STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365817	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Samaritan Care Center and Villa	806 E Washington Street Medina, OH 44256

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure water temperatures were maintained at appropriate temperatures. This affected Resident #1 and had the potential to affect all 6 residents on 100 Hall. Findings include:Interview 02/11/26 at 10:18 A.M. with Resident #2 revealed the water in his bathroom sink is cold.Interview and observation on 02/11/26 at 10:44 A.M. with Maintenance Director (MD) #326 of water temperatures in resident rooms. Resident #1 in room [ROOM NUMBER] water temperature was 101 degrees Fahrenheit (F) after running for 3 minutes. room [ROOM NUMBER] that was not occupied had a water temperature of 102 F. Interview on 02/11/26 at 2:00 P.M. with Resident #1 revealed the water in her room had not been hot since she was admitted in September 2025. Resident #1 said she had told staff previously about the cold water. Review of Tap Water Temperature Checks from July 2025 through January 2026 revealed in August 2025 the water temperature was 101 F in room [ROOM NUMBER]. January 2026 log revealed room [ROOM NUMBER] water temperature was 101 F, room [ROOM NUMBER] water temperature was 103 and room [ROOM NUMBER] water temperature was 104.This deficiency represents non-compliance investigated under Complaint Number 2722647.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were provided assistance safely to prevent falls during care. This affected two residents (Resident #9 and #39) of three reviewed for falls. The facility census was 38.Findings include:1. Review of the closed medical record for Resident #39 revealed an admission date of 07/14/25 with diagnosis that included chronic obstructive pulmonary disease (COPD), emphysema, lack of coordination, cognitive communication deficit, abnormalities of gait and mobility, abnormal posture, muscle weakness, dementia, cardiac murmur, hyperlipidemia and venous insufficiency. The minimum data set (MDS) assessment dated [DATE] revealed the resident was dependent for bed mobility, transfers and mobility. The brief interview mental status (BIMS) score of 02 indicated the resident was severely cognitively impaired. Review of the quarterly Fall Risk assessment dated [DATE] revealed Resident #39 was a high risk for falls with a score of 16.Review of the Care Plan dated 10/21/25 revealed the resident was at risk for falls related to COPD, weakness, arthritis, abnormal posture, PVD, And dementia. Interventions included following facility fall protocol, anticipate and meet the resident's needs, mat to floor bedside bed and place in supervised area during restlessness.Review of the Incident Log from August 2025 through February 2026 revealed Resident #39 had a witnessed fall on 10/17/25 and had un-witnessed falls on 08/13/25, 08/16/25 and 09/14/25.Review of Resident #39 progress note revealed an Incident Note dated 10/17/25 at 4:25 A.M. that hospice was notified of resident's fall and was being sent to the emergency department. Review of the Fall Investigation for Resident #39 dated 10/17/25 revealed that resident was left unattended inappropriately. The root cause of the fall was documented as STNA left resident unattended on R side with bed elevated. Review of Certified Nursing Assistant (CNA) #367 Witness Statement dated 10/17/25 revealed she changed the resident's brief and placed it on the bedside floor mat. She then cleaned off the bedside floor mat and moved it to the side to dry. Next she left the bedside and went to get a clean brief while the resident was on her side. Resident #39 then turned and fell out of the bed.Review of the hospital notes dated 10/17/25 revealed resident had a 4 centimeter (cm) laceration to right forehead with small amount of active bleeding. Resident received sutures to her head laceration and imaging showed no fractures or intracranial hemorrhage.Interview on 02/11/26 at 9:05 A.M. with Resident #39 daughter revealed resident was transferred to inpatient hospice facility on 10/17/25 and passed away at the facility on 10/23/25.Interview on 02/11/26 at 4:41 P.M. with the Director of Nursing (DON) #310 revealed CNA #367 was given a Teachable Moment dated 10/20/25 regarding preventing falls, which CNA #367 refused to sign. There were no evidence of additional measures taken to ensure CNA #367 transferred residents properly. Interview on 02/11/26 at 6:05 P.M. with DON #310 and Administrator revealed CNA #367 was observed by nursing staff after the fall on 10/23/25 to ensure she was not leaving residents unattended but they did not document observations.2. Review of the medical record for Resident #9 revealed an admission date of 05/03/23 with diagnosis that included cerebral infarction due to unspecified occlusion, hemiplegia, major depressive disorder, dysphagia, insomnia, cognitive communication deficit, muscle weakness, acute kidney failure, congestive heart failure, osteoarthritis, obesity, hypotension, essential hypertension, hyperlipidemia.