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	04/21/2025

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

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 - Some	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. 47570 Based on observation, record review, interview and review of facility policy, the facility failed to maintain a safe, clean, comfortable and homelike environment for all residents. This affected one resident (Resident #29) of three residents reviewed for environment on the Cascade unit, and had the potential to affect an additional 35 residents (Resident #1, #2, #5, #6, #8, #10, #11, #12, #13, #15, #17, #18, #21, #22, #23, #24, #26, #28, #30, #31, #34, #36, #37, #38, #40, #41, #42, #43, #45, #48, #49, #50, #33, #19,and #32) the facility identified as living on the Buckeye and Memory Care (MC) units. The facility census was 51. Findings include: Record review of the Resident Council Meeting Minutes dated 02/05/25 revealed residents had concerns staff were not making beds or changing sheets, not emptying trash cans or putting bags in the trash cans. Record review of Resident Council Meeting Minutes dated 03/26/25 revealed a concern regarding rooms needing swept more than once a week. Review of the facility cleaning checklist revealed bathrooms were to be swept, and bedrooms were to have the floor swept and trash cans emptied daily. An interview was conducted on 04/14/25 at 9:02 A.M. with Resident # 29 who revealed she was waiting for staff to clean her trash can because it was overflowing to the top and stated the trash bothered her. Observation at the time of the interview revealed Resident #29's trash can was overflowing with trash. An interview was conducted on 04/14/25 at 2:05 P.M. with the Ombudsman who revealed a resident had complained they did not receive showers due to lack of towels and washcloths. Observations were conducted on 04/14/25 from 4:00 P.M. to 4:40 P.M. with Housekeeping and Maintenance Supervisor (HMS) #131 and revealed the following findings: (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #29's room smelled of urine and feces, and there was a soiled brief in the unlined trash can next to the bed, and under the bed there was spilled liquids that had disintegrated tissues in it and a toilet paper roll. HMS #131 verified the findings at the time of the observation and stated it was a big mess under the bed. There was a seven-inch hole in the wall by the utility room entrance on the MC unit. Wallpaper was ripped in the Buckeye unit hallway due to a handrail that was pulled away from the wall and in need of being secured to the wall. A comb with hair on it was observed to be laying in the common area on the floor under a dresser but visible to the eye on the Buckeye unit. A lounge chair in the MC unit had dark brown stains on the side of the chair. The linen closet on the Cascade unit had no washcloths or towels available for use. The linen closets on the Buckeye and MC units had no washcloths available for use and 17 towels in each closet. An interview on 04/14/25 at 4:45 P.M. with HMS #131 revealed the last time the facility ordered ten wash clothes was 03/21/25, and the facility did not have any pending orders for more. HMS #131 verified there was not enough washcloths or towels in the observed linen closets. An interview on 04/16/25 at 2:01 P.M. with Resident #5 revealed she did not receive showers or bed baths because staff stated they ran out of wash cloths. An interview on 04/16/25 at 2:10 P.M. with Certified Nurse Assistant (CNA) # 130 revealed the facility could use more wash cloths for resident care. An interview on 04/16/25 at 2:15 P.M. with CNA #133 revealed the facility could use more washcloths for resident care. Review of the facility policy titled, General Environmental Cleaning Techniques, revised February 2022, revealed the facility established a policy to maintain a standardized approach to environmental cleaning to promote a clean, sanitary living environment. This deficiency represents non-compliance identified during investigation of Complaint Number OH00164096 and OH00164189.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on record review, interview and review of facility policy, the facility did not ensure facility staff did not neglect Resident #5 when in need of staff assistance to meet care needs. This affected one resident (Resident #5) of three residents reviewed for abuse/neglect. The facility census was 51. Findings include: Record review for Resident #5 revealed an admitted [DATE] and a readmitted [DATE] with diagnoses including heart failure, cardiomegaly (enlarged heart) with atheroscerotic heart disease, , atrial fibrillation (heart arrhythmia), osteoarthritis, diabetes mellitus, palpitations, insomnia, chronic embolism and thrombosis of unspecified vein and hypokalemia (low potassium level). A review of Resident #5's most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #5 was always incontinent of bowel and bladder. Record review of Resident #5's plan of care initiated on 06/02/2022 revealed Resident #5 had an alteration in elimination related to bowel and bladder incontinence. The goal of the plan of care was to ensure Resident #5 was clean, dry and odor free. Interventions on the plan of care initiated on 03/25/25 and 06/02/22 respectively indicated to check and change Resident #5 for incontinence every two hours and as needed per Resident #5's request and provide incontinence care as ordered. Further review of Resident #5's medical record contained no documentation of an incident regarding the staff refusing to assist Resident #5 back to bed to provide incontinence care. An interview