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	04/24/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review, interview and review of facility policy, the facility did not ensure a comprehensive care plan was developed to include the need for Enhanced Barrier Precautions (EBP) for Resident #267. This affected one resident (#267) of 25 residents reviewed for care plans. The facility census was 62. Findings include: Review of the medical record for Resident #267 revealed an admitted [DATE] with diagnosis including malignant neoplasm of the mouth, malignant neoplasm of the head, dysphagia, severe protein calorie malnutrition, bacteremia, attention to gastrostomy (a surgical procedure used to insert a tube through the abdomen and into the stomach), and cachexia. Review of Resident #267 Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact and had a feeding (gastrostomy) tube. Review of the physician order dated 04/14/25 revealed the feeding tube site needed cleansed with soap and water and apply dry dressing every night shift. There was no order for EBP. Review of Resident #267's care plan dated 04/10/25 revealed there was no care plan developed regarding the need for EBP due to use of a feeding tube. Interview on 04/24/25 at 12:00 P.M. with the Director of Nursing confirmed there was no order for EBP for Resident #267 and the care plan did not include the need for EBP. Review of the policy titled, Comprehensive Person-Centered Care Planning, dated for the year 2025, revealed the comprehensive care plan would describe the resident's highest practicable physical, mental and psychosocial well-being as required.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on observation, interview, record review and review of facility policy, the facility failed to ensure medications were disposed of timely when discontinued or a resident was discharged . This had the potential to affect all 29 residents residing on the [NAME] Unit (Residents #2, #3, #4, #6, #8, #16, #19, #20, #26, #31, #35, #36, #38, #39, #40, #41, #42, #43, #45, #46, #47, #49, #52, #62, #116, #117, #118, #120 and #267). The facility census was 62. Findings include: Observation on 04/21/25 at 1:48 P.M. of the medication storage room on the [NAME] Unit with Licensed Practical Nurse (LPN) #338 revealed the room had resident medication cards, pill bottles and boxes of aerosol medications piled on shelves, on the floor, in baskets on the floor and in bags. There were four white pills in a plastic cup sitting on the shelf. LPN #338 verified she was unsure what pills were in the cup and who they belonged to. LPN #338 stated staff were to fill out a pharmacy paper and send the medications back to pharmacy when the medication was discontinued, the resident was discharged or the medication expired. Interview on 04/21/25 at 1:50 P.M. with the Director of Nursing (DON) revealed she had been in her position since the last week of March 2025. She stated the medication room on the [NAME] Unit had many medications in the room that needed sent back to the pharmacy when she started. She verified the nursing staff was supposed to fill out a log and send the medications back to the pharmacy in a bag so they could be credited back to the resident or facility. She stated this should be done timely, within a few days of the medication being discontinued or the resident being discharged . Review of the Medication Disposition Sheet completed on 04/21/25 by LPN #245 for the [NAME] Unit medication storage room revealed a total of 100 medication cards, bottles and boxes were in the medication storage room. Review of the Medication Disposition Sheet completed on 04/22/25 by LPN #245 for the [NAME] Unit medication storage room revealed a total of 178 medication cards, bottles and boxes were in the medication storage room. A total of 278 medication cards, bottles and boxes were in the medication storage room with dispensing dates ranging from 12/14/21 through 04/16/25. Interview on 04/21/25 at 1:51 P.M. with LPN #245 revealed she was cleaning the medication room on the [NAME] Unit. She verified the DON had instructed her today, 04/21/25, to clean the medication room and return all of the expired and discontinued medications to the pharmacy. Review of the facility policy titled, Medication Labeling and Storage, dated 2021, revealed the nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy was to be contacted for instructions regarding returning or destroying these items. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Pharmacy Services, dated 2025, revealed the pharmacist, in collaboration with the facility and medical director would help develop and evaluate the implementation of pharmaceutical services procedures that address the needs of the residents and reflect current standards of practice. These included disposing of medication and storage of medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on observation, record review, interview and review of facility policy the facility failed to ensure enhanced barrier precautions (EBP) were implemented for Resident #216 and Resident #267. This affected two residents (#216 and #267) of 21 residents (Resident #36, #35, #45, #46, #34, #6, #47, #40, #38 #2, #51, #7,#36, #48, #5, #32, #33, #53, #118, #216 and #267) the facility identified as requiring EBP. The facility census was 62. Findings include: 1. Review of Resident #216's medical record revealed a readmitted [DATE] with diagnoses including intracranial hemorrhage, malignant neoplasm of prostate, type two diabetes, altered mental status, chronic obstructive pulmonary disease, and pneumonia. