STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365826	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on the observation, review of the Centers for Medicare and Medicaid (CMS) 802 Matrix form, review of the nursing staff assignment sheets, review of the education in-service attendance record, and interview, the facility failed to ensure sufficient nursing staff to provide appropriate supervision to residents residing on the secured memory care unit. This affected 19 residents (Resident #29, #53, #48, #12, #34, #30, #56, #38, #16, #44, #17, #58, #9, #42, #19, #2, #13, #45 and #20) who resided on the [NAME] Hills unit (the secured memory care unit). Facility census was 59. Findings include: Review of the Daily Assignment Sheet [for nursing staff] dated 01/23/25 revealed Registered Nurse (RN) #9 and Certified Nurse Aide (CNA) #21 were assigned to [NAME] Hills unit (secured memory care unit) from 7:00 A.M. to 7:00 P.M. and CNA #8 was assigned to [NAME] Hills unit from 7:00 A.M. to 3:00 P.M. Review of the Education In-Service Attendance Record dated 01/23/25 timed 7:00 A.M. and 2:30 P.M. revealed RN #9, CNA #21 and CNA #8's signatures were in proximity to each other on the attendance record (the three staff were assigned to work on the [NAME] Hills unit). Review of the Daily Assignment Sheet [for nursing staff] dated 01/25/25 revealed two nurses had called off so the Director of Nursing (DON) and CNA #8 were assigned to the [NAME] Hills unit from 7:00 A.M. to 7:00 P.M. There was not a nurse assigned to the Buckeye Trail unit. Review of the Daily Assignment Sheet [for nursing staff] dated 01/30/25 revealed CNA #8 was assigned to the [NAME] Hills unit from 7:00 A.M. to 7:00 P.M. and Licensed Practical Nurse (LPN) #16 was assigned to the [NAME] Hills unit from 7:00 A.M. to 3:00 P.M. RN #9 was assigned the [NAME] Hills unit after 3:00 P.M. however RN #9 called off. Review of the Daily Assignment Sheet [for nursing staff] dated 02/09/25 revealed LPN #18 and CNA #19 were assigned to the [NAME] Hills unit from 7:00 P.M. to 7:00 P.M. CNA #20 was assigned to part of Buckeye Trail unit and there was not a nurse assigned to Buckeye Trail unit from 7:00 P.M. to 7:00 A.M. (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
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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Daily Assignment Sheet [for nursing staff] dated 02/10/25 revealed LPN #22 and CNA #23 were assigned to the [NAME] Hills unit from 7:00 P.M. to 7:00 A.M. There was not a nurse assigned to the Buckeye Trail unit. Review of the CMS-802 Matrix form dated 02/04/25 revealed the following regarding the residents residing on the secured memory care unit: Resident #17 had a fall and fall with injury, Resident #34 had a fall, a fall with injury and a fall with major injury, Resident #38 had a fall and Resident #53 had a fall. There were 16 residents (Residents #2, #9, #12, #13, #16, #17, #19, #20, #29, #30, #38, #42, #44, #48, #53, and #56) with a diagnosis of Alzheimer's disease and/or dementia. Observation on 02/04/25 at 9:08 A.M. revealed Resident #9's door was closed. The surveyor knocked and opened the door to find Resident #9 walking/wandering around aimlessly in his room. Resident #9 did not respond or make eye contact when spoken to. At 9:23 A.M., Resident #9 continued walking/wandering around his room now wearing a soft helmet strapped underneath his chin. At 10:20 A.M., Resident #9 was walking/wandering around the dining room on the secured memory care unit. Interview on 02/04/25 at 11:50 A.M. with Resident #9's spouse revealed she visited Resident #9 daily and was in the building until after 7:00 P.M. The secured memory care unit was left unattended and there were not any staff on the unit during an all-staff meeting a couple of weeks ago (01/23/25). Observation on 02/04/25 at 1:25 P.M. revealed Resident #9 lying on his left side on the floor, awake and not talking, while in the hallway on the secured memory care unit. Interview, during the observation, with RN #9 (who was sitting at the nurses station watching him) revealed Resident #9 puts himself on the floor. Observation on 02/04/24 at approximately 2:36 P.M. of the memory care unit revealed Resident #58 lying on the floor of his room on his side with his head under the bed near the door. He had the bed's grab bar in one hand and was fiddling with bed parts underneath the bed. He was wearing one shoe. There were no staff in the area. Observation and interview on 02/04/25 at 2:45 P.M. with CNA #8 confirmed Resident #58 was still on the floor fiddling with the bed parts. CNA #8 assisted Resident #58 to his feet. Interview on 02/04/25 at 2:50 P.M. with Resident #16's daughter revealed there was not enough staff on the secured memory unit. At times, there was one nurse aide and one nurse working on the secured memory unit and when the nurse had to leave the unit to go to another unit that she was also responsible for, that left one nurse aide on the unit to tend to all the residents. There was an all-staff meeting a couple of days ago (01/23/25) and there were no staff on the unit. While there were no staff on the unit, Resident #19, a new resident who had physical aggression, was attempting to get out of his chair so Resident #16's daughter had to assist him. Interview on 02/04/25 at 3:40 P.M. with the Director of Nursing (DON) revealed two nurses had called off so he worked as a floor nurse on [NAME] Hills unit (the secured memory care unit) and half of Buckeye Trail unit with one nurse aide on [NAME] Hills on 01/25/25. The DON verified when he left [NAME] Hills unit to go to Buckeye Trail unit, one nurse aide was working on [NAME] Hills to tend to all the residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tour of the memory care unit on 02/04/25 at 3:50 P.M. revealed a strong odor of urine was detected outside of Resident #12's room. Upon entering the room, the ambient room temperature was cold and the odor of stale urine stronger. The window in the room was open. Resident #12 was observed bent over at the waist using her hands to sweep up pieces of rice, peas and carrots that were scattered between the two beds in the room into a pile. Resident #12 was speaking to herself although the words were not intelligible. Resident #12's clothing did not appear wet, but she did have an odor of urine about her. Upon further observation a meal tray was observed on Resident #12's bed, the plate cover was facing up and held two drinking cups and other items. The cups within the plate cover were filled with liquid and wet napkins or paper towels. Observation and interview on 02/04/25 at 3:55 P.M. with CNA #7 confirmed the strong smell of urine in Resident #12's room. CNA #7 indicated Resident #12 was frequently incontinent which caused the room to always have an odor of urine, and the room was cold because the window was open. During interview with CNA #7, Resident #12 continued to fuss over the food on the floor while speaking unintelligibly. Observation of Resident #12's bed with CNA #7 revealed upon lifting the blanket, top sheet, and incontinence pad, the fitted sheet had a large wet area with a yellow/brown ring around the edge that had the distinct odor of stale urine measuring approximately 24 inches by 16 inches. CNA #7 guided Resident #12 to the bathroom and sat her on the toilet. Resident #12's clothing was dry and her incontinence brief did not appear wet. CNA #7 indicated she was unaware of the wet bed linen because she provided Resident #12's incontinence care in the common bathroom. Observation on 02/10/25 at 7:40 A.M. of the secured memory care unit revealed LPN #18 was standing at the medication cart counting narcotics with RN #9. Interview on 02/10/25 at 7:45 A.M. with LPN #18 verified she worked night shift from 02/09/25 to 02/10/25 and was assigned to work on both the [NAME] Hills unit and Buckeye Trail unit. LPN #18 stated CNA #19 was the assigned nurse aid on the [NAME] Hills unit and CNA #20 floated between units that night. LPN #18 verified, at times, there was only one nursing staff on the secured memory unit. Observation on 02/10/25 at 8:35 A.M. revealed Resident #17 was sitting in a wheelchair in the dining room of the secured memory care unit. Resident #17 had a black/blue/yellow bruising to the right side of her face covering her right eye, right temple, and right forehead measuring approximately six inches by six inches. Observation upon entering the memory care unit on 02/10/15 at 9:45 A.M. revealed Resident #58 kneeling on floor directly in front of the exit door fiddling with the underside of the push bar. Resident #58 said he did not understand why he could not exit; he wanted to leave and did not want to be where he was. I just want to go home. A staff, not assigned to the work in the memory care unit, responded to the alarming door and helped Resident #58 to his feet. The staff walked Resident #58 to the common area telling him the doctor wanted him to stay for a few more days. Resident #12's room smelled of stale urine. There was no obvious urine on the floor, bathroom or on Resident #12's bed linens. Resident #12 was not present in room. Interview on 02/10/25 at 12:50 P.M. with Ombudsman #24 revealed there were no staff on the secured memory care unit when Ombudsman #24 visited sometimes, and Ombudsman #24 was fearful to leave the unit since it would be unattended. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/10/25 at 2:50 P.M. with [NAME] President of Operations (VPO) #11 verified RN #9, CNA #21 and CNA #8 were in the all-staff meeting on 01/23/25 while assigned to provide care and services to the residents on the [NAME] Hills unit. VPO #11 also verified on 01/25/25, 01/30/25 and 02/09/25 when a nurse was assigned to both [NAME] Hills unit and Buckeye Trail unit and the nurse left the [NAME] Hills unit to go tend to Buckeye Trail unit, it left one CNA to care for all the residents in the [NAME] Hills unit. VPO #11 also confirmed if a CNA was assisting a resident with care or toileting, the other residents were left unsupervised for falls and behaviors on the [NAME] Hills unit. Observation on 02/11/25 at 9:15 A.M. revealed Resident #2 was walking/wandering around the common area on the secured memory care unit. This deficiency represents non-compliance investigated under Complaint Number OH00162019.