with Resident #5 on 04/14/25 at 7:45 A.M. revealed approximately two weeks ago on a Sunday at 12:30 P.M. she had asked Certified Nursing Assistant (CNA) #90 to assist her with incontinence care after having a bowel movement. Resident #5 stated CNA #90 told her she would need to wait for assistance with incontinence care. Resident #5 stated she waited for a long time and when CNA #90 walked in her room, she blocked the doorway while seated in her wheelchair to prevent CNA #90 from leaving her room. Resident #5 stated she told CNA #90 that she would not allow her to exit the room until after she was assisted with incontinence care. Resident #5 stated she argued with CNA #90 and CNA #90 was not allowed to provide care for her. Resident #5 stated a different staff member finally assisted her with incontinence care at approximately 4:15 P.M. in the afternoon. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) #62 on 04/14/25 at 2:54 P.M. revealed LPN #62 had assisted Resident #5 with incontinence care on the day Resident #5 had an argument with CNA #90 over incontinence care. LPN #62 stated the facility was short staffed at that time due to a CNA reporting off for the 12 hour day shift (7:00 A.M. to 7:00 P.M.) on the day the above incident occurred between Resident #5 and CNA #90. LPN #62 stated CNA #90 had informed her of an incident with Resident #5. Resident #5 had blocked CNA #90 in Resident #5's room demanding CNA #90 assist her back to bed and provide incontinence care. LPN #62 stated she and another CNA from the staffing agency assisted Resident #5 back to bed and provided incontinence care at approximately 4:15 P.M. LPN #62 stated she informed the Assistant Director of Nursing (ADON) of the situation and was informed by the ADON to figure it out. LPN #62 stated the ADON did not want to have to come in to the facility and threatened the staff if she had to come in to the facility the staff would be in trouble. LPN #62 stated she had called the ADON for advice on how she should respond to the incident but was not given instruction from the ADON on how to proceed. An interview with CNA #90 on 04/16/25 at 10:15 A.M. revealed she felt the facility was short staffed on the day she had an altercation with Resident #5. CNA #90 stated several weeks ago she had assisted Resident #5 out of bed (unable to remember date or day of the week) and told Resident #5 she would not be able to assist her back to bed until later in the day due to she needed to make her rounds and see the other residents assigned to her. CNA #90 stated a short time later she saw Resident #5 straining in her wheelchair having a bowel movement. At approximately 12:30 P.M. Resident #5 asked CNA #90 to assist her back to bed and provide incontinence care. CNA #90 stated the nurse assigned to the area was taking her break and she entered Resident #5's room to make her bed when Resident #5 blocked the doorway to the room to prevent her from leaving the room. Resident #5 demanded CNA #90 assist her back to bed and provide incontinence care. CNA #90 stated Resident #5 accused her of neglect and backed her wheelchair into CNA #90 and threatened to call the police. CNA #90 stated she told Resident #5 she would report her for assault. CNA #90 stated Resident #5 eventually allowed her to leave the room and the police were not called. CNA #90 stated she reported the incident to LPN #62. CNA #90 stated LPN #62 and another staff member assisted Resident #5 with the use of a mechanical lift back to bed and provided incontinence care later in the afternoon at approximately 4:30 P.M. CNA #90 stated she reported the incident to the ADON and the Director of Nursing (DON). CNA #90 stated she now was not permitted to provide care for Resident #5. CNA #90 stated she was not instructed to write a statement regarding the incident and was unsure if the administrative staff investigated the incident. An interview with the Director of Nursing (DON) on 04/16/25 at 10:38 A.M. revealed she was informed that the ADON received a text message from LPN #62. LPN #62 texted the ADON and reported that Resident #5 had trapped CNA #90 in her room with her wheelchair. The ADON talked to LPN #62 and told her to assist Resident #5 back to bed. The DON stated she had talked to CNA #90 who was upset about Resident #5's behavior and that Resident #5 had blocked CNA #90 in her room using her wheelchair. DON stated she was not aware of the full story and had not conducted a thorough investigation of the incident. An interview with the ADON on 04/16/25 at 10:46 A.M. revealed CNA #90 had informed her that Resident #5 wanted assistance to get in bed. The ADON stated Resident #5 did not get along with CNA #90, she was not aware of the whole story and did not investigate the incident further by interviewing other staff or Resident #5. The ADON told LPN #62 to assist Resident #5 back to bed and provide incontinence care. The ADON informed LPN #62 that if she had to personally come in to the facility the staff would be in trouble. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property, dated 11/01/19, indicated the definition of neglect was the failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy stated the facility will not tolerate abuse, neglect, exploitation of its residents or the misappropriation of resident property. All alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, including injuries of unknown source should be thoroughly investigated and immediately reported to the administrator/designee and to the Ohio Department of Health in accordance with the procedures in this policy. In cases where a crime is suspected, staff should also report the same to local law enforcement in accordance the facility's crime reporting policy. This deficiency represents non-compliance investigated under Complaint Number OH00164297, Complaint Number OH00164189, and Complaint Number OH00164096

