

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Samaritan Care Center and Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure Resident #27's responsible party was notified of a change of condition. This affected one resident (#27) of one residents reviewed for notification of change. The facility census was 34.</p> <p>Findings include:</p> <p>Review of Resident #27 medical record revealed admission date of 02/27/25 with diagnosis of diabetes type II with foot ulcer, protein-calorie malnutrition, cognitive communication deficit, dysphagia, abnormal posture, benign prostatic hyperplasia, essential hypertension, fatigue, nonrheumatic aortic stenosis, polymyalgia rheumatica, major depressive disorder, history of traumatic brain injury, heart failure, history of pulmonary embolism, hypoglycemia, hyperlipidemia, dementia, mild cognitive impairment, and acquired absence of left leg above knee.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had a Brief Interview for Mental Status (BIMS) of 2, indicating severely impaired cognition.</p> <p>Review of court records dated 03/21/25 revealed there had been paperwork filed regarding guardianship for Resident #27. The records indicated a hearing was scheduled on 05/07/25 to establish guardianship. As of 06/18/25, the facility had not yet received notice of the outcome of the hearing.</p> <p>Review of an incident note dated 06/05/25 revealed the facility's management and physician were updated regarding Resident #27 having obtained new skin abrasions. The note stated Resident #27 was his own responsible party.</p> <p>Interview on 06/16/25 at 12:52 P.M. with Resident #27's spouse revealed the facility does not always update her of changes with Resident #27's care, and communication from the facility was not very good.</p> <p>Interview on 06/18/25 at 11:15 AM with the Director of Nursing (DON) and Regional Clinical Manager #272 revealed the facility determines if a resident is able to make their own decisions by their BIMS score. If residents had a BIMS score of less than 8, if the doctor has determined resident was incapable of making decisions, or if the resident has a guardian then residents would not be able to make their own decisions or be considered their own responsible party. Regional Clinical Manager #272 revealed the facility usually notified the next of kin if residents were in the process of obtaining guardianship.</p> <p>(continued on next page)</p>

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Notification of Change Policy dated 2024 revealed circumstances required notification include: accidents, significant change in the resident's status, circumstance that require a need to alter treatment, transfer or discharge, change of room or roommate assignment, and a change in resident rights. For competent individuals the facility must still contact the resident's physician and notify representative, if known. For residents incapable of making decisions the representative would make any decisions that have to be made.		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record for Resident #30 revealed an admission date 09/07/23 with diagnoses bipolar, acute respiratory failure, post-traumatic stress disorder (PTSD), anxiety, and type II diabetes.</p> <p>Review of the Minimum Data Set 3.0 MDS comprehensive assessment, dated 05/23/25, revealed Resident #30 had moderate cognitive impairment and required substantial/maximum assistance from staff for activities of daily living.</p> <p>Review of the plan of care for Resident #30 dated 02/25/25 revealed a plan for alteration in mood and behavior related to bipolar disorder, anxiety, depression and unspecified mood disorder. Resident #30 shows little interest or pleasure in doing things and frequent crying. There was no evidence of a plan of care that addressed the resident's history of PTSD.</p> <p>Observation on 06/16/25 at 11:34 A.M. Resident #30 was in her room lying in bed grunting and yelling out.</p> <p>Interview on 06/18/25 at 11:28 A.M. with the Assistant Director of Nursing (ADON) #249 revealed Resident #30 yells out, cries frequently, and gets upset over things that happened long time ago such as her cat dying. ADON #249 reported redirection and spending time with Resident #30 was usually effective.</p> <p>Interview on 06/18/25 at 4:00 P.M. with the Regional Clinical Manager #272 verified Resident #30 had a diagnosis of PTSD and did not have a care plan that addressed the resident's PTSD.</p> <p>Review of the policy called Comprehensive Care Plans dated 2025 revealed it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality.</p> <p>Based on medical record review and interview, the facility failed to ensure a comprehensive care plan was created and implemented for two residents (#4 and #30) of 14 residents reviewed for care plans. This facility census was 34.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #4 revealed an admission date of 03/14/24. Diagnoses included but were not limited to acute respiratory failure with hypoxia, hemiplegia and hemiparesis, and general anxiety disorder.</p> <p>Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] for Resident #4 revealed intact cognition. Resident #4 was noted to be dependent for the activities of daily living.