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on observation, record review, and interview, the facility failed to ensure all residents in the memory care unit received appropriate dementia care and services. This affected three of three residents (Residents #9, #58 and #12) reviewed for dementia care and had the potential to affect 19 (Resident #29, #53, #48, #12, #34, #30, #56, #38, #16, #44, #17, #58, #9, #42, #19, #2, #13, #45 and #20) residents residing in the memory care unit. Findings include: 1. Medical record review revealed Resident #58 was admitted on [DATE]. Resident #58's date of birth was 01/06/66 and he had diagnoses including cognitive communication deficit, restlessness, agitation, insomnia, hepatic encephalopathy (loss of brain function when a damaged liver does not remove toxins from the blood), alcohol dependence and homelessness on admit. Review of the Minimum Data Set (MDS) assessment with an initiation date of 01/22/25 revealed Resident #58 had a Brief Interview Mental Status (BIMS) score of 13 indicating he was cognitively intact. Resident #58 was receiving antipsychotic, antianxiety and antidepressant medications. It was very important for Resident #58 to go outside and get fresh air when the weather was good and very important to listen to music he liked. It was somewhat important to do things with groups of people and participate in religious service. Review of Resident #58's care plan revealed a focus dated 01/17/25 indicating he required a secure unit related to cognitive disorder, dementia/Alzheimer's, need for structured environment, and wandering. The goal included Resident #58's safety would be maintained through appropriate supervision and a structured/supportive environment. Interventions included administering medications as ordered, utilizing techniques such as redirection, distraction, and calming, planning and facilitating activities that were meaningful and appropriate to resident's cognitive abilities. A focus of elopement risk, dated 01/17/25 had interventions including offer engaging activities that interest the resident and reduce restlessness and Resident #58 required reminders and assistance to activities. A focus of activities dated 01/22/25 indicated Resident #58's activities of preference included sip and chat, cards, and music with interventions including requires reminders and assistance to activities and needs calming activities. Observation in the memory care unit on 02/04/24 at approximately 2:36 P.M. revealed Resident #58 lying on the floor of his room on his side with his head under the bed near the door. He had the bed's grab bar in one hand and was fiddling with bed parts underneath the bed. He was wearing one shoe. There were no staff in the area. Observation and interview with Certified Nurse Aide (CNA) #8 at 2:45 P.M. confirmed Resident #58 was still on the floor fiddling with the bed parts. CNA #8 assisted Resident #58 to his feet and told Resident #58 she would get maintenance to look at the bed. There were no organized activities in progress at that time of the observation. There was no activity Colander posted in the room and no device to allow Resident #58 to listen to music. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon entering the memory care unit on 02/10/15 at 9:45 A.M. Resident #58 was observed kneeling on floor directly in front of the exit door fiddling with the underside of the push bar. Resident #58 said he did not understand why he could not exit; he wanted to leave and did not want to be where he was. I just want to go home. A staff, not assigned to the work in the memory care unit responded to the alarming door and helped Resident #58 to his feet. The staff walked Resident #58 to the common area telling him the doctor wanted him to stay for a few more days. Continued observation revealed eleven residents seated around a TV located in hallway across from one of the two dining rooms. Registered Nurse (RN) #9 and a CNA were observed inside the nurse's station and, another CNA (CNA #7) was observed going room to room making beds. Observation of the activity calendar hanging on bulletin board revealed Daily Chronicle at 10:00 A.M. and Sip and chat at 10:30 A.M. Observation at 9:57 A.M. revealed Resident #58 walking to the exit door located next to his room, hitting the door's release bar with his fist and then entering his room. At 9:58 A.M. RN #9 exited the nurse's station retrieved a beach ball and began playing ball toss with the residents seated near the TV. Resident #58 was not invited to join the activity. No attempt was made to engage any resident who was not in the immediate area. At 10:05 A.M. Resident #58 was observed in his room picking up debris from the floor while holding a fist full of disposable gloves. There was no Daily Chronicle activity observed. 2. Medical record review revealed Resident #12 was admitted on [DATE]. Resident #12 had diagnoses including altered mental status, insomnia, anxiety disorder and vascular dementia. Review of Resident #12's Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. Resident #12 was receiving an antianxiety. Resident #12 rarely/never understood and was rarely/never understood and had rejection of care one to three days of the seven-day assessment period. Resident #12 was always incontinent of bowel and bladder and was not on a toileting program. Review of Resident #12's care plan revealed a focus with a revision date of 07/18/24 indicating Resident #12 required a secure dementia unit related to disoriented to place, wandering and motor agitation. The care plan further indicated to monitor for fatigue and weight loss, provide structured activities including toileting (not a structured activity), walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Review of a focus for activities with a revision date of 12/12/24 revealed Resident #12 had difficulties focusing throughout the day and required reminders/encouragement to attend activities of choice/preference. The interventions also included to respect right to refuse to attend activities. During tour of the memory care unit on 02/04/25 at 3:50 P.M. a strong odor of urine was detected outside of Resident #12's room. Upon entering the room, the ambient room temperature was cold and the odor of stale urine stronger. The window in the room was open. Resident #12 was observed bent over at the waist using her hands to sweep up pieces of rice, peas and carrots that were scattered between the two beds in the room into a pile. Resident #12 was speaking to herself although the words were not intelligible. Resident #12's clothing did not appear wet, but she did have an odor of urine about her. Upon further observation a meal tray was observed on Resident #12's bed, the plate cover was facing up and held two drinking cups and other items. The cups within the plate cover were filled with liquid and wet napkins or paper towels. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with Certified Nurse Aide (CNA) #7 on 02/04/25 at 3:55 P.M. confirmed the strong smell of urine in Resident #12's room. CNA #7 indicated Resident #12 was frequently incontinent which caused the room to always have an odor of urine, and the room was cold because the window was open. During interview with CNA #7, Resident #12 continued to fuss over the food on the floor while speaking unintelligibly. Observation of Resident #12's bed with CNA #7 revealed upon lifting the blanket, top sheet, and incontinence pad, the fitted sheet had a large wet area with a yellow/brown ring around the edge that had the distinct odor of stale urine measuring approximately 24 inches by 16 inches. CNA #7 guided Resident #12 to the bathroom and sat her on the toilet. Resident #12's clothing was dry and her incontinence brief did not appear wet. CNA #7 indicated she was unaware of the wet bed linen because she provided Resident #12's incontinence care in the common bathroom. Observation on the memory care unit on 02/10/15 at 9:45 A.M. revealed upon entering Resident #12's room there was an odor of stale urine. There was no obvious urine on the floor, bathroom or on Resident #12's bed linens. Resident #12 was not present in room. Observation on 02/11/25 at 3:30 P.M. revealed a game of Bingo was in progress with four residents in attendance. Observation of Resident #12's room revealed the door was closed and upon knocking there was no reply. Upon entering the room Resident #12 was observed sitting in a straight back chair next to her bed speaking to herself with unintelligible words. There was no memory box, signs, pictures, or monthly calendar in the room as indicated in the care plan. There was not a memory box, sign or pictures immediately outside of Resident #12's room. Registered Nurse (RN) #9 was seated inside the nurse's station. 3. Medical record review revealed Resident #9 was admitted to the facility on [DATE]. Resident #9's date of birth was 11/23/58. Resident #9 had diagnoses including early onset Alzheimer's disease, anxiety disorder, insomnia, and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was severely cognitively impaired. Resident #9 was receiving antipsychotic, antianxiety and antidepressant medications. Review of Resident #9's care plan revealed focus areas of falls and potential injury related to Alzheimer's disease, anxiety, frequent urination, disorientation and unspecified convulsions with a revision date of 07/21/23. The plan indicated Resident #9 was ambulatory on unit and would place self on floor throughout the shift. Interventions dated 07/03/23 indicated to encourage to get off floor when he laid on it and to ambulate in common area to increase supervision, bedroom door to remain closed when not occupied, rearranging furniture in common area, offering snack when wandering, helmet on when out of bed, bed in lowest position, monitor for effects of psychotropic medications, offer wheelchair for mobility during times of weakness, planned activity during restlessness (did not include what planned activity), resident education (resident severely cognitively impaired) and rehabilitation referral. A focus area for behavior problem revised 09/27/23 revealed Resident #9 chose to put himself on the floor and was not aware of personal space and surroundings. The interventions indicated refer to psych as needed and redirect to sleep only in his bed. There were no other interventions to provide staff with guidance on how to redirect or interventions to prevent the behaviors. A focus area for activities initiated 12/24/24 indicated to post monthly calendar in room, remind/encourage to attend activities, assist to activities of interest (did not indicate activities of interest or activity preferences) and respect right to refuse activities. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/04/25 at 9:08 A.M. revealed Resident #9's door was closed. The surveyor knocked and opened to the door to find Resident #9 walking/wandering around aimlessly in his room. Resident #9 did not respond or make eye contact when spoken to. Observation on 02/04/25 at 9:23 A.M. revealed Resident #9 continued walking/wandering around his room now wearing a soft helmet strapped underneath his chin. At 10:20 A.M., Resident #9 was walking/wandering around the dining room on the secured memory care unit. Interview on 02/04/25 at 11:50 A.M. with Resident #9's spouse revealed she visited Resident #9 every day and was in the building until after 7:00 P.M. The secured memory care unit was left unattended and there were not any staff on the unit during an all-staff meeting a couple of weeks ago. Observation on 02/04/25 at 1:25 P.M. revealed Resident #9 lying on his left side on the floor, awake and not talking, while in the hallway on the secured memory care unit. There were no staff reassuring him and/or asking if he wanted to get off the