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on record review, interview and review of facility policy, the facility did not ensure an allegation of neglect of Resident #5 was reported to the state agency and administrator as required. This affected one resident (Resident #5) of three residents reviewed for abuse/neglect. The facility census was 51. Findings include: Review of the medical record for Resident #5 revealed an admitted [DATE] and a readmitted [DATE] with diagnoses including heart failure, cardiomegaly (enlarged heart)with atherosclerotic heart disease, , atrial fibrillation (heart arrhythmia), osteoarthritis, diabetes mellitus, palpitations, insomnia, chronic embolism and thrombosis of unspecified vein and hypokalemia (low potassium level). A review of Resident #5's most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #5 was always incontinent of bowel and bladder. Review of Resident #5's plan of care initiated on 06/02/2022 revealed Resident #5 had an alteration in elimination related to bowel and bladder incontinence. The goal of the plan of care was to ensure Resident #5 was clean, dry and odor free. Interventions on the plan of care initiated on 03/25/25 and 06/02/22 respectively indicated to check and change Resident #5 for incontinence every two hours and as needed per Resident #5's request and provide incontinence care as ordered. Resident #5's clinical record contained no documentation of an incident regarding the staff refusing to assist Resident #5 back to bed to provide incontinence care. An interview with Resident #5 on 04/14/25 at 7:45 A.M. revealed approximately two weeks ago on a Sunday at 12:30 P.M. she had asked Certified Nursing Assistant (CNA) #90 to assist her with incontinence care after having a bowel movement. Resident #5 stated CNA #90 told her she would need to wait for assistance with incontinence care. Resident #5 stated she waited for a long time and when CNA #90 walked in her room, she blocked the doorway while seated in her wheelchair to prevent CNA #90 from leaving her room. Resident #5 stated she told CNA #90 that she would not allow her to exit the room until after she was assisted with incontinence care. Resident #5 stated she argued with CNA #90 and CNA #90 was not allowed to provide care for her. Resident #5 stated a different staff member finally assisted her with incontinence care at approximately 4:15 P.M. in the afternoon. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) #62 on 04/14/25 at 2:54 P.M. revealed LPN #62 had assisted Resident #5 with incontinence care on the day Resident #5 had an argument with CNA #90 over incontinence care. LPN #62 stated the facility was short staffed at that time due to a CNA reporting off for the 12 hour day shift (7:00 A.M. to 7:00 P.M.) on the day the above incident occurred between Resident #5 and CNA #90. LPN #62 stated CNA #90 had informed her of an incident with Resident #5. Resident #5 had blocked CNA #90 in Resident #5's room demanding CNA #90 assist her back to bed and provide incontinence care. LPN #62 stated she and another CNA from the staffing agency assisted Resident #5 back to bed and provided incontinence care at approximately 4:15 P.M. LPN #62 stated she informed the Assistant Director of Nursing (ADON) of the situation and was informed by the ADON to figure it out. LPN #62 stated the ADON did not want to have to come in to the facility and threatened the staff if she had to come in to the facility the staff would be in trouble. LPN #62 stated she had called the ADON for advice on how she should respond to the incident but was not given instruction from the ADON on how to proceed. An interview with CNA #90 on 04/16/25 at 10:15 A.M. revealed she felt the facility was short staffed on the day she had an altercation with Resident #5. CNA #90 stated several weeks ago she had assisted Resident #5 out of bed (unable to remember date or day of the week) and told Resident #5 she would not be able to assist her back to bed until later in the day due to she needed to make her rounds and see the other residents assigned to her. CNA #90 stated a short time later she saw Resident #5 straining in her wheelchair having a bowel movement. At approximately 12:30 P.M. Resident #5 asked CNA #90 to assist her back to bed and provide incontinence care. CNA #90 stated the nurse assigned to the area was taking her break and she entered Resident #5's room to make her bed when Resident #5 blocked the doorway to the room to prevent her from leaving the room. Resident #5 demanded CNA #90 assist her back to bed and provide incontinence care. CNA #90 stated Resident #5 accused her of neglect and backed her wheelchair into CNA #90 and threatened to call the police. CNA #90 stated she told Resident #5 she would report her for assault. CNA #90 stated Resident #5 eventually allowed her to leave the room and the police were not called. CNA #90 stated she reported the incident to LPN #62. CNA #90 stated LPN #62 and another staff member assisted Resident #5 with the use of a mechanical lift back to bed and provided incontinence care later in the afternoon at approximately 4:30 P.M. CNA #90 stated she reported the incident to the ADON and the Director of Nursing (DON). CNA #90 stated she now was not permitted to provide care for Resident #5. CNA #90 stated she was not instructed to write a statement regarding the incident and was unsure if the administrative staff investigated the