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #216's cognition was intact, and unhealed pressure ulcers were present upon admission/re-entry. Review of Resident #216's physician orders for April 2025 revealed no active orders for EBP. There was an order with a start date of 04/19/24 for buttocks to be cleansed with normal saline, pat dry and apply Triad cover with foam dressing every day shift for wound care. Observation on 04/23/25 at 1:35 P.M. of Resident #216's room revealed an EBP sign was on the door frame and no cart was available outside the door with personal protection equipment (PPE). Licensed practical nurse (LPN) #400 was present during the observation and verified there was an EBP sign on the door frame but no PPE was available for staff to put on before entering the room. LPN #400 stated she thought the room mate of Resident #216 required EBP for care. Observation on 04/23/25 at 2:45 P.M. was conducted with the Director of Nursing (DON) of a wound dressing change to the buttock for Resident #216. The DON washed her hands, applied gloves and did not put on a gown before completing the dressing change. The DON assisted Resident #216 with rolling in bed and removed the old dressing exposing an open wound. The DON measured the bilateral buttocks wound to be 0.4 centimeters (cm) by 0.2 cm by 0.1 cm. The DON verified the buttock wound had open skin and she did not wear a gown during the dressing change. Interview on 04/23/25 at 3:01 P.M. with the DON and the Corporate Registered Nurse (RN) #401 revealed if a resident was admitted with an active wound the facility would place the resident on EBP based on the order in the medical record and a sign would be placed outside the door. Corporate RN #401 verified there was no physician order for EBP for Resident #216, and stated LPN #400 was confused regarding which resident in the room required EBP. The DON again verified she did not wear a gown during the dressing change to the buttocks and verified the buttocks wound did have open skin. 2. Review of Resident #267's medical record revealed an admitted [DATE] with diagnoses including malignant neoplasm of the mouth, malignant neoplasm of the head, dysphagia, bacteremia, and encounter for attention to gastrostomy (a surgical procedure used to insert a tube through the abdomen and into the stomach). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #267's MDS 3.0 assessment dated [DATE] revealed the resident was cognitively intact with a feeding tube. Review of a physician order dated 04/14/25 revealed the feeding tube site needed cleansed with soap and water and apply dry dressing every night shift. Observation with the DON on 04/24/25 at 12:00 P.M. revealed no EBP sign was outside the door of Resident #267's room and there was no cart outside the door with PPE for staff to put. The DON verified EBP was needed for Resident #267 because Resident #267 had a gastrostomy tube and stated EBP was needed for any resident who had an opening to the skin. The DON verified no order was written for EBP and no sign was outside Resident #267 door to notify staff. Review of the facility policy titled Enhanced Barrier Precautions, revision date March 2024, revealed enhanced barrier precautions were utilized to reduce the transmission of multi-drug-resistant organisms to residents. EBP employ targeted gown and glove use during high-contact resident care. Examples of high-contact resident care requiring the use of gown and gloves include wound care (any skin opening requiring a dressing). EBPs are indicated for residents with wounds and/or indwelling medical devices including feeding tubes. EBPs remained for the duration of the resident stay or until resolution of the wound or discontinuation of the indwelling medical device that deemed the resident at increased risk.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on observation, interview and review of facility policy, the facility failed to maintain a safe, functional, sanitary and comfortable environment. This had the potential to affect all 29 residents (Residents #2, #3, #4, #6, #8, #16, #19, #20, #26, #31, #35, #36, #38, #39, #40, #41, #42, #43, #45, #46, #47, #49, #52, #62, #116, #117, #118, #120 and #267) who resided on the [NAME] Unit, one resident (Resident #1) on the [NAME] Unit, and an additional 13 residents (Residents 9, #11, #27, #23, #48, #22, #29, #17, #37, #28, #59, #53, #62) the facility identified as residents who smoke. The facility census was 62. Findings include: Observation was conducted on 04/22/25 from 3:45 P.M. to 4:01 P.M. with Maintenance Director (MD) #314 of the facility physical environment and the following concerns were identified and verified with MD #314 at the time of the observations: On theWashington Unit hallway there was a solid, dark brown water stain on the ceiling which MD #314 stated it was caused from a water leak. In the hall of the [NAME] Unit was a broken handrail with exposed edges. In the resident room of Resident #42 and Resident #19 the closet dresser drawer was missing, and a brownish-red stain was around the perimeter of the toilet bowl. MD #314 stated the stain was a result of frequent leaks from the toilet and toilet overflow. In the [NAME] Unit dining room four light bulbs of the 16 light fixtures in the dining room were not working, and a dining room cabinet was covered in thick dust on the surface and the back of the cabinet was missing so the linens inside of it had fallen out the back and were piled on the floor behind the cabinet. In Resident #1's room there was a broken window blind, missing cabinet drawers, and the cover to the radiator was off exposing the inside of the radiator with dust and debris. MD #314 stated someone must have smashed the radiator. In the designated resident smoking area outside of the facility there were more than 20 cigarette butts discarded on the ground into dead leaves laying on the ground and also into a trash can with combustible refuse inside such as paper and other trash items despite there being a metal, self-closing lid container designated for safe disposal of cigarette butts. MD #314 verified the cigarette butts should not be on the ground or in the trash can. Review of the facility policy titled Homelike Environment, revised September 2010, revealed residents were provided a safe, homelike, clean, and comfortable environment. This deficiency represents non-compliance identified during investigation of Complaint Number OH00164934 and OH00162776.