floor. Interview, during the observation, with Registered Nurse (RN) #9 (who was sitting at the nurses station watching him) revealed Resident #9 put himself on the floor. Observation of the memory care unit on 02/04/25 at 2:15 P.M. revealed residents seated at dining tables in the two dining areas. Resident #9 was seated at a table with his lap full of food crumbs. His eyes were closed, and his arms were hanging below the arms of the chair. An unidentified resident was sitting in a wheelchair across from Resident #9 with a partially eaten meal in front of her; her eyes were closed with her chin resting on her chest. A third resident was seated to Resident #9's left. All around the residents were food crumbs and spilled liquids on the floor. Observation of the table to Resident #9's right revealed two residents seated at a table with their meal trays in front of them. Neither resident was actively eating. There was food crumbs scattered about the table and on the floor and liquid spilled next to a chair. There were no staff in the dining area with the residents. Three staff were at the nurse's station; Certified Nurse Aide (CNA) #8, and the Assistant Director of Nursing (ADON) were standing in front of the nurse's station and RN #9 was seated behind the desk inside the nurse's station. Upon being observed, CNA #8 went to the dining area. When asked when the meal was served CNA #8 indicated she did not know and began removing meals from the tables placing them in the meal transport cart. CNA #8 looked at the schedule for meal delivery and indicated the meal was scheduled to be delivered at 12:15 P.M. but could not say for certain when the meal arrived to the unit. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 02/04/25 at approximately 2:50 P.M. revealed three staff were scheduled to work in the memory care unit, two CNAs (#7 and #8) and one RN (#9). The ADON said during the 2:15 P.M. observation she was in the memory care unit because one of the CNAs was on break. The ADON was not in the dining room assisting the residents with their meals because she was delivering a message to RN #9. The ADON indicated she was newly hired and on orientation. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/10/15 at 9:45 A.M. in the memory care unit revealed an activity calendar hanging on bulletin board. Further review scheduled activities included Daily Chronicle at 10:00 A.M. and Sip and chat at 10:30 A.M. Resident #9 was observed wondering about the two halls and into the dining area. At 9:58 A.M. RN #9 exited the nurse's station retrieved a beach ball and began playing ball toss with the residents seated near the TV. Resident #9 was lying on the floor in the dining room located in front of the kitchenette. Resident #9 was not invited to join the activity. No attempt was made to engage any resident who was not in the immediate area. At 10:05 A.M. Resident #9 got off floor and resumed wandering. Observation on 02/10/25 at 3:30 P.M. on the memory care unit revealed a game of Bingo was in progress with four residents in attendance. RN #9 was seated inside the nurse's station. Two residents were seated in their wheelchairs in front of TV located in hallway; both were sleeping with eyes closed and their chins resting on their chests. Resident #9 was wandering about the unit occasionally stopping to lay on the floor for a short period of time then getting back up to resume wandering. 4. Observation on 02/04/25 at 9:10 A.M. revealed residents in the memory care unit eating breakfast. The memory care unit was [NAME] with multiple areas of peeling wallpaper in the hallways and the unit smelled of urine. Interview on 02/04/25 at 2:50 P.M. with Resident #16's daughter revealed there was not enough staff on the secured memory unit. At times, there was one nurse aide and one nurse working on the secured memory unit and when the nurse unit had to leave the unit to go to another unit that she was responsible for, that would leave one nurse aide on the unit to tend to all the residents. There was an all-staff meeting a couple of days ago and there were no staff on the unit. Resident #19, a new resident who had physical aggression, was attempting to get out of his chair so Resident #16's daughter had to assist him. Interview on 02/04/25 at 3:40 P.M. with the Director of Nursing (DON) revealed two nurses called off so he had to work as a floor nurse on [NAME] Hills (the secured memory care unit) and half of Buckeye Trail unit with one nurse aide on [NAME] Hills on 01/25/25. The DON verified when he left [NAME] Hills to go to Buckeye Trail unit, one nurse aide was working on [NAME] Hills to tend to all the residents. Observation on 02/10/25 at 7:40 A.M. of the secured memory care unit revealed Licensed Practical Nurse (LPN) #18 was standing at the medication cart counting narcotics with RN #9. Interview on 02/10/25 at 7:45 A.M. with LPN #18 verified she worked night shift from 02/09/25 to 02/10/25 and was assigned [NAME] Hills and Buckeye Trail unit. LPN #18 stated Certified Nurse Aide (CNA) #19 was the assigned CNA for the [NAME] Hills unit and CNA #20 floated between units that night. LPN #18 verified there was only one nursing staff on the secured memory unit at times. Observation on 02/10/25 at 8:35 A.M. revealed Resident #17 was sitting in a wheelchair in the dining room of the secured memory care unit. Resident #17 had black/blue/yellow bruising on the right side of her face covering her right eye, right temple, and right forehead measure approximately six inches by six inches. Interview on 02/10/25 at 12:50 P.M. with Ombudsman #24 revealed there were no staff on the secured memory care unit when Ombudsman #24 visited sometimes, and Ombudsman #24 was fearful to leave the unit since it would be unattended. (continued on next page)