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the annual activity assessment dated [DATE] for Resident #4 revealed he was somewhat interested in books, newspapers, and magazines to read, liked to listen to music, and liked to be around pets. It was also noted it was not important to do group activities, and somewhat important to do his favorite activities. Resident #4 was noted to prefer to stay in his room and participated in self-directed leisure pursuits. Staff were to encourage group participation, but respect the resident's right to refuse.</p> <p>Review of the care plan dated 05/16/25 for Resident #4 revealed no evidence of a care plan for activities.</p> <p>Interview on 06/17/25 at 7:48 A.M. with Activities Director #221 confirmed an activities care plan was never developed for Resident #4 following his admission on [DATE].</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and staff interview, the facility failed to ensure the food stored in a designated refrigerator for resident use and resident personal room refrigerators were labeled, dated and expired items were disposed of timely. This affected three (Residents #8, #11, and #18) of five residents reviewed for personal resident refrigerators. The facility indicated 17 residents had personal refrigerators in their rooms. This had the potential to affect all 34 residents at the facility using facility refrigeration for personal food items. The facility census was 34.</p> <p>Findings include:</p> <p>Observation on 06/17/25 at 11:05 A.M. with the Assistant Director of Nursing (ADON) #249 of the nutrition refrigerator for resident use located on the 300 hall revealed the following concerns:</p> <ul style="list-style-type: none"> - A four ounce (oz) nutritional shake with a use by of 06/05/25. - An undated, unlabeled foil wrapped breadstick and red sauce that appeared to be hard and stale. - An unlabeled, undated 16-ounce bottle with unidentified liquid with separated particles. - A one-cup container of a facility prepared side salad that was unlabeled, undated and was visibly wilted and moldy - A four-ounce vanilla yogurt with use by date of 03/17/25. - A four-ounce raspberry yogurt with use by date of 05/01/25. - A four-ounce vanilla yogurt with use by date of 05/29/25. - An unlabeled, undated, foil-wrapped and partially eaten baked potato with sour cream with mold. <p>The above-mentioned concerns were confirmed by ADON #249 at the time of the observations.</p> <p>Observation on 06/17/25 at 11:20 A.M. with ADON #249 of five resident personal room refrigerators revealed the following concerns:</p> <ul style="list-style-type: none"> - Resident #8's personal refrigerator had an eight oz cream cheese spread with a use by date of 03/04/25, an 11.5 ounce protein shake with a use by date of 05/29/24, a four-ounce raspberry yogurt with a use by date of 06/03/25, a four-ounce vanilla yogurt with a use by date of 01/20/25, and a six pack of four-ounce rice pudding with a use by date of 05/11/25. - Resident #11's personal refrigerator had a four-ounce vanilla yogurt with a use by date of 06/03/25. - Resident #18's personal refrigerator had an opened and undated 64-ounce jar of pickles slices with a use by date of 05/30/25. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The above listed concerns were confirmed by ADON #249 at the time of the observations.</p> <p>Review of the facility policy called Use and Storage of Food Brought in by Family or Visitors revised 2025 revealed all food items that are already prepared by the family or visitor brought in must be labeled with content and dated. The prepared food must be consumed by the resident within three days. If not consumed within three days, food will be thrown away by the facility staff. All items not maintained are subjected to being thrown away if not removed by the resident or/or resident representative.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy and procedure, the facility failed to ensure infection prevention protocols were maintained for Resident #27, who required enhanced barrier precautions. This affected one resident (#27) of three residents reviewed for enhanced barrier precautions. The facility census was 34.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #27 was admitted on [DATE] with diagnosis of diabetes type 2 with foot ulcer, protein-calorie malnutrition, cognitive communication deficit, dysphagia, benign prostatic hyperplasia, essential hypertension, fatigue, nonrheumatic aortic stenosis, polymyalgia rheumatica, major depressive disorder, history of traumatic brain injury, heart failure, history of pulmonary embolism, hypoglycemia, hyperlipidemia, dementia, mild cognitive impairment, and acquired absence of left leg above knee.</p> <p>Review of Resident #27's physician order for enhanced barrier precautions dated 6/14/25 revealed a gown and gloves were required during high-contact care activities due to a chronic wound on the resident's right heel.</p> <p>Observation on 06/17/25 at 10:07 A.M. of Certified Nurse Assistant (CNA) #253 revealed CNA #253 entered Resident #27's room with gloves and a face mask on. CNA #253 closed the door to provide care and exited room with a mask and gloves on at 10:18 A.M. At 10:19 A.M., Licensed Practical Nurse (LPN) #215 placed a gown and gloves on before entering room to do wound care. Resident #27 refused wound care and LPN #215 removed gown while in room and placed it in the trash. CNA #253 then brought the hooyer lift inside the room and closed the door. LPN #215 and CNA #253 exited room at 10:24 A.M. with Resident #27 dressed and in his wheelchair.