incident. An interview with the Director of Nursing (DON) and Administrator on 04/16/25 at 10:38 A.M. revealed the DON was informed that the ADON received a text message from LPN #62. LPN #62 texted the ADON and reported that Resident #5 had trapped CNA #90 in her room with her wheelchair. The ADON talked to LPN #62 and told her to assist Resident #5 back to bed. The DON stated she had talked to CNA #90 who was upset about Resident #5's behavior and that Resident #5 had blocked CNA #90 in her room using her wheelchair. The DON stated she was not aware of the full story, had not conducted a thorough investigation of the incident and did not report the incident to the state agency as required. The Administrator confirmed the incident had not been reported to the state agency and Administrator as required and an investigation had not been conducted. An interview with the ADON on 04/16/25 at 10:46 A.M. revealed CNA #90 had informed her that Resident #5 wanted assistance to get in bed. The ADON stated Resident #5 did not get along with CNA #90, she was not aware of the whole story and did not investigate the incident further by interviewing other staff or Resident #5 nor was it reported to the Administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property, dated 11/01/19, indicated the definition of neglect was the failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy stated the facility will not tolerate abuse, neglect, exploitation of its residents or the misappropriation of resident property. All alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, including injuries of unknown source should be thoroughly investigated and immediately reported to the administrator/designee and to the Ohio Department of Health in accordance with the procedures in this policy. If a staff member was accused or suspected of abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, the facility should immediately remove that staff member from the facility and the schedule pending the outcome of the investigation. Documentation in the nurses' notes should include the results of the resident's assessment, notification of the physician and the resident representative, and any treatment provided. Appropriate quality assurance documentation should be completed as well. Once the Administrator and Ohio Department of Health were notified, an investigation of the allegation violation would be conducted and completed within five working days, unless there were special circumstances causing the investigation to continue beyond 5 working days. There should be documented evidence of the investigation. This deficiency represents non-compliance investigated under Complaint Number OH00164297, Complaint Number OH00164189, and Complaint Number OH00164096

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on record review, interview and review of facility policy, the facility did not ensure an allegation of neglect of Resident #5 was thoroughly investigated and corrective action taken as required. This affected one resident (Resident #5) of three residents reviewed for abuse/neglect. The facility census was 51. Findings include: Review of the medical record for Resident #5 revealed an admitted [DATE] and a readmitted [DATE] with diagnoses including heart failure, cardiomegaly (enlarged heart)with atherosclerotic heart disease, , atrial fibrillation (heart arrhythmia), osteoarthritis, diabetes mellitus, palpitations, insomnia, chronic embolism and thrombosis of unspecified vein and hypokalemia (low potassium level). A review of Resident #5's most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #5 was always incontinent of bowel and bladder. Review of Resident #5's plan of care initiated on 06/02/2022 revealed Resident #5 had an alteration in elimination related to bowel and bladder incontinence. The goal of the plan of care was to ensure Resident #5 was clean, dry and odor free. Interventions on the plan of care initiated on 03/25/25 and 06/02/22 respectively indicated to check and change Resident #5 for incontinence every two hours and as needed per Resident #5's request and provide incontinence care as ordered. Further review of Resident #5's clinical record revealed it contained no documentation of an incident regarding the staff refusing to assist Resident #5 back to bed to provide incontinence care. An interview with Resident #5 on 04/14/25 at 7:45 A.M. revealed approximately two weeks ago on a Sunday at 12:30 P.M. she had asked Certified Nursing Assistant (CNA) #90 to assist her with incontinence care after having a bowel movement. Resident #5 stated CNA #90 told her she would need to wait for assistance with incontinence care. Resident #5 stated she waited for a long time and when CNA #90 walked in her room, she blocked the doorway while seated in her wheelchair to prevent CNA #90 from leaving her room. Resident #5 stated she told CNA #90 that she would not allow her to exit the room until after she was assisted with incontinence care. Resident #5 stated she argued with CNA #90 and CNA #90 was not allowed to provide care for her. Resident #5 stated a different staff member finally assisted her with incontinence care at approximately 4:15 P.M. in the afternoon. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) #62 on 04/14/25 at 2:54 P.M. revealed LPN #62 had assisted Resident #5 with incontinence care on the day Resident #5 had an argument with CNA #90 over incontinence care. LPN #62 stated the facility was short staffed at that time due to a CNA reporting off for the 12 hour day shift (7:00 A.M. to 7:00 P.M.) on the day the above incident occurred between Resident #5 and CNA #90. LPN #62 stated CNA #90 had informed her of an incident with Resident #5. Resident #5 had blocked CNA #90 in Resident #5's room demanding CNA #90 assist her back to bed and provide incontinence care. LPN #62 stated she and another CNA from the staffing agency assisted Resident #5 back to bed and provided incontinence care at approximately 4:15 P.M. LPN #62 stated she informed the Assistant Director of Nursing (ADON) of the situation and was informed by the ADON to figure it out. LPN #62 stated the ADON did not want to have to come in to the facility and threatened the staff if she had to come in to the facility the staff would be in trouble. LPN #62 stated she had called the ADON for advice on how she should respond to the incident but was not given instruction from the ADON on how to proceed. An interview with CNA #90 on 04/16/25 at 10:15 A.M. revealed she felt the facility was short staffed on the day she had an altercation with Resident #5. CNA #90 stated several weeks ago she had assisted Resident #5 out of bed (unable to remember date or day of the week) and told Resident #5 she would not be able to assist her back to bed until later in the day due to she needed to make her rounds and see the other residents assigned to her. CNA #90 stated a short time later she saw Resident #5 straining in her wheelchair having a bowel movement. At approximately 12:30 P.M. Resident #5 asked CNA #90 to assist her back to bed and provide incontinence care. CNA #90 stated the nurse assigned to the area was taking her break and she entered Resident #5's room to make her bed when Resident #5 blocked the doorway to the room to prevent her from leaving the room. Resident #5 demanded CNA #90 assist her back to bed and provide incontinence care. CNA #90 stated Resident #5 accused her of neglect and backed her wheelchair into CNA #90 and threatened to call the police. CNA #90 stated she told Resident #5 she would report her for assault. CNA #90 stated Resident #5 eventually allowed her to leave the room and the police were not called. CNA #90 stated she reported the incident to LPN #62. CNA #90 stated LPN #62 and another staff member assisted Resident #5 with the use of a mechanical lift back to bed and provided incontinence care later in the afternoon at approximately 4:30 P.M. CNA #90 stated she reported the incident to the ADON and the Director of Nursing (DON). CNA #90 stated she now was not permitted to provide care for Resident #5. CNA #90 stated she was not instructed to write a statement regarding the incident and was unsure if the administrative staff investigated the incident. An interview with the Director of Nursing (DON) and Administrator on 04/16/25 at 10:38 A.M. revealed the DON was informed that the ADON received a text message from LPN #62. LPN #62 texted the ADON and reported that Resident #5 had trapped CNA #90 in her room with her wheelchair. The ADON talked to LPN #62 and told her to assist Resident #5 back to bed. The DON stated she had talked to CNA #90 who was upset about Resident #5's behavior and that Resident #5 had blocked CNA #90 in her room using her wheelchair. The DON stated she was not aware of the full story, had not conducted a thorough investigation of the incident and did not report the incident to the state agency as required. The Administrator confirmed the incident had not been reported to the state agency and Administrator as required and an investigation had not been conducted therefore no corrective action was taken related to the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the ADON on 04/16/25 at 10:46 A.M. revealed CNA #90 had informed her that Resident #5 wanted assistance to get in bed. The ADON stated Resident #5 did not get along with CNA #90, she was not aware of the whole story and did not investigate the incident further by interviewing other staff or Resident #5 nor was it reported to the Administrator. Review of the facility policy titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property, dated 11/01/19, indicated the definition of neglect was the failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy stated the facility will not tolerate abuse, neglect, exploitation of its residents or the misappropriation of resident property. All alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, including injuries of unknown source should be thoroughly investigated and immediately reported to the administrator/designee and to the Ohio Department of Health in accordance with the procedures in this policy. If a staff member was accused or suspected of abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, the facility should immediately remove that staff member from the facility and the schedule pending the outcome of the investigation. Documentation in the nurses' notes should include the results of the resident's assessment, notification of the physician and the resident representative, and any treatment provided. Appropriate quality assurance documentation should be completed as well. Once the Administrator and Ohio Department of Health were notified, an investigation of the allegation violation would be conducted and completed within five working days, unless there were special circumstances causing the investigation to continue beyond five working days. Investigation protocol of the person investigating the incident should generally take the following actions: Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. If there are no direct witnesses, then the interviews may be expanded. For example, to cover all employees on the unit, or, as appropriate, the shift. Obtain a statement from the resident, if possible, the accused, and each witness. Obtain all medical reports and statements from physicians and/or hospitals, if applicable. Review the residents records. If the accused is an employee, then review his/her employment records. Evidence of the investigation should be documented. This deficiency represents non-compliance investigated under Complaint Number OH00164297, Complaint Number OH00164189, and Complaint Number OH00164096