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	365826	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/10/25 at 2:50 P.M. with [NAME] President of Operations (VPO) #11 verified RN #9, CNA #21 and CNA #8 were in the all-staff meeting on 01/23/25 while assigned to the [NAME] Hills unit (memory care unit). VPO #11 also verified on 01/25/25, 01/30/25 and 02/09/25 when a nurse was assigned to [NAME] Hills unit and Buckeye Trails unit and the nurse left the [NAME] Hills unit to tend to the Buckeye Trail unit, it left one CNA for all the resident on the [NAME] Hills unit. VPO #11 also confirmed if a CNA was assisting a resident with incontinence care or toileting, the other residents were left unsupervised for falls and behaviors on the [NAME] Hills unit. Observation on 02/11/25 at 9:15 A.M. revealed Resident #2 was walking/wandering around the common area on the secured memory care unit. This deficiency represents non-compliance investigated under Complaint Number OH00162019.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35771 Based on observation, review of diet order report, policy review, and interview, the facility failed to follow the menu to ensure nutritional adequacy. This affected 12 residents (Residents #1, #3, #9, #15, #19, #24, #25, #41, #42, #48, #51, and #53) who were ordered a mechanical soft diet or a pureed diet. The census was 59. Findings include: Review of the of Week One 2024-2025 for Tuesday [02/04/25] Menu Spreadsheet revealed residents ordered a pureed diet were supposed to receive pureed scrambled eggs, pureed toast and six ounces of pureed hot or cold cereal with beverages for breakfast. Residents ordered a mechanical soft diet were supposed to receive three ounces of ground lemon pepper chicken for lunch. Residents ordered a pureed diet were supposed to receive three ounces of pureed lemon pepper chicken, four ounces of pureed fluffy steamed rice, four ounces of peas and carrots and two ounces of pureed dinner roll for lunch. The menu was signed by a Registered Dietitian (RD). Observation on 02/04/25 at 8:54 A.M. of [NAME] #3 serving breakfast from the steam table in the kitchen revealed [NAME] #3 served Residents #9 and #42 pureed eggs and pureed toast with thickened water, thickened juice and thickened milk. Interview, during the observation, with [NAME] #3 verified Residents #9 and #42 were only receiving pureed eggs and pureed toast along with the beverages. Observation on 02/04/25 at 9:13 A.M. of the secured memory care unit revealed Registered Nurse (RN) #9 feeding Resident #42 her meal. There was not pureed hot or cold cereal on the resident's meal tray. Interviews on 02/04/25 between 10:45 A.M. and 10:50 A.M. with Residents #6 and #43 revealed portion sizes were small. Observation on 02/04/25 at 12:23 P.M. and 1:06 P.M. of [NAME] #3 serving lunch from the steam table in the kitchen revealed [NAME] #3 used a two and two-thirds scoop to serve the ground chicken, two-ounce scoop to serve the pureed rice, a two-ounce scoop to serve the pureed peas and carrots, and a two-ounce scoop to serve the pureed chicken. [NAME] #3 served Residents #9 and #42's meal tray and there was not a pureed dinner roll on the meal trays for the residents. Interview, during the observation, with [NAME] #3 verified he did not prepare or serve pureed dinner rolls. Interview on 02/04/25 at 1:19 P.M. with RD #14 verified the incorrect serving scoops were used to serve the ground chicken, pureed rice, pureed peas and carrots and pureed chicken. RD #14 verified the residents ordered mechanical soft and pureed diets were served a lesser amount than what the menu spreadsheet directed. RD #14 also confirmed pureed dinner rolls were not prepared or served. Interviews on 02/10/25 between 10:05 A.M. and 10:20 A.M. with Residents #37, #14 and #49 revealed the portion sizes were small. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's undated Menu policy and procedure revealed menus met the requirements of the Food and Nutrition Board of the Nutritional Research Council of the National Academy of Science. Menus must be followed as written with the following exceptions: when ethnic, cultural, geographic, or religious habits of the resident population required a substitution. Review of the diet order report dated 02/04/25 revealed Residents #3, #15, #19, #24, #25, #41, #48, and #51. Residents #1, #9, and #42 were ordered a pureed diet. Resident #53 was ordered a mechanical soft diet with pureed meats. This deficiency represents non-compliance investigated under Complaint Number OH00161747.