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	06/30/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, hospital record review, review of email communication, policy review and interview, the facility failed to readmit Resident #69 during the appeal of a discharge notice. After issuing a discharge notice, the resident became distressed, made threats toward the Administrator, and was hospitalized for psychiatric evaluation. Once stabilized and cleared by hospital staff, the facility refused timely readmission and did not provide required documentation showing an inability to meet the resident's ongoing needs or a safe long-term discharge plan, leaving the resident without appropriate long-term placement. This affected one resident (#69) of three residents reviewed for discharge. The facility census was 68.Findings include:Review of the closed medical record revealed Resident #69 was admitted on [DATE] and discharged on 06/09/26. Resident #69 had diagnoses including heart failure, type II diabetes mellitus, chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), hypertension, and post-traumatic-stress disorder (PTSD). Record review revealed the resident was admitted for long term placement from the Veteran's Affairs after facing eviction from his apartment because he was unable to care for the apartment and himself.Review of the physician's order dated 01/28/26 revealed to assess Resident #69 every shift for behaviors and record. Review of the care plan dated 04/05/26 revealed Resident #69 was resistive to care. Interventions included allowing the resident to make his own decisions and encourage participation in decision making.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #69 had intact cognition. Resident #69 required extensive assistance for all activities of daily living.Review of a 30-Day discharge notice dated 06/08/26, signed by Resident #69, revealed the resident was given a discharge notice stating he would be discharged and transferred from the facility on or prior to 07/12/26 because the facility was unable to meet his care needs and he was a danger to others in the facility. The notice informed the resident of his right to an impartial hearing at the facility regarding the proposed discharge and transfer and how to request a hearing. Review of the Treatment Administration Record (TAR) for June 2026 revealed Resident #69 had no behaviors documented until 06/09/26.Review of the nursing progress note dated 06/09/26 at 10:30 A.M. revealed Resident #69 was seen by the psychiatrist and reported homicidal thoughts pertaining to shooting the Administrator after receiving a thirty-day notice for smoking. He stated he ordered a gun and had it sent to his cousin who was going to bring it. Resident #69 was given a pink slip to the emergency department for a psychiatric evaluation.Review of a psychiatric note dated 06/09/26 at 9:30 A.M. authored by Psychiatric Nurse Practitioner #701revealed Resident #69 was evaluated after staff reported escalating threats, including statements about obtaining a gun to harm the facility administrator. The note also included there were recent concerns included smoking in the room and making verbal threats over the weekend. During assessment, the patient was visibly agitated, expressed anger about a 35ˆday eviction notice, insisted on confronting the administrator, and made additional violent statements. The patient reported not feeling safe, was unable to agree to a safety plan, and displayed behavior that raised significant safety concerns for both the resident and others. Due to the severity of the threats and (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inability to contract for safety, an involuntary psychiatric hospitalization was initiated for emergency evaluation and stabilization. The note did not include any information related to the resident's ability to return to the facility following evaluation and if stabilization was achieved. Review of a thirty-day notice form dated 06/09/26 revealed Resident #69 was given an Immediate Discharge Notice, effective 06/09/26 because the resident poses a risk and is a danger to the residents and staff. The notice included at this time, the facility proposed to relocate the resident to the local hospital. The notice informed the resident of his right to an impartial hearing at the facility regarding the proposed discharge and transfer and how to request a hearing. The resident signed the form and wrote in June 10.Review of the Immediate Discharge Notice dated 06/09/26 revealed Resident #69 was given an Immediate Discharge Notice for the safety of staff and other residents in the facility.Review of the medical record revealed Resident #69 was transported to the emergency department on 06/09/26 after reporting homicidal ideation toward the Administrator following receipt of a thirtyˆday discharge notice for smoking. The note included the resident was pinkˆslipped for psychiatric evaluation.Review of the hospital transfer form dated 06/09/26 revealed Resident #69 was being sent to the hospital for homicidal ideations but on the assessment, it was marked the resident had no behavioral issues noted and no interventions completed.Review of the emergency room evaluation dated 06/09/26 for Resident #69 revealed the resident presented to the emergency department for psychiatric evaluation after being homicidal at his nursing home after receiving an eviction notice. Resident #69 denied homicidal ideations and stated, no comment when asked. Lab work showed an acute kidney injury. The resident was given a liter of normal saline and repeat lab work was ordered. The lab work did not show improvement, and a bladder scan was ordered which showed urinary retention. A Foley catheter was placed. Resident #69 was medically cleared on 06/12/26 and admitted to the psychiatric unit.Review of the psychiatric history and physical dated 06/12/26 revealed Resident #69 was admitted to the hospital after making homicidal threats at his nursing home. Resident #69 reported to the psychiatrist his girlfriend of 20 years passed away five weeks ago, and he was depressed. On examination, Resident #69 was tearful and said that he was grieving, and he wished the facility staff would just understand