bruise to right lower extremity with fluid filled center. Resident #5 had sustained a skin tear and blister had opened up, and during treatment they were able to express pus. Resident #5 had a temperature of (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	04/20/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	100.7 degrees. Orders were given to administer Cephalexin (antibiotic) 500 milligrams (mg) twice a day for five days. Review of late entry progress note created on 03/16/26 for an effective date of 03/13/26 authored by ADON revealed she had been requested in the facilities transport bus at approximately 3:00 P.M. for assistance with repositioning of Resident #5. Upon entering the bus Resident #5 was found to be leaning back in his chair with buttocks slightly slid forward, however ADON could see the wheelchair seat in between his legs, and it did not appear Resident #5 was going to fall from the wheelchair. Both of Resident #5's feet were firmly planted on the ground and lateral legs were resting against the leg rests on the outside of the legs. Resident #5 legs were repositioned, and aide had placed legs on the leg rests and maneuvered the chair out of the transport van. Review of progress note dated 03/15/26 timed 2:52 A.M. authored by LPN #722 revealed she had been alerted by an aide that Resident #5 was not himself and had increased shaking/tremors, eyes rolling back and increased slurred speech with an elevated temperature of 99.1. The NP had been notified, and orders were received to send Resident #5 to the hospital. Further review of Resident #5's medical records revealed no evidence of temperature, pulse, or blood pressure monitoring of Resident #5's change in condition related to the right leg injury or elevated temperature between 03/14/26 at 7:00 A.M. to 03/15/26 at 2:52 A.M. Review of the hospital records dated 03/15/26 revealed Resident #5 presented to the hospital on [DATE] with altered mental status (AMS). A computed tomography (CT) tibia fibula right without contrast (scan of the bones in the right lower leg) result on 03/15/26 indicated Resident #5 had a nondisplaced fracture of the proximal tibia, soft tissue edema about the leg, and small suprapatellar joint effusion. An X-ray of the of the tibia fibula right (two views) revealed an acute, nondisplaced transverse fracture of the proximal tibial metaphysis (below the knee joint). The care coordination section of the record indicated Resident #5 was admitted for AMS, fall and right tibia fracture. Orthopedic surgery was consulted with no plans for surgical intervention. Resident #5 was provided with intravenous (IV) Zosyn (an antibiotic) and fluids. He was discharged back to the nursing facility on 03/16/26 on narcotic pain medication, anticoagulant medication and non-weight bearing on right leg. Telephone interview on 04/14/26 at 8:25 A.M. with LPN #722 revealed she had worked on 03/13/25 from approximately 6:30 P.M. to 03/14/25 until approximately 7:30 A.M. LPN #722 stated at approximately 2:00 A.M. she had been notified by Certified Nursing Assistant (CNA) #615 Resident #5 had a large bruise to his leg. LPN #722 stated she had immediately went to Resident #5's room and observed the area and had obtained measurement and called the DON and the NP. LPN #722 stated Resident #5 was unable to state what had occurred and she stated she had looked through Resident #5's medical records and no documentation was done regarding the injury. LPN #722 stated Resident #5 had not verbalized pain however she had noticed he was having facial grimacing when she had cleaned the area. LPN #722 stated the DON had arrived at the facility at approximately 4:00 A.M. and she stated the DON had informed her Resident #5 had slid out of his wheelchair per the ADON. LPN #722 stated she had returned the next day on 03/15/26 to 03/16/26 and during the evening she had noted Resident #5 to have had a decline from the previous shift. LPN #722 stated she had assessed Resident #5 and he had an elevated temperature, he was shaking and she had observed his eye rolling back into his head. LPN #722 stated she had contacted the NP who had advised to send Resident #5 to the hospital for evaluation. LPN #722 stated she had later been informed Resident #5 had a broken tibia. LPN #722 further stated the DON had advised that she not document her findings in Resident (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	04/20/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	#5's medical records and had asked that she write her findings down on paper, however LPN #722 had refused and had documented her assessment in Resident #5's medical records. Interview on 04/15/26 at 7:51 A.M. with CNA #615 revealed on 03/14/26 at approximately 4:30 A.M. she had assisted Resident #5 with care and as she removed his blanket the blanket was wet and she had observed what looked like a hole that had burst open and a large bruise. CNA #615 stated she had immediately informed the nurse and asked Resident #5 what happened, however he had not been able to say. An interview on 04/15/26 at 9:54 A.M. with DON verified no documented evidence in Resident #5's medical records of vital signs monitoring for Resident #5's change in condition related to the right leg injury or elevated temperature between 03/14/26 at 7:00 A.M. to 03/15/26 at 2:52 A.M. The facility could not provide a policy on Quality of Care. 2. Review of the medical record for Resident #41 revealed an admission date of 10/10/25 with diagnosis of cellulitis, pain in left knee, chest pain, chronic kidney disease stage five, end stage renal disease, dependence on renal dialysis, hypertension, hepatitis C, noncompliance with medical regimen due to unspecified reason, cocaine abuse, alcohol abuse. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #41 had intact cognition (Brief Interview Mental Status score of 15 . No indicators of psychosis, no behavior symptoms present, no rejection of care exhibited. Supervision was needed for toilet hygiene, set up assist for personal hygiene. Supervision was needed to roll left and right in bed. Moderate assistance to walk ten feet. No pressure ulcers. Resident #41 received hemodialysis. Review of the Care Plan Report, date initiated 11/05/25, revealed Resident #41 had hypertension related to chronic kidney disease. Interventions include hypertensive medication, monitor for side effects such as hypotension or increased heart rate, monitor and document any edema and notify the physician. Further review of the medical record revealed a Mercy Health hospital visit dated 03/01/26 where Resident #41 was seen for neck swelling and was diagnosed with acute deep vein thrombosis. New medication of Eliquis was started and Vascular Surgery in Cleveland was to be contacted. Review of a Nursing Note dated 03/06/26 at 6:13 P.M. written by Registered Nurse (RN)#603 revealed Resident #41 returned from an appointment with orders to stop Eliquis and surgery scheduled for Monday 03/09/26. Review the After Visit Summary dated 03/10/26 from the Cleveland Clinic revealed a date of admission [DATE] and date of discharge 03/10/26 for end stage renal disease and left upper extremity brachial axillary loop graft and ligation of a brachial pre-conditioning fistula. Resident #41 recovered in the PACU (patient acute care unit) and step- down unit. Resident #41 was cleared for discharge post-op day one to a skilled nursing facility. Discharge instructions included daily wound inspection to ensure the site remained clean and dry, nursing staff monitor and report any fever, chills, localized infection, uncontrolled bleeding or numbness and coldness in the extremities and report to the surgeon immediately. Discharge instructions were printed on 03/10/26 at 10:32 A.M. Review of a Nursing Note dated 03/10/26 at 10:16 P.M. written by Licensed Practical Nurse (LPN) # (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	04/20/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	622 revealed Resident #41 returned at an unknown time this shift. Resident #41 was upset because of transportation taking so long and he was outside. Resident #41 refused to give the nurse paperwork from the appointment. Resident requested as needed pain medication at 6:45 P.M. for a pain rating of six (moderate pain) out of ten . Vitals were obtained that revealed blood pressure 126/74, pulse 86, oxygen 96 percent. Resident #41 refused a skin assessment. Resident had a bandage to left arm that was clean and intact. Follow up with physician in the morning. Review of Medication Administration Record, dated March 2026, revealed Resident #41 had a pain level recorded at six (moderate pain) and was administered oxycodone-acetaminophen (narcotic pain medication with a non-narcotic pain medication) 10-325 milligrams one tablet by mouth for moderate to severe pain. The order start date was 03/10/26 and the time stamp on the MAR was 6:56 P.M. Further review of the March 2026 MAR revealed Resident #41 did not receive the 5:00 P.M. dose of Sodium Bicarbonate (a medication prescribed for dialysis patients to prevent metabolic acidosis/high blood acid) oral tablet 650 milligrams related to chronic kidney disease, and Sevelamer HCL (a medication used to control phosphorus levels) tablet 800 milligrams at 5:00 P.M. because Resident #41 was LOA (leave of absence). Interview on 04/08/26 at 12:00 P.M. with Activities Assistant (AA) #719 revealed Resident #41 stayed in the hospital overnight after his procedure. AA #719 stated he and the Activity Director (AD) #612 picked up Resident #41 when they could. Interview on 04/08/26 at 12:01 P.M. with the Administrator revealed Resident #41 needed transportation to the Cleveland Clinic in Cleveland for a procedure. The Administrator stated he had no knowledge of Resident #41's procedure and need for transportation to Cleveland. The Administrator stated he drove up with AA # 719 the morning of 03/09/26 to Cleveland to ensure Resident #41 had his procedure on time but when the hospital explained Resident #41 would be ready for pick up at 8:00 P.M. the Administrator explained the facility could not pick Resident #41 up that late. The Administrator stated the Nurse Practitioner agreed to keep Resident #41 overnight so the facility could pick Resident #41 up in the morning. The Administrator verified the over-night hospital stay was due to the lack of transportation back to the facility. Interview on 04/08/26 at 12:10 P.M. with the AD #612 revealed she picked Resident #41 up on 03/10/26 later in the day because the facility bus was busy all day long. AD #612 stated she and AA #719 drove to Cleveland and brought Resident #41 back to the facility around 4:30 P.M. or 5:00 P.M. Interview on 04/08/26 at 12:10 P.M. with Assistant Director of Nursing #519 revealed the facility did not know Resident #41 had a surgery in Cleveland until the day before and the facility assumed he had a ride until we found out he needed picked up. Interview on 04/08/26 at 12:30 P.M. with facility Transportation Scheduler #600 revealed the resident, or nurse was to provide appointment paperwork to her to schedule transportation to and from appointments, if she did not receive notification she cannot schedule transportation. Interview on 04/08/26 at 1:00 P.M. with Certified Nursing Assistant (CNA) #512 revealed Resident #41 called him on 03/10/26 when he was discharged from the hospital at 10:00 A.M. asking for the facility to pick him up. Resident #41 called the facility on 03/10/26 every twenty minutes asking to be picked up. (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	04/20/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/08/26 at 1:10 P.M. with CNA #725 revealed Resident #41 did not return to the facility until late in the evening on 03/10/26 after his surgery. Resident #41 kept calling the facility for someone to pick him up. CNA #725 verified on her cell phone Resident #41 called her at 10:00 A.M. and called the facility nurse station prior. Resident #41 left a voice message at 2:06 P.M. stating he was still in Cleveland. Resident #41 stated he had his phone charger in the facility van and his phone battery was low. CNA #725 stated she observed AA #719 in the facility until 3:00 P.M. when he left to pick up Resident #41. Interview on 04/08/26 at 4:00 P.M. with Transportation Scheduler #600 verified the facility drove Resident #41 to Cleveland on 03/09/26 and left for Cleveland on 03/10/26 at 4:00 P.M. Interview on 04/08/26 at 4:58 P.M. with Resident #41 revealed the Cleveland Clinic set up his appointment and notified him through email when his surgery was scheduled. Resident #41 stated he told the nurse the day and time of his surgery but was told by the nurse I needed to find my own ride. Resident #41 stated he then told the Administrator in fear he would not have a ride to Cleveland for his surgery. Resident #41 verified he received dialysis on 03/10/26, received his morning medication and ate prior to discharge from the hospital. Resident #41 stated the hospital told him his ride was on the way so Resident #41 assumed the facility transportation would be at the Cleveland Clinic in 45 minutes, therefore he told the nurse he would wait outside for his transportation. Resident #41 stated he waited two to three hours outside until the facility picked him up, he stated he called the facility to notify them he was discharged around 10:00 A.M. Interview on 04/08/26 at 5:20 P.M. with Registered Nurse (RN) #603 revealed she was notified by Resident #41 of his upcoming surgery on 03/09/26 after Resident #41 gave his paperwork to her. RN #603 stated she was not sure of the facility protocol for resident transportation to surgery and documentation because she worked in the facility as needed. RN #603 verified she wrote a progress note but did not write an order or notify the transportation scheduler because the scheduler was gone for the day and verified she did not confirm if Resident #41 had transportation to and from his surgery. Interview on 04/09/26 at 10:10 A.M. with Transportation Scheduler #600 revealed if a nurse does not put an order in the medical record or bring the paperwork to her office she would not know to arrange transportation for that resident. If a nurse received information on an appointment during the evening or weekends the nurse could put the paperwork in her box outside her office. Interview on 04/09/26 at 10:11 A.M. with the DON revealed nurse staff should put outside appointments in the Medical Record Orders Tab to ensure visibility across all shifts and departments. If a nurse received paperwork after hours they can put the paperwork in a box outside the transportation scheduler door. The nurse is expected to notify the transportation scheduler or the DON if an outside appointment was made and a resident needed transportation. Interview on 04/09/26 at 5:25 P.M. with the DON revealed Resident #41 was admitted to the hospital after his procedure for observation. The DON verified RN #603 was notified on Resident #41 surgery in Cleveland but did not notify the DON or the transportation scheduler. Interview on 04/13/26 at 12:46 P.M. with the DON verified Resident #41 was upset about his late return and had stayed overnight in the hospital because there was no one from the facility to go get him after his procedure. The DON verified as a result of the delayed return Resident #41 did not receive all of his 5:00 P.M. medications as ordered and was in moderate pain upon return to the facility. (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	04/20/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Transporting a Resident (Facility Van) dated March 2026, revealed the facility would provide residents a safe, non-emergency transportation to doctor's appointments, activity outings, and any other trips the facility deemed necessary. This deficiency represents non-compliance investigated under Master Complaint Number 2978911 and Complaint Number 2967092.