</p> <p>Interview with LPN #215 at 10:25 A.M. revealed they do not wear gowns during transferring and confirmed they transferred Resident #27 from the bed to his wheelchair with the hooyer. Interview with CNA #253 at 10:26 A.M. revealed she removed Resident #27 clothes, gave him a bed bath, and dressed him in new clothes. CNA #253 revealed she was told she only needed to wear a gown when residents wounds are seeping and Resident #27 wounds are not currently seeping and confirmed she was not wearing a gown during resident care.</p> <p>Interview on 06/17/25 at 10:34 A.M. with DON said they are required to wear gowns and gloves while providing showering, catheter care, transfers and other high-contact care activities. The DON stated she will re-educate staff.</p> <p>Review of the facility policy Enhanced Barrier Precautions dated 2025 revealed residents with wounds even if the resident is not known to be infected or colonized with a multi-drug resistant organism (MDRO) should be placed on precautions. Personal Protective Equipment (PPE) only needs to be used when performing high-contact care activities including: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility policy review, and review of manufacturer prescribing information, revealed the facility failed to ensure antibiotics were appropriately prescribed with a correct indication, dose, and duration. This affected one resident (#1) of five residents reviewed for unnecessary medications. The facility census was 34.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, anxiety, type II diabetes, atrial fibrillation, and peripheral vascular disease.</p> <p>Review of Resident #1's hospital Discharge summary dated [DATE] revealed an order for Macrobid 100 milligrams (mg) every ten days to be administered at 9:00 A.M. and 9:00 P.M.</p> <p>Review of Resident #1's physician's orders revealed an order dated 11/27/24 for Macrobid 100 milligrams (mg), give one capsule by mouth two times a day, every ten days, for urinary tract infection (UTI) prophylaxis (prevention).</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 had intact cognition and received scheduled and as needed pain medications, an antipsychotic, antidepressant and an antibiotic.</p> <p>Review of the Medication Administration Record revealed from November 2024 through June 2025 revealed Macrobid 100 mg was administered two times a day every ten days. Resident #1 received the Macrobid 100 mg two times a day on: 11/27/24, 12/07/24, 12/17/24. 12/27/24, 01/05/25, 01/16/25, 01/27/25, 02/05/25, 02/15/25, 02/25/25, 03/07/25, 03/17/25. 03/27/25, 04/06/25, 04/16/25, 04/26/25, 05/06/25, 05/16/25, 05/26/25, 06/05/25, and 06/15/25.</p> <p>Interview on 06/17/25 at 11:25 A.M. with Certified Nurse Practitioner (CNP) #273 stated he would never write an order for Macrobid to be administered prophylactically two times a day every ten days. CNP #273 stated the Macrobid order may have been written by a hospice provider.</p> <p>Interview on 06/18/25 at 8:13 A.M. with Pharmacist #269 stated the Macrobid order was written to give one capsule twice daily for ten days. Pharmacist #269 noted this was different than the facility's Macrobid order dated 11/27/24. Pharmacist #269 stated she would expect the nursing staff to call the provider for clarification. Pharmacist #269 stated the ordered dosage was not therapeutic for Resident #1.</p> <p>Interview on 06/18/25 at 9:34 A.M. with Pharmacist #270 stated recently the facility's pharmacy had merged to another pharmacy within the same corporation and the original order should have been canceled due to not meeting the Food and Drug Administration (FDA) approved dosage for UTI prophylaxis. Pharmacist #270 stated the pharmacy's original order called for Macrobid 100 mg to be administered twice daily for ten days, which differed from the facility's Macrobid order dated 11/27/25. Pharmacist #270 confirmed the pharmacy had not previously recommended the Macrobid order be clarified, but stated the pharmacy would be making a recommendation to clarify Resident #1's Macrobid order.</p> <p>(continued on next page)</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/18/25 at 4:28 P.M. with the Director of Nursing (DON) revealed the order was brought to the attention of CNP #273, who would clarify the order. The DON stated Resident #1's monthly pharmacy reviews and recommendations did not indicate a clarification for the order.</p> <p>Review of the undated manufacturer's prescribing information revealed Macrobid is commonly used as an antibacterial agent specific for urinary tract infections. The prescribing information noted that a common adult dosage is one 100 mg capsule every twelve hours for a duration of seven days. The prescribing information noted that in the absence of a proven or strongly suspected bacterial infection, a prophylactic indication is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.</p> <p>Review of the undated facility policy titled Medication Administration stated to compare the MAR to the medication and refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects.</p>		