that. The resident reported he never actually wanted to hurt anyone. The resident denied access to guns.Review of a facility social service progress note dated 06/12/26 at 9:18 A.M. revealed she (the facility social worker) spoke with the social worker at the hospital and informed her Resident #69 would need to get his car from the facility parking lot. Review of a hospital social service note dated 06/12/26 at 3:26 P.M. authored by Hospital Licensed Social Worker (LSW) #702 revealed she spoke with administrative staff from the nursing home who said Resident #69 was not permitted to return to the facility. They stated they gave the resident an Immediate Discharge Notice and he signed the paper. Review of email communication dated 06/18/26 at 3:02 P.M. between Regional Administrator #581 and the Ombudsman #700 revealed the Regional Administrator was following up for the Administrator regarding the decision to issue an Immediate Discharge Notice to Resident #69.Review of an email dated 06/18/26 at 7:02 P.M. from Ombudsman #700 to Regional Administrator #581 revealed the Ombudsman she was not questioning the Immediate Discharge versus the 30-Day Discharge for the resident. Ombudsman #700 indicated the issue was that it was not a proper discharge. The hospital was listed as the location, which was not a discharge location. She informed Regional Administrator #581 that she had been in contact with Resident #69 and the hospital, and there had been no concerns related to the resident's behavior. The resident sought treatment and was ready to return. Ombudsman #700 suggested readmitting the resident and following the correct (discharge) process. The Ombudsman agree there was a safety issue that needed to be addressed, but currently, the resident's rights were being violated. She asked if the facility would take Resident #69 back.Review of an mail dated 06/18/26 at 7:42 P.M. from Regional Administrator #581 to Ombudsman #700 revealed they (the facility) were discussing and would get back to her as soon as possible. Review of an email dated 06/18/26 at 7:51 P.M. from Ombudsman #700 to Regional Administrator #581 revealed if the facility had not made a decision by the end of the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day, she would schedule a hearing, but the hearing request could be rescinded in the event the resident returned.There were no follow-up emails provided. Review of hospital paperwork dated 06/19/26 revealed Resident #69 was calm, cooperative, and was brighter today, smiling more. He stated he was doing good and hoped he could return to the nursing home because he had friends there. He reported he made a statement that he was going to hurt someone in administration there but stated, I would never do anything. He stated he gets upset sometimes and says things he does not mean. He denied suicidal homicidal ideation intent or plan, denied auditory or visual hallucinations. The paperwork included the resident had been taking his medications, has had no behavioral disturbances, sleep and appetite reported to be fair.Review of hospital paperwork dated 06/24/26 revealed Resident #69 was calm and cooperative. He stated he was doing okay and just waiting to hear whether he would be able to go back to the nursing home. He stated he really hoped he was able to as he reported overall, he was doing well there and had friends. He denied suicidal homicidal ideation intent or plan, denied auditory or visual hallucinations. He had been taking his medications, had no behavioral disturbances, sleep and appetite reported to be fair. Review of a social service note dated 06/26/26 revealed the facility social worker only became aware on this date, two weeks after transfer, that Resident #69 had no safe discharge location (as the facility refused to allow him to return) and only then began assisting with referrals. On 06/29/26 at 10:10 A.M. interview with Ombudsman #700 revealed Resident #69 was known as a quiet older individual who used a scooter and had no prior history of violence, though the nursing home reported the resident threatened the administrator and referenced shooting him. The resident told her that he may have made the statement (about shooting) but does not clearly remember and believed he was only venting, adding that he had no weapons and would not act on such comments. The resident said he signed Immediate Discharge papers but was never given a 30ˆday discharge notice, despite the nursing home later claiming otherwise. The Ombudsman indicated they had received discharge paperwork that appeared inaccurate, with incorrect dates and a second page listing a different resident's name and stated that she was never properly notified by the facility of any discharge. She noted that a discharge hearing was scheduled for 07/01/26, and that the behavioral health hospital was attempting to keep the resident until the hearing, though she was uncertain whether they could legally do so, and the resident was very distressed by the situation.An interview 06/29/26 at 1:45 P.M., with Regional Clinical Director #580 revealed although the facility historically accepted residents with psychiatric conditions, the facility refused to readmit Resident #69 despite the hospital's determination that he was medically and psychiatrically stable. She reported the decision was based on the resident's earlier verbal statement about ordering a gun, although she acknowledged there was no verification of this information. She confirmed the facility would not accept the resident back.As of 06/30/26, Resident #69 remained hospitalized with no evidence he was receiving acute medical or psychological care due to the facility refusing to allow him to return, pending a discharge hearing or assisting with discharge to an appropriate agreed upon long term care location that met the resident's needs.Review of the facility's undated Resident Transfer and Discharge Policy revealed residents sent to an acute care setting shall be permitted to return to the facility unless documentation clearly shows why the facility can no longer care for the resident. The policy also stated the facility would ensure safe discharge planning.This deficiency represents non-compliance identified under Complaint Number 3052695.