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	04/20/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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, interview and policy review, the facility failed to ensure a resident was properly transported in a wheelchair to prevent injury. Actual harm occurred on 03/13/26 when Resident #5, who had hemiplegia (total loss of voluntary movement of affected muscle resulting in stiffness or spasticity) in his right leg and required a wheelchair for mobility, was transported to an appointment under the supervision of Transporter #719. Transporter #719 failed to maintain proper positioning of Resident #5, causing his right leg to press into the leg rests. His foot also repeatedly hit the ground when being pushed in a wheelchair to his physician appointment. Resident #5 winced in pain and complained of pain in his right leg to the staff at the physician's office. Resident #5 developed bruising and a wound infection of the right leg and was hospitalized on [DATE]. Resident #5 was diagnosed with an acute, nondisplaced transverse fracture of the proximal tibial metaphysis. No surgical intervention was recommended and Resident #5 returned to the facility on [DATE] on opioid pain medication, anticoagulant medication (blood thinner) and orders for non-weight bearing on the right leg. This affected one (Resident #5) of three residents reviewed for accidents. The facility census was 67. Findings include:Record review revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, hemiplegia and hemiparesis (partial weakness) following cerebral infarction affecting right dominant side.Review of the care plan revised 02/28/26 revealed Resident #5 had hemiplegia related to a stroke. Interventions included reposition as tolerated every two hours. Resident #5 had self-care deficits that included dressing, personal hygiene, eating, toileting and bathing. Resident #5 required extensive assistance of one to two staff for bed mobility and was dependent on staff for bathing and toileting and required a Hoyer (mechanical lift) for transfers. Review of the Medication Administration Record (MAR) dated March 2026 revealed Resident #5 had an outside appointment with a physician on 03/13/26 at 1:00 P.M.Review of the note from the physician office dated 03/13/26, revealed Resident #5 was referred to the center's hematology office for an initial visit due to anemia. Physician #980 wrote the resident had aphasia, chronic psychosis, was unable to give any history, was not able to answer questions, and was only able to state that his right leg hurt. Physician #980 documented Resident #5 was there with an aide from the facility however the aide did not have any information regarding the resident's health history, status or complaints. health history was obtained from medical records sent with referral. Physician #980 noted there was worse edema in the right extremity than the left. Review of late entry progress note, effective date of 03/13/26 and created date of 03/16/26, authored by the Assistant Director of Nursing (ADON) revealed she had been requested in the facility's transport bus at approximately 3:00 P.M. for assistance with repositioning of Resident #5. Upon entering the bus, Resident #5 was leaning back in his chair with buttocks slightly slid forward, however ADON could see the wheelchair seat in between his legs, and it did not appear Resident #5 was going to fall from the wheelchair. Both of Resident #5's feet were firmly planted on the ground and lateral legs were resting against the leg rests on the outside of the legs. Resident #5 legs were repositioned, and aide had placed legs on the leg rests and maneuvered the chair out of the transport van.Review of the facility document Disciplinary Action Report: Written or Verbal dated 03/13/26 for Transporter #719 revealed it was a written final warning. The reason for the warning was employee needs to ensure residents are positioned in wheelchairs appropriately and secured in van appropriately with every transport. Corrective action required: if a resident is not positioned appropriately, the resident needs to be returned to their nurse. If employee fails to comply within 30 days, progressive disciplinary action will occur. The disciplinary action was signed by the Administrator and Human Resources (HR) #626 and Transporter #719 refused to sign.Review of a nursing note dated 03/14/26 at 5:25 A.M. authored by Licensed Practical Nurse (LPN) #722 revealed the aide alerted the nurse that Resident #5 had a large (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	04/20/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	bruise and fluid filled sac the right lower extremity. Upon assessment this nurse observed a bruise measuring approximately 11 centimeters (cm) wide and 16 cm long. There was a fluid filled sac measuring approximately 6 cm wide and 11cm long with a tear in the center measuring approximately 4 cm long and 1.5 cm wide with serosanguineous [clear, bloody] drainage. area drained, cleansed with normal saline. An ABD pad was applied and covered with gauze. The Director of Nursing (DON) and the Resident #5's physician was notified. There was no documentation Resident #5's was notified. Review of the nursing note dated 03/14/26 at 6:10 A.M. written by the (DON) documented she came to assess a bruise to the right lower extremity. The ADON stated Resident #5 had an incident on the transport