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, record review and interview the facility failed to ensure staff provided the physician ordered wound treatment during Resident #47's wound treatment procedure. This affected one resident (Resident #47) out of three residents reviewed for wounds. The facility census was 51. Findings include: Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses including bullous penphigoid (a rare autoimmune disease that causes blisters or sores on the skin.), morbid obesity, anxiety, depression, insomnia, lymphedema, adult failure to thrive and high blood pressure. Review of a wound assessment dated [DATE] for Resident #47 revealed Resident #47 had severe edema of the lower extremities, and multiple sores and blisters on the thighs, abdominal fold, buttocks, and back. Resident #47's physician order dated 06/25/24 indicated to implement enhanced barrier isolation precautions during resident care tasks. Resident #47 had a stage three pressure ulcer located on the posterior right thigh measuring 4 centimeters (cm) long by 4.5 cm wide by 0.2 cm deep and right lower back measuring 4.1 cm long by 4.5 cm wide by 0.2 cm deep. Resident #47's physician orders dated 03/23/25 instructed to cleanse the left abdominal fold with normal saline and apply betadine, cover with abdominal pad once a day and as needed, cleanse the right upper buttocks wound with normal saline, apply calcium alginate to wound bed and dress with silicone super absorbent dressing once a day as needed, cleanse the right posterior thigh stage three wound with normal saline, apply calcium alginate and cover with foam dressing once a day as needed, and to cleanse the right flank with normal saline, apply silicone super absorbent dressing once a day as needed. An observation of Licensed Practical Nurse (LPN) #130 performing Resident #47's wound treatment procedure on 04/16/25 at 9:00 A.M. revealed a failure to apply the physician ordered wound treatment to Resident #47's left abdominal fold, right upper buttocks, right posterior thigh and right flank. LPN #130 cleaned the above listed wounds with normal saline, applied calcium alginate with silver to all the wounds and covered the wounds with abdominal pads and 4 inch long by 4 inch wide gauze pads securing the dressings with paper tape. LPN #130 stated during the observation the silicone super absorbent dressing and foam dressing were not available in the facility so abdominal pads and gauze were used instead to cover Resident #47's wounds. An interview with LPN #130 on 04/16/25 at 10:10 A.M. verified she did not apply the wound treatments as ordered by the physician for Resident #47. Review of the facility policy and procedure titled Dressing Change: Wound dated 06/2019 indicated it was the policy of this facility that dressing changes will follow specific manufacture's guidelines and general infection control principles. The procedure included item number 16 which indicated for staff to follow manufacturer's guidelines (available on the wound care product's package insert) and physician orders when using any wound care product. This deficiency represents non-compliance investigated under Complaint Number OH00164297.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, record review and interview the facility failed to ensure the staff administered medications with a less than five percent error rate. Three errors occurred within 24 opportunities for error resulting in a medication error rate of 12.5 percent. This affected two residents (Resident #13 and Resident #28) out of six resident observed for medication administration. The facility census was 51. Findings include: 1. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including chronic respiratory disease including respiratory failure, chronic obstructive pulmonary disease, hypercapnea, hypoxia, high cholesterol, atherosclerotic heart disease, anemia, psychoactive substance abuse, cocaine/cannabis abuse, alcohol abuse, hemophilus influenza and insomnia. A review of Resident #28's physician order dated 04/10/25 indicated to administer 25 milligrams (mg) of metoprolol tartrate orally twice a day. An observation on 04/14/25 at 7:58 A.M. of Registered Nurse (RN) #61 administering medications to Resident #28 revealed RN #61 administered two tablets of metoprolol 25 mg orally to Resident #28 during the observation. An interview with RN #61 on 04/14/25 at 2:48 P.M. verified she had administered two tablets of the metoprolol tartrate 25 mg to Resident #28 erroneously. RN #61 stated she should have administered one tablet of the metoprolol tartrate 25 mg medication in the morning. 2. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including hypertensive heart failure, bipolar disorder, low thyroid level, benign prostatic hyperplasia, gastroesophageal reflux disease, vitamin D deficiency, chronic pain syndrome, restless leg syndrome, anemia, constipation, high cholesterol, chronic obstructive pulmonary disease, diverticulosis, insomnia, diabetes mellitus with diabetic neuropathy, vascular dementia with agitation and anxiety. A review of Resident #13's physician order dated 09/19/25 indicated to administer cyanobalamin 1000 micrograms (mcg) tablet orally once a day in the morning and on 03/26/25 to administer vitamin D2 50 mcg tablet orally once a day in the morning. An observation of RN #61 administer medications to Resident #13 on 04/14/25 at 8:32 A.M. revealed RN #61 administered 500 mcg of cyanobalamin orally and failed to administer the vitamin D2 50 mcg tablet orally to Resident #13 as ordered by the physician. \ An interview with RN #61 on 04/14/25 at 2:48 P.M. verified she had administered the incorrect dosage of the cyanobalamin medications and had failed to administer the vitamin D2 medication as ordered by the physician to Resident #13. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Medication Administration and Management dated 06/2019 indicated only authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff, pass and sign for medications administered. Authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff must understand: A. Indications/Reasons for therapy; B. Effectiveness of the therapeutic goal; C. Drug actions; D. The 8 Rights for administering medication including the right resident, the right drug, the right dose, the right time, the right route, the right charting and the right result. This deficiency represents non-compliance investigated under Complaint Number OH00164189.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47570 Based on observation and interview the facility did not ensure food served to Resident #5, #46 and #47 was palatable and attractive. This affected three residents (#5, #46 and #47) of seven residents reviewed for food and nutrition. The facility census was 51. Findings include: An interview was conducted on 04/14/25 at 9:20 A.M. with Resident #47 who revealed she did not like the taste of the facility food. An observation was conducted on 04/14/25 from 12:45 P.M. to 12:57 P.M. of the kitchen tray line for the lunch meal. [NAME] # 112 had placed a shallow pan of meatloaf on the trayline for the meal service. The meatloaf had burnt edges and [NAME] #112 needed to scrape between the pan and the burnt edges of the meatloaf in order to release pieces of meatloaf. Observation of the mashed potatoes on tray line revealed the mashed potatoes were so runny/watery [NAME] #112 had to serve them with a serving spoon instead of a measured scoop. In addition, [NAME] #112 was serving rice that had a clumped, ball-like shape when scooped onto the plate. [NAME] #112 verified the findings at the time of the observation. An observation of a test tray on 04/14/25 revealed the test tray was plated and left the kitchen at 1:20 P.M., and arrived to the Cascade unit at 1:22 P.M. Certified Dietary Manager (CDM) #132 removed the test tray after the other trays were passed and obtained food temperatures using a calibrated thermometer used by the facility. The food temperatures were at acceptable temperatures for point of service ranging between 135 to 138 degrees Fahrenheit. The appearance of the food on the plate revealed burnt meatloaf pieces instead of an intact slice of meatloaf. The mashed potatoes looked watery and had spilled over three-quarters of the plate, touching other food items making the presentation unappetizing. A taste of the meatloaf revealed hard burnt edges and the mashed potato tasted watery with no spice and improper consistency. An interview on 04/14/25 at 1:25 P.M. with CDM #132 at the time of the test tray observation revealed CDM #132 verified the mashed potatoes lacked flavor and were runny and the meatloaf was burnt and unappetizing in appearance. CDM #132 stated the cook had used the wrong size pan causing the meatloaf to appear flat and more easily burnt during the cooking process. An interview on 04/14/25 at 1:50 P.M. with Resident # 46 revealed he did not eat his lunch because the meat looked different and was not appetizing. An interview on 04/14/25 at 4:37 P.M. with Resident #5 revealed she did not eat the meatloaf served to her at lunch because the meat was burnt, and the rice was overcooked. An interview on 04/16 /25 at 2:30 P.M. with the Administrator revealed the facility did not have a policy or procedure for food palatability. This deficiency represents non-compliance investigated under Complaint Number OH00164096.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, interview, record review and review of facility policy the facility failed to ensure staff performed hand hygiene and implemented proper glove use during medication administration for Resident #6, Resident #13, and Resident #22, and failed to disinfect the glucometer after using it to check Resident #13's blood sugar. This affected three residents (#6, #13 and #22) out of six residents reviewed for medication administration. In addition, the facility failed to ensure staff donned appropriate personal protective equipment (PPE) during wound care for Resident #47. This affected one resident (Resident #47) out of three residents reviewed for wound care. The facility census was 51 Findings include: 1. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including hypertensive heart disease, bipolar disorder, hypothyroidism, benign prostatic hyperplasia, gastroesophageal reflux disease, vitamin D deficiency, chronic pain syndrome, restless leg syndrome, anemia, constipation, hyperlipidemia, asthma, diabetes mellitus with diabetic neuropathy, and chronic obstructive pulmonary disease, and diverticulosis. 