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was dependent for chair to bed transfer. The brief interview mental status (BIMS) score of 12 indicated the resident had moderate cognitive impairment. Review of the quarterly Fall Risk assessment dated [DATE] revealed Resident #9 was a high risk for falls with a score of 14.Review of the Care Plan dated 12/23/25 revealed the resident was at risk for falls related to gait/balance problems, history of falls, incontinence, poor (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	balance and weakness. Interventions included anticipate and meet the resident's needs, call light within reach, encourage resident to wear proper and non-slip footwear and have commonly used articles within easy reach.Review of Resident #9 progress notes revealed an Incident Note dated 11/11/25 that the nurse was approached by CNA #367 that while transferring the resident via sit to stand, the resident slid out of the sit to stand. Review of the Fall Investigation dated 11/11/25 revealed the appropriate amount of assistance and technique was not used due to CNA #367 using the sit to stand lift by herself. The root cause of the fall was listed as sit to stand operated with only one person. Resident #9 did not sustain any injuries.Interview on 02/11/26 at 5:31 P.M. with Resident #9 revealed she was not injured during the fall and had not had a fall since. Interview on 02/11/26 at 4:41 P.M. with the DON #310 revealed CNA #367 was given a Teachable Moment dated 10/20/25 regarding preventing falls, which CNA #367 refused to sign. There were no evidence of additional measures taken to ensure CNA #367 transferred residents properly. DON #310 revealed CNA #367 was terminated on 11/12/26 after she used a sit-to-stand alone with Resident #9 that resulted in a fall.Interview on 02/11/26 at 6:05 P.M. with DON #310 and Administrator revealed CNA #367 was observed by nursing staff after the fall on 10/23/25 to ensure she was not leaving residents unattended but they did not document observations.Review of facility policy Fall Risk Assessment dated 2025 revealed: It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents.This deficiency represents non-compliance investigated under Complaint Number 2658686.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review the facility failed to provide residents with food that met their preference. This affected two residents (Resident #1 and #22) of three reviewed for food preferences. The facility census was 38.Findings include:1. Review of the medical record for Resident #1 revealed an admission date of 09/11/25 with diagnosis that include post-traumatic stress disorder, alcohol use, major depressive disorder, generalized anxiety disorder, history of traumatic brain injury, convulsions, anemia, essential hypertension, vitamin D deficiency and insomnia. Review of Resident #1 food preferences and allergy dietary sheet revealed resident dislikes any type of tomato products, apricots, pears, pineapple, raisins, hotdogs, liver, fish, tuna, egg, salad, rice, spaghetti, goulash, pancakes, rye bread, lemon bars, salami, lima beans and stewed tomato. Observation and interview on 02/11/26 at 11:35 A.M. through 12:12 P.M. of lunch tray line revealed Resident #1 was plated rice. Review of Resident #1 tray card on tray revealed resident disliked rice. The observation was confirmed with Dietary Manager #346 and [NAME] #303. Interview on 02/11/26 at 2:00 P.M. with Resident #1 revealed tomato's upset her stomach and often will get tomato based soups or spaghetti sauce. Resident #1 said she will not eat those items when they are on her plate.2. Review of the medical record for Resident #22 revealed an admission date of 05/24/24 with diagnosis that included chronic obstructive pulmonary disease, emphysema, acute chronic respiratory failure, anxiety disorder, essential hypertension and major depressive disorder. Review of Resident #22 food preferences and allergy dietary sheet revealed resident is allergic to raw onions and dislikes tomatoes or tomato products and yogurt.Observation and interview on 02/11/26 at 11:35 A.M. through 12:12 P.M. of lunch tray line revealed Dietary Manager #346 remined [NAME] #303 to not give Resident #22 the sauteed peppers and onions. Observation of Resident #22 tray card revealed resident was allergic to raw onions. Observation of the plated meal revealed Resident #22 was given the sauteed peppers and onions. This observation was confirmed with Dietary Manager #346 and [NAME] #303. Interview on 02/11/26 at 5:46 P.M. with Resident #22 revealed he keeps getting onions and had told staff multiple times he did not want onions. Resident #22 revealed he also does not like mayonnaise or sour cream but keeps getting these items as well. This deficiency represents non-compliance investigated under Complaint Number 2722647.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review the facility failed to label food items to prevent potential food borne illnesses. This had the potential to affect all 38 residents at the facility. Findings include:Observation and interview on 02/11/26 at 9:34 A.M. with Dietary Manager #346 revealed the following items in the fridge that were not labeled or dated: two containers of mushrooms, a plastic container of cooked vegetable mix, peaches, potato soup, a pitcher of tea, a pitcher of lemonade, a plastic package of cheese slices, a plastic container of cooked steak for Philly cheese steak, plastic container of chicken salad, a plastic container of Jell-O, a container of muffins, a bag of shredded cheese and plastic container of chili. This observation was confirmed with Dietary Manager #346 who revealed she did not work last night and staff from last night did not label or date the food.Review of facility policy Date Marking for Food Safety dated 2025 revealed the following: The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. The marking system shall consist of a color-coded label, the day/date of opening, the day/date the item must be consumed or discarded. The Dietary Manager, or designee, shall spot check refrigerator weekly for compliance, and document accordingly.