bus on 03/13/26. Resident #5 slid down in a chair and the left leg had pressed up against the footrest. The DON wrote this lines up with placement and injury. The ADON stated she and staff had assisted with repositioning in the chair and the resident had minimal pain which had been controlled with Tylenol. The DON wrote that the Nurse Practitioner was notified and a new order was obtained to cleanse right lower leg with normal saline solution, apply petroleum gauze and a dry dressing until healed. The DON wrote that a message was left with Resident #5's family to notify. Review of a late entry Provider Note, effective date of 03/14/26 at 11:00 A.M. and created date of 04/11/26, revealed Physician #806 stated they were notified of injury to patient's right lower extremity. He is severely aphasic with a right hemiparesis due to stroke. He was in the facility transport bus and checked by nursing home staff. Based on the way he was found as described in the notes due to the flaccidity of his right side he slid in the chair and the right lower extremity was up against the leg rest during his transport. That extremity ended up with a bruise clearly caused by the pressure of the leg rest on his very flaccid leg. Review of the progress note entry dated 03/14/26 at 6:12 A.M. authored by LPN #722 revealed the entry was a Situation, Background, Assessment and Recommendation (SBAR)) entry. LPN #722 documented the reported change of condition was fever with a temperature of 100.7 degrees Fahrenheit (F), relevant medical history was cancer, diabetes, the resident had pain, and the primary care provider was notified and started Resident #5 on Cephalexin (an antibiotic) 500 milligrams twice a day and Tylenol for temperature and pain. There was no documentation Resident #5's representative was notified. Review of the progress note dated 03/14/26 at 9:31 A.M. authored by Nurse Practitioner (NP) #981 revealed the NP received a call from LPN #722 reporting a bruise to the right lower extremity with a fluid filled center. The blister opened and pus expressed. LPN #722 was concerned it might be cellulitis. Temperature 100.7 degrees F. Review of a progress note dated 03/15/26 at 2:52 A.M. authored by LPN #722 revealed Resident #5 was sent out to the emergency room after being found with slurred speech, shaking and eyes rolling back in his head by a certified nursing assistant (CNA). Resident #5's family and the DON were notified.Review of the hospital records dated 03/15/26 revealed Resident #5 presented to the hospital on [DATE] with altered mental status. Resident #5 was sent to the hospital from his nursing facility due to a chief complaint of altered mental status and a fall. The fall happened last Friday during transfer. X-ray of the right tibia/fibula revealed an acute, nondisplaced transverse fracture of the proximal tibial metaphysis. Orthopedic surgery was consulted with no plans for surgical intervention. A computed tomography (CT) of the tibia fibula right without contrast (scan of the bones in the right lower leg) result on 03/15/26 indicated Resident #5 had a nondisplaced fracture of the proximal tibia, soft tissue edema about the leg, and small suprapatellar joint effusion. An X-ray of the tibia fibula right (two views) revealed an acute, nondisplaced transverse fracture of the proximal tibial metaphysis (below the knee joint). The care coordination section of the record documented Resident #5 was admitted for altered mental status, a fall and a right tibia fracture. Resident #5 was provided with intravenous (IV) Zosyn (an antibiotic) and fluids. The resident was a poor historian and could provide no history. He did state he felt fine. He was discharged back to the nursing facility on 03/16/26 on narcotic pain medication, anticoagulant medication and non-weight bearing on right leg. Review of a written statement provided by physician office Resident #5 had visited on 03/13/26 was dated 03/17/26 authored by Office Manager #812. It documented Resident #5 had arrived at the (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	04/20/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	center on 03/13/26 in a van and was put into a wheelchair. The transporter was observed yelling at patient and was not very patient with him per the secretary. Resident #5's right leg was elevated on a pillow and his leg kept falling off. Resident #5 had complained of pain when he arrived and while being placed in an exam room. This information was reported to the Ombudsman via telephone.Review of a written statement dated 03/17/26 authored by physician office Secretary #813 revealed Resident #5 had arrived at the facility with transportation driver who had appeared upset and stated, he was having a bad day with the patient. The transport driver had gone out the van to get Resident #5 and he had got into the patients face and was yelling at him. Resident #5's legs were not in the footrests at any time during his visit and driver was very rough with patient.During an interview on 04/14/26 at 8:25 A.M., LPN #722 stated she had worked the night shift on 03/13/25. At 2:00 A.M. she had been notified by CNA #615 that Resident #5 had a large bruise on his leg. LPN #722 stated she immediately went to Resident #5's room and observed the area, obtained measurements and called the DON and NP #981. LPN #722 stated Resident #5 was unable to state what had occurred and she stated she had looked through Resident #5's medical records and no documentation was done regarding the injury. LPN #722 stated Resident #5 had not verbalized pain however she had noticed he was having facial grimacing when she had cleaned the area. LPN #722 stated the DON had arrived at the facility at approximately 4:00 A.M. and she stated the DON had informed her Resident #5 had slid out of his wheelchair per the ADON. LPN #722 stated she had returned the next day on 03/15/26 to 03/16/26 and during the evening she noticed Resident #5 had a decline from the previous shift. LPN #722 stated she had assessed Resident #5 and he had an elevated temperature, he was shaking and she had observed his eyes rolling back into his head. LPN #722 stated she had contacted NP #981 who advised sending Resident #5 to the hospital for evaluation. LPN #722 stated she had later been informed Resident #5 had a broken tibia. During an interview on 04/14/26 at 8:52 A.M., Ombudsman #801 stated she had been notified of Resident #5 having a fall on 03/13/26 in the facilities transport van by LPN #511 during an outside appointment.During an interview on 04/14/26 at 9:36 A.M., CNA #705 stated she had been told Resident #5 had a fall on the transport bus. She observed Resident #5 after he had returned from the hospital and his right leg was in a brace and she had observed a bruise and a large, scabbed area. CNA #705 stated Resident #5 was unable to say exactly what happened and but did say they did this. Resident #5 was unable to move himself and he was total care for his activities of daily living. CNA #705 stated he had preferred to stay in bed most of the time and when he had gotten up to a wheelchair the chair appeared to be too small for him and he had not fit in it properly. CNA #705 verified his right leg should not drag the ground when he was in wheelchair because he could not move it himself. During observation at the time of the interview, Resident #5 was in bed, on his back. Resident #5's right leg had a large, discolored area to the outer portion and he was not wearing a brace at that time. During an interview on 04/14/26 at 10:54 A.M., Transporter #719 stated he had transported Resident #5 to an outside appointment on 03/13/26. Transporter #719 stated when he had arrived back at the facility at approximately 3:00 P.M. he had observed Resident #5 sliding down in his wheelchair and had called for assistance with repositioning him. Transporter #719 stated the ADON had come out to the transportation van and had repositioned him and Resident #5 was then taken inside the facility by staff. Transporter #719 stated Resident #5 had not fallen out of the wheelchair and had no complaints of pain during transportation. Transporter #719 stated he had not received a disciplinary write up for Resident #5's transportation.During an interview on 04/15/26 at 7:51 A.M., CNA #615 stated she had been present on 03/13/26 when Resident #5 had returned from his appointment and she had been informed he had a fall in the transport van. She assisted with using a Hoyer lift to assist Resident #5 back into bed and she had not observed any injuries. CNA #615 stated at approximately 4:30 A.M. she had assisted Resident #5 with care and as she removed his blanket the blanket was wet, and she had observed what looked like a hole on his leg that had burst open and a large bruise. CNA #615 stated she had immediately informed the nurse and asked Resident #5 what happened; however, he had not been able to say.During an interview on 04/15/26 at 9:19 (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	04/20/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A.M., the ADON stated on 03/13/26 at approximately 3:00 P.M. she had been in the hallway and several employees had come inside and stated Resident #5 needed assistance with repositioning on the transport van. She went outside and saw Transporter #719 on the bus with Resident #5. Resident #5 was in his wheelchair and he was not in danger of falling out of the chair. Both of Resident #5's legs were planted firmly on the ground, and his leg was up against the metal part of the wheelchair. She called other staff to come out and help reposition Resident #5. She did not see any injuries and Resident #5 had not complained of pain. CNA #610 took Resident #5 back into the facility and she did not see Resident #5 after that. The DON had been alerted later that evening about the bruise to Resident #5's leg and stated the DON had called her to see if she was aware of any injuries and she told the DON about the incident on the transportation van earlier that afternoon.During an interview on 04/15/26 at 9:54 A.M., the DON stated she received a call from LPN #722 on 03/14/26 at around 4:00 A.M. and was informed of a bruise and a fluid filled blister to Resident #5's right leg. The DON stated LPN #722 had asked if the injury was considered an injury of unknown origin and the DON stated she needed to gather some information to determine what occurred. The DON stated she had arrived at the facility shortly after LPN #722 had called and she had observed Resident #5's leg and observed the blister and a significant bruise and stated LPN #722 had obtained the measurements. The DON stated she had called the ADON to ask if she had been aware of any concerns and the ADON had informed of Resident #5 needing repositioning while on the transport van, and his leg was resting on the metal part of the wheelchair and it was likely how