2. Review of the medical record for Resident #6 revealed an admitted [DATE] and readmitted on [DATE] with diagnoses including chronic pain syndrome, anemia in chronic kidney disease, insomnia, heart/respiratory failure, hyperlipidemia, high blood pressure, diabetes mellitus with diabetic neuropathy, morbid obesity, lymphedema, obstructive sleep apnea, adjustment disorder with anxiety, delusional disorder, gout, and chronic pansinusitis. An observation was conducted of Registered Nurse (RN) #61 on 04/14/25 at 7:58 A.M. administering medications to Resident #13 and Resident #6, and obtaining Resident #13's blood sugar. After RN #61 completed medication administration to Resident #28, RN #61 did not perform hand hygiene and proceeded to don a pair of gloves and obtained Resident #13's blood sugar. After obtaining Resident #13's blood sugar, RN #61 removed her gloves, did not perform hand hygiene and obtained Resident #13's Basaglar insulin pen from the medication cart. RN #61 administered the insulin (Basaglar insulin 30 units) subcutaneously in Resident #13's left upper arm. RN #61 did not don a pair of gloves or perform hand hygiene prior to administering Resident #13's insulin. After obtaining Resident #13's blood sugar level, RN #61 placed the used glucometer on the medication cart and did not clean/disinfect the glucometer prior to using the glucometer to obtain Resident # 6's blood sugar level. RN #61 did not don a pair of gloves or perform hand hygiene prior to dispensing and administering Basaglar insulin 38 units and Novolog insulin 4 units subcutaneously to Resident #6. An interview with RN #61 on 04/14/25 at 8:55 A.M. verified she failed to perform hand hygiene to prevent possible spread of germs during Resident #13's and Resident #6's medication administration and failed to clean/disinfect the glucometer after obtaining Resident #13's blood sugar and failed to don a pair of gloves prior to administering Resident #13's and Resident #6's insulin subcutaneously. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #22 revealed an admitted [DATE] and re-admitted [DATE] with diagnoses including Alzheimer's disease, fractured right femur, atrial fibrillation, urinary tract infection, malnutrition, osteoarthritis, high blood pressure, benign prostatic hyperplasia, lung cancer, gastroenteritis and diverticulosis. An observation was conducted of Licensed Practical Nurse (LPN) #62 on 04/14/25 at 9:00 A.M. administering medications to Resident #22. LPN #62 had just completed administering medications to Resident #34 and proceeded to obtain Resident #22's medications from the medication cart without performing hand hygiene. LPN #62 dispensed Resident #22's medications in a medication cup, handed the cup to Resident #22 and watched Resident #22 consume the medication. An interview with LPN #62 on 04/14/25 at 9:05 A.M. confirmed she had failed to perform hand hygiene before administering Resident #22's medications. 4. Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses including bullous penphigoid (a rare autoimmune disease that causes blisters or sores on the skin.), morbid obesity, anxiety, depression, insomnia, lymphedema, adult failure to thrive and high blood pressure. Review of a wound assessment dated [DATE] for Resident #47 revealed Resident #47 had severe edema of the lower extremities, and multiple sores and blisters on Resident #47's thighs, abdominal fold, and buttocks. Resident #47's physician order dated 06/25/24 indicated to implement enhanced barrier isolation precautions during resident care tasks. An observation of LPN #130 perform Resident #47's wound treatment revealed a failure to don a gown prior to performing the task. An interview with LPN #130 on 04/16/25 at 10:10 A.M. verified she should have worn a gown during Resident #47's wound treatment procedure for enhanced barrier precautions. A review of the facility policy titled Infection Control: Cleaning and Disinfecting Resident Care Equipment dated 06/2024 indicated using medical devices on more than one person increases the risk of infections. Devices such as blood glucose monitors, blood pressure cuffs, electronic thermometers, and stethoscopes are all devices that can potentially spread infection from one resident to the other. Equipment will be maintained and kept clean or disinfected in accordance with acceptable policies. Manufacturers' recommendations will be followed when cleaning or disinfecting medical equipment. Blood glucose monitors wound be cleaned and disinfected by using germicidal wipes and allow to air dry. A fresh wipe would be used each time a blood glucose monitor was cleaned. Cleanse all surfaces on the top, bottom and sides of the glucometer. A review of the facility policy titled Hand Hygiene dated 12/2024 indicated the policy was for the facility to prioritize hand hygiene with soap and water and/or alcohol based hand sanitizer as a fundamental practice in preventing the spread of infections. All staff must perform hand hygiene before/after resident contact, after removing gloves or personal protective equipment (PPE), after contact with bodily fluids, surface, or contaminated equipment, and before eating and after using the restroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Centers for Disease Control and Prevention (CDC) guidelines for use of enhanced barrier precautions in skilled nursing facilities dated 06/2021 indicated multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to significant morbidity and mortality for residents and increased costs for the health care system. Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce the transmission of staphylococcus aureus and MDROs EBP should be applied to residents with wounds, indwelling medical devices, regardless of MDRO colonization status and infection of colonization with a MDRO. Effective implementation of EBP requires staff training on proper use of PPE and availability of PPE with hand hygiene products at the point of care. This deficiency represents non-compliance investigated under Complaint Number OH00164297.