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on observation, review of the diet order report, and interview, the facility failed to serve food at an appetizing taste and temperature. This had the potential to affect all 59 residents who received meals from the kitchen. The census was 59. Findings include: Observation on 02/04/25 at 1:19 P.M. revealed [NAME] #3 served a test tray consisting of a lemon pepper chicken breast, white rice and cooked peas and carrots from the kitchen tray line and placed the meal tray within the meal cart. At 1:23 P.M., the meal cart was delivered to [NAME] Hills unit (secured memory care unit). At 1:28 P.M., the nursing staff began serving residents meals within the dining room on the secured memory unit. At 1:39 P.M., all residents had been served their lunch tray, and the test tray was tested . Registered Dietitian (RD) #14 used a facility thermometer to take the temperature of the food while the surveyor taste tested the food. RD #14 confirmed the following temperatures: 93.5 degrees Fahrenheit (F) for the chicken breast, 84 degrees F for the white rice and 94 degrees F for the peas and carrots. The chicken, rice and peas and carrots were all at room temperature. The rice was hard. Interview, during the observation, with RD #14 verified all the meal trays took appropriately 20 minutes to serve from the time the meals were plated until the time the meals were served on the secured memory care unit and verified the meal was not at an appetizing taste and temperature. Interview on 02/04/25 at 10:15 A.M. with Resident #14 revealed hot food was served cold. Review of the diet order report dated 02/04/25 revealed all 59 residents had a diet order. This deficiency represents non-compliance investigated under Complaint Number OH00161747.

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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. 35771 Based on observation, review of the food temperature log, review of the FoodSafety.gov website, review of the diet order report, policy review and interview, the facility failed to store and prepare food in a sanitary manner. This affected all 59 residents who received meals from the kitchen. The census was 59. Findings include: Observation on 02/04/25 at 7:55 A.M. during the initial tour of the kitchen revealed the tiled floor was black and sticky in the kitchen servery and in the kitchen. There were no paper towels in the paper towel dispenser at the handwashing sink in the dish machine room. There was a food temperature log dated the First Week of February hanging on the bulletin board outside of Dietary Manager (DM) #4's office within the kitchen. There was a cardboard box full of four-ounce milk cartons sitting on the floor, an opened plastic bag of hot dogs in a metal pan without a date, and four slices of what appeared to be pie covered with plastic wrap without a date sitting on a tray on a metal food cart within Fridge #1 which was the walk-in refrigerator. At 8:15 A.M., the outside walk-in freezer was observed with Director of Maintenance (DOM) #5. The outside freezer door was propped opened by ice buildup on the ground. There was an unlocked padlock hanging from the freezer door handle. DOM #5 was unsuccessful with fully shutting the freezer door due the built-up ice on the ground after making multiple attempts. Interview, during the observation, with DOM #5 verified the outside freezer door could not be closed and the outside freezer had been found unlocked. Review of the food temperature log dated the first week of February revealed instructions that stated, record food temperature when taking out of the oven, prior to service, and halfway after meals have been served. The egg temperature was 149 degrees Fahrenheit (F) for Sunday [02/02/25] breakfast and the egg temperature was 149 degrees F for Monday breakfast [02/03/25]. There was no future temperatures taken of the eggs on those days. Interview on 02/04/25 at 8:20 A.M. with Dietary Aide (DA) #2 revealed she had gone to the outside freezer that morning and found the padlock unlocked and she had to force the freezer door shut due to the build up of ice on the ground. Observation on 02/04/25 at 8:43 A.M. of Fridge #2 (a reach-in refrigerator in the kitchen) revealed there was what appeared to be cornbread pieces in plastic bag that was not labeled or dated and nine four-ounce and one two-ounce plastic containers of what appeared to be gelled peaches without a label or a date. At 8:58 A. M., there was a two feet by two feet buildup of ice noted on the ceiling by the fan hanging over frozen food in the walk-in freezer within the walk-in refrigerator. Observation on 02/04/25 at 9:30 A.M. in the kitchen revealed [NAME] #3 had patches of facial hair not covered with a beard restraint while preparing peas and carrots in a large metal pan. At 11:30 A.M., DM #5 was preparing peanut butter and jelly sandwiches without a hair restraint. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 02/04/25 at 9:30 A.M. and 11:30 A.M. with DM #5 verified [NAME] #3 should be donning a beard restraint while preparing food, the gelled peaches did not have a label or date, the cornbread pieces did not have a label or date, food should not be sitting on the floor in the walk-in refrigerator, the hotdog bag was open and did not have a date, the pie pieces did not have a date, the kitchen floor was dirty, and the ice build up hanging over the frozen food within the walk-in freezer. DM #5 also confirmed the February 2025 food temperature log for the eggs prepared during Sunday [02/02/25] and Monday [02/03/25] breakfast did not meet the appropriate temperature to ensure a proper cooked temperature and confirmed she (DM #5) was not wearing a hairnet while preparing food. Observation on 02/04/25 at 12:46 P.M. at 1:06 P.M. during lunch service revealed [NAME] #3 carrying five frozen hamburger patties with a bare hand from the freezer and touching a hot dog bun with a bare left hand with a band aide on his left thumb. Review of the facility's Food Safety Receiving and Storage policy revised 08/12/19 revealed store food at least six inches off the floor. Keep the doors on the cold storage units shut as much as possible. Refrigerated, ready to eat Time/Temperature Control for Safety Foods (TCS) were properly covered, labeled, dated with a use-by-date and refrigerated immediately. [NAME] them clearly to indicate the date by which the food shall be consumed or discarded. The day of preparation or day the original container was opened shall be considered Day 1. Discard after three days unless otherwise indicated. Review of the Safe Minimum Internal Temperature Chart for Cooking via www.FoodSaftey.gov website accessed on 02/11/25 revealed the minimum internal temperature chart for egg dishes was 160 degrees F. Review of the facility's Safe Food Preparation policy dated June 2019 revealed avoid touching ready-to-eat foods that were not subsequently cooked with bare hands. Use tongs (or other utensils) or gloves instead. Anyone working in, visiting, or inspecting the kitchen during normal food production hours was expected to wear appropriate hair restraint. Review of the diet order report dated 02/04/25 revealed all 59 residents had a diet order. This deficiency represents non-compliance investigated under Complaint Number OH00161747.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on medical record review, review of the Centers of Disease Control and Prevention (CDC) COVID-19 vaccination guidelines, policy review and interview, the facility failed to offer any 2024-2025 COVID-19 vaccinations to residents. This affected five (Residents #9, #43, #38, #17 and #34) residents reviewed for COVID-19 vaccination. The census was 59. Findings include: Review of the CDC's Interim Clinical Considerations for COVID-19 Vaccines in the United States dated 01/31/25 revealed people ages 65 and older, vaccinated under the routine schedule, were recommended to receive two doses of any 2024-2025 COVID-19 vaccine separated by six months (minimum interval two months) regardless of vaccination history with one exception: unvaccinated people who initiated vaccination with 2024-2025 Novavax COVID-19 vaccine were recommended to receive two doses of Novavax followed by a third dose of any COVID-19 vaccine six months (minimum interval two months) later. Review of the facility's COVID-19 policy revised April 2024 revealed long-term care facilities should offer residents COVID-19 vaccination. 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses of Alzheimer's disease, anxiety disorder, convulsion, and dementia. Resident #9 was over [AGE] years old, resided in the secured memory care unit and his spouse was his responsible party. Review of the immunization audit report dated 02/11/25 revealed Resident #9 received the COVID-19 Pfizer booster vaccine on 06/30/22. There was no evidence Resident #9 was offered and/or received any 2024-2025 COVID-19 vaccine. Interview on 02/10/25 at 2:20 P.M. with [NAME] President of Operations (VPO) #11 verified there was no evidence Resident #9 was offered and/or received any 2024-2025 vaccine. 2. Review of medical record for Resident #43 revealed an admitted [DATE] with diagnoses of schizophrenia, hypertension, hyperlipidemia, delusional disorder, and absence of left foot. Resident #43 was over [AGE] years old and was his own responsible party. Review of the immunization audit report dated 02/11/25 revealed Resident #43 refused COVID-19 Pfizer vaccine on 04/26/23. There was no evidence Resident #43 was offered and/or received any 2024-2025 COVID-19 vaccine. Interview on 02/10/25 at 2:20 P.M. with [NAME] President of Operations (VPO) #11 verified there was no evidence Resident #43 was offered and/or received any 2024-2025 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), asthma, diabetes, emphysema, atrial fibrillation, epilepsy, dementia, heart failure. Resident #38 was over [AGE] years old, resided on the secured memory care unit and Resident #38's son was the resident's Power of Attorney (POA). Review of the immunization audit report dated 02/11/25 revealed there was no evidence Resident #38 was offered and/or received any COVID-19 vaccine. Interview on 02/10/25 at 2:20 P.M. with [NAME] President of Operations (VPO) #11 verified there was no evidence Resident #38 was offered and/or received any 2024-2025 vaccine. 4. Review of the medical record for Resident #17 revealed an admitted [DATE] with diagnoses of dementia with behavioral disturbance, diabetes, hyperlipidemia, and intestinal malabsorption. Resident #17 was over [AGE] years old, resided in the secured memory care unit and Resident #17's granddaughter was the resident's responsible party. Review of the immunization record report dated 02/11/25 revealed there was no evidence Resident #17 was offered and/or received any COVID-19 vaccine. Interview on 02/10/25 at 2:20 P.M. with [NAME] President of Operations (VPO) #11 verified there was no evidence Resident #17 was offered and/or received any 2024-2025 vaccine. 5. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses of acute kidney failure, Alzheimer's disease, diabetes, protein-calorie malnutrition, and restless and agitation. Resident #34 was over [AGE] years old, resided in the secured memory care unit and Resident #34's daughter was her legal guardian. Review of the immunization record report dated 02/11/25 revealed Resident #34 received the COVID-19 vaccine on 06/27/21 and 07/28/21. There was no evidence Resident #43 was offered and/or received any 2024-2025 COVID-19 vaccine. Interview on 02/10/25 at 2:20 P.M. with [NAME] President of Operations (VPO) #11 verified there was no evidence Resident #34 was offered and/or received any 2024-2025 vaccine. This deficiency represents non-compliance investigated under Complaint Number OH00162019.