the bruising had occurred. The DON stated Resident #5 had not complained of pain or appeared to be in pain, however LPN #722 had administered Tylenol. She educated LPN #722 on how to document the incident and stated it was not an injury of unknown origin and the injury had likely occurred when his leg was against the wheelchair on the transportation bus. The DON further stated LPN #722 had contacted the NP who had given orders for an antibiotic due to the increased temperature and the warmth on his left leg. The DON recalled speaking with the Physician the next day and had been informed Resident #5 had a tibia fracture. The DON confirmed the injury occurred during the transport of Resident #5. During an interview on 04/15/26 at 11:27 A.M., Physician #806 stated she spoke to the DON and floor nurse about Resident #5 and the incident on 03/13/26. She looked through the notes and the hospital documents. Physician #806 stated based on what she knew the resident did not have a fall but was transferred from the van and was slipping out of position and the leg might have hit against the leg rest. Physician #806 stated if he was slipping the whole trip in the van and hitting the leg rest that would be how the bruise would happen and if a hard enough blow was repeated at some point, the bone could have been damaged. Physician #806 stated the DON told her it happened in the van and not in the facility. Physician #806 verified Resident #5 could not move his right leg on his own and was non-ambulatory. During an interview on 04/15/26 at 1:03 P.M., the Secretary #813 from the physician office where Resident #5 had his appointment stated on 03/13/26, Transporter #719 had arrived at the facility in the afternoon and had appeared to be upset and he had stated I have had the worst day and I need to check this resident in. Secretary #813 stated Transporter #719 exited the facility. She saw him outside the building in Resident #5's face and he was flailing his arms around and was yelling at Resident #5. Secretary #813 stated Transporter #719 had entered the facility with Resident #5 and she his legs were not in the leg rest and his right leg was repeatedly hitting the ground while he was being pushed in the wheelchair. Secretary #813 stated the staff had assisted with placing Resident #5 into a room and when the staff had moved his leg Resident #5 had winced in pain. Secretary #813 stated she had reported the incident to the office manager. Secretary #813 stated the wheelchair looked too small to fit Resident #5. During an interview on 04/15/26 at 2:56 P.M., Ombudsman #814 stated she had emailed the facility regarding a transportation issue regarding Resident #5 that occurred on 03/13/26. Ombudsman #814 stated the DON had provided her with a copy of Transporter #719's disciplinary write up via email.This deficiency represents non-compliance investigated under Complaint number 2978911.

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	04/20/2026

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: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident #69 was free from a significant medication error. This affected one resident (#69) of three residents reviewed for medication administration. The facility census was 67. Findings include:Review of Resident #69's medical records revealed an admission date of 12/12/25. Diagnoses included diabetes, hypertension and difficulty walking. Review of care plan dated 03/11/26 revealed Resident #69 had diabetes. Interventions included administer diabetic medications as ordered, monitor/document/report signs and symptoms of hyperglycemia (high blood sugar) that included increased thirst.Review of physician orders for April 2026 included administer Humalog (fast acting insulin) subcutaneously per sliding scale before meals and at bedtime. If blood sugar 150 to 200 milligrams per deciliter (mg/dl) give two units, 201 to 250 give four units, 251 to 300 give six units, 301 to 350 give eight units, 351 to 400 give 10 units and if over 401 contact physician. Review of Medication Administration Record (MAR) revealed on 04/16/26 Licensed Practical Nurse (LPN) #614 documented Resident #69's blood sugar of 131 (normal range is 60-100). Resident #69's sliding scale indicated no insulin required for a blood sugar reading of less than 150.Review of Resident #69's vital signs documentation revealed a blood sugar reading of 131 on 04/16/26 recorded at 9:45 A.M. by LPN #614 and a reading of 400 recorded on 04/16/26 at 10:26 A.M.Interview on 04/16/26 at 9:53 A.M. with Resident #69 revealed his blood sugar had not been taken yet. During interview Resident #69 was shaking and had asked for ice water. Regional Director of Operations (RDO) #805 was present at time of interview and was asked if facility staff could provide Resident #69 with water, and RDO #805 stated he could. RDO #805 returned with Resident #69's water, which Resident #69 had quickly drunk. After completion of interview Resident #69 stated my head doesn't feel right. Resident #69 was taken to LPN #614 who had stated he had not taken Resident #69's blood sugar due to the previous nurse had taken it. LPN #614 was asked about the recorded blood sugar reading of 131 he had documented and LPN #614 stated he didn't know where that number had come from. LPN #614 then verified he had signed off on the blood sugar reading of 131 but did not actually check the blood sugar. LPN #614 had then proceeded to obtain Resident #69's blood sugar and a reading of 472 was observed. LPN #614 had then stated he would check Resident #69's orders and administer insulin according to his sliding scale.Follow up interview on 04/16/26 at 3:30 P.M. with Resident #69 revealed his blood sugar had not been taken since previous observation and he still felt off. Resident #69 had then wheeled himself out to LPN #614 and LPN #614 stated he had not obtained another blood sugar check and had used the previous reading to administer Resident #69's insulin. LPN #614 had proceeded to obtain Resident #69's blood sugar and a reading of 400 was observed. LPN #614 stated Resident #69's afternoon insulin could be administered at 4:00 P.M. and had then obtained Resident #69's insulin pen and had drawn up 10 units of Humalog. LPN #614 had then administered 10 units of Resident #69's Humalog.Interview on 04/20/26 at 2:08 P.M. with Director of Nursing (DON) revealed no specific facility policy related to diabetic management. DON further stated blood sugars should have been documented accurately and should not be documented other than the person who had obtained them, The DON verified not obtaining a blood sugar for a resident on sliding scale insulin to determine if insulin was needed was a medication error. Review of the facility policy titled Nursing Care of the Older Adult with Diabetes, revised 11/2020, revealed the provider will order the frequency of glucose monitoring and establish glycemic targets for individual residents. If on insulin, monitor blood glucose levels as ordered. Assist the resident with specific medication regimen as ordered. The nurse will document the blood sugar history over the last 48 hours and the dose and time of the antihyperglycemic given. This deficiency represents an incidental finding investigated under Complaint 2978911and is an example of continued non-compliance from the survey dated 03/25/26.

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	04/20/2026

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 Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review the facility failed to ensure accurate documentation of blood sugar values. This affected one resident (#69) of three residents reviewed for medication administration. The facility census was 67.Review of Resident #69's medical records revealed an admission date of 12/12/25. Diagnoses included diabetes, hypertension and difficulty walking. Review of care plan dated 03/11/26 revealed Resident #69 had diabetes. Interventions included administer diabetic medications as ordered, monitor/document/report signs and symptoms of hyperglycemia (high blood sugar) that included increased thirst.Review of physician orders for April 2026 included administer Humalog (fast acting insulin) subcutaneously per sliding scale before meals and at bedtime.Review of Medication Administration Record (MAR) revealed on 04/16/26 Licensed Practical Nurse (LPN) #614 documented Resident #69's blood sugar of 131 (normal range is 60-100). Resident #69's sliding scale indicated no insulin required for a blood sugar reading of less than 150.Review of Resident #69's vital signs documentation revealed a blood sugar reading of 131 on 04/16/26 recorded at 9:45 A.M. by LPN #614 and a reading of 400 recorded on 04/16/26 at 10:26 A.M.Interview on 04/16/26 at 9:53 A.M. with Resident #69 revealed his blood sugar had not been taken yet. During interview Resident #69 was shaking and had asked for ice water. Regional Director of Operations (RDO) #805 was present at time of interview and was asked if facility staff could provide Resident #69 with water, and RDO #805 stated he could. RDO#805 returned with Resident #69's water, which Resident #69 had quickly drank. After completion of interview Resident #69 stated my head doesn't feel right. Resident #69 was taken to LPN #614 who had stated he had not taken Resident #69's blood sugar due to the previous nurse had taken it. LPN #614 was asked about the recorded blood sugar reading of 131 he had documented and LPN #614 stated he didn't know where that number had come from and verified he documented a blood sugar value of 131 that he did not actually obtain from Resident #69. LPN #614 had then proceeded to obtain Resident #69's blood sugar and a reading of 472 was observed. LPN #614 had then stated he would check Resident #69's orders and administer insulin according to his sliding scale.Follow up interview on 04/16/16 at 3:30 P.M. with Resident #69 revealed his blood sugar had not been taken since previous observation and he still felt off. Resident #69 had then wheeled himself out to LPN #614 and LPN #614 stated he had not obtained another blood sugar check and had used the previous reading to administer Resident #69's insulin. LPN #614 had proceeded to obtain Resident #69's blood sugar and a reading of 400 was observed. LPN #614 stated Resident #69's afternoon insulin could be administered at 4:00 P.M. and had then obtained Resident #69's insulin pen and had drawn up 10 units of Humalog. LPN #614 had then administered 10 units of Resident #69's Humalog.Interview on 04/20/26 at 2:08 P.M. with Director of Nursing (DON) revealed no specific facility policy related to diabetic management. DON further stated blood sugars should have been documented accurately and should not be documented other than the person who had obtained themThis deficiency represents non-compliance investigated under Complaint number 2978911.