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	11/19/2025

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 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. Based on observation and interviews, the facility failed to maintain resident rooms in a safe and sanitary condition. This affected six residents (#18, #20, #22, #24, #55, and #56) of 12 residents observed for environment. The facility census was 56.Findings include:1. Observation on 09/23/25 at 12:08 P.M. of Resident #18 room revealed numerous stains on carpet. Observation and interview on 09/24/25 at 8:19 A.M. with Administrator confirmed above observations.2. Observation on 09/23/25 at 12:33 P.M. of Resident #20 room revealed a strong odor, the toilet was dirty and a bed pan was on the floor with brown stains. Resident's wheelchair was in bathroom with opened boxes of medical equipment placed on top and other various items including a brief.Observation and interview on 09/23/25 at 12:44 P.M. with CNA #354 confirmed the observations.3. Observation on 09/23/25 at 4:37 P.M. of Resident #24 room revealed a chair with numerous stains, floor boards and walls were dirty and dusty, the floor was extremely sticky, various debris on floor, brown stain around the toilet rim, the walls in bathroom had brown dried stains, numerous holes and dents on the walls, a wet wipe was stuck to the wall. In the kitchen area the shelf underneath the fridge had a brown dried liquid stain and the cabinets had various dried splatter on them. A drawer in the kitchen and a handle on a cabinet were missing. Observation and interview on 09/24/25 at 8:19 A.M. with Administrator confirmed above observations.Observation and interview on 09/25/25 at 3:37 P.M. of Resident #24 with Director of Nursing (DON) present revealed he had been wearing the same clothes for multiple days and said he did not have any clean clothes. Observation of resident's closet revealed the door was unable to be opened fully due to items blocking door. There were six boxes on the ground, a rollator, an oversized teddy bear, clothes and various other items. Multiple clothes in closet appear dirty with brown stains. Observation confirmed with DON #335.4. Observation on 09/24/25 at 9:30 A.M. of Resident #55 room revealed floor was extremely sticky, kitchen cabinets were dirty, a missing drawer in the kitchen, kitchen sink had a large amount of black dirt around rim, debris all around refrigerator, food debris and dried liquid all over wall and brown dirt debris around toilet.Observation and interview on 09/24/25 at 9:52 A.M. with Administrator confirmed above observations.5. Observation on 09/23/25 at 3:32 P.M. of Resident #56 room revealed a dried brown liquid under open shelf below the mini fridge, dirt on the vents of the air-conditioning unit, dust and a brown dried stain on the blinds, dirt and dust on the window seal, dust and stains on the floor boards, splatter on the wall, moldy food in blue container on top of fridge and the floor was sticky. Observation confirmed at 3:51 P.M. by CNA #369 and moldy food was thrown away.Observation and interview on 09/24/25 at 8:19 A.M. with Administrator confirmed above observations.6. Observation and interview on 09/23/25 at 3:57 P.M. with CNA #409 of Resident #22 room revealed numerous dirty dishes in the sink, a moldy cup on the nightstand, sticky dried red Jell-O on the floor with other various debris including a fingernail. Resident revealed they last cleaned her room on 09/19/25 and they swept and mopped the floor. Resident #22 revealed there were flies in her room and her son brought her a Levo fly trap. CNA #409 confirmed these observations. This deficiency represents non-compliance investigated under Complaint Number 2624366.

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
	365826	A. Building B. Wing	11/19/2025

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident and staff interviews, and review of facility policy, the facility failed to ensure residents received adequate nutritional and communication assistance. This affected one Resident (#20) of three reviewed for activities of daily living (ADL's). The facility census was 56.Review of Resident #20's medical record revealed an admission date of 10/01/21. Diagnoses included dementia, dysphagia, psoriatic arthritis, essential hypertension, neuromuscular dysfunction of bladder, anxiety and colostomy. Review of Resident #20 Care Plan dated 04/22/25 revealed resident was at risk for malnutrition and weight loss and required interventions including providing assistance with all meals, snacks and supplements. Resident had a communication impairment with interventions that included using communication tools, terms, gestures the resident can understand.Review of Resident #20 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident required setup or clean-up assistance with eating but was dependent on all other ADL areas. Resident's Brief Interview for Mental Status (BIMS) score was zero, which indicated severe cognitive impairment. Review of Resident #20 Eating task dated 09/11/25 through 09/24/25 revealed resident fluctuates from independent to dependent with eating.Observation on 09/24/25 at 1:20 P. M. revealed Resident #20 trying to open her milk carton. Resident was unable to use built-up silverware fork and was using her hands to eat a corndog and bread. After surveyor intervention, facility staff were aware the resident needed assistance. No communication tools were observed in the resident's room.Observation and interview on 9/25/25 at 08:38 A.M. with Resident #20 revealed resident was eating breakfast and using her hands to eat pieces of French toast. Resident was unable to use built-up silverware spoon to eat cereal. Resident revealed she had cut up food with scissors. Resident #20 was very hard to understand and no communication tools were observed at bedside. Observation and interview on 09/25/25 at 08:42 A.M. with Certified Nursing Assistant (CNA) #364 revealed Resident #20 being unable to feed herself with the spoon. CNA #20 revealed she had cut up the residents food and resident was able to feed herself sometimes. CNA #20 assisted Resident #20 with eating her cereal. CNA #364 revealed Resident #20 can sometimes be hard to understand and she has not seen any communication tools at bedside to assist with understanding what the resident needed.Review of facilities Activities of Daily Living-Highest Level of Functioning Policy with a revised date of 03/2019 revealed the facility is responsible to provide necessary care to all residents who are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition. This deficiency represents non-compliance investigated under Complaint Number 2624366.

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	365826	A. Building B. Wing	11/19/2025

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. (continued on next page)

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	365826	A. Building B. Wing	11/19/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review, observations and interview, the facility failed to provide therapeutic activities in the secured memory care unit to meet the physical, mental and pscyho-social wellbeing of the residents. This affected all 18 residents in the memory care unit. The facility census was 56. Findings include:Observations throughout investigation from 09/23/25 through 10/21/25 on the memory unit revealed activities on the memory care unit not being done as scheduled with memory care residents sitting in common areas with one television on. There was one activity board in the common area but residents were not observed using it. The large common area had multiple single chairs arranged in front of the walls but the space was so large residents could not converse with each other if sitting across from each other. There was a television in the large common area that was never on and only observed the television on in the smaller sitting area. Observation of bingo, magician and musician activities off the memory care unit revealed some memory care residents were taken to the activities, but not all residents were able to leave the memory care unit and there were no additional activities planned for those residents.Review of the activities calendar for October revealed activities on secured memory unit for 10/08/25 included: Sip & Chat at 9:45 A.M., Sittercise at 10:15 A.M., Manicures at 10:30 A.M., Freshen Up at 11:15 A.M., and Baseball Trivia & Games at 2:30 P.M. Observation and interview on 10/08/25 at 10:20 A.M. with Licensed Practical Nurse (LPN) #351 revealed she was not sure why the activity had not started. She thinks there is enough for the most part but that they need an activity aide on the unit everyday, including on 2nd shift due to sundowning behaviors. LPN #351 revealed that the Freshen Up activity is a drink cart and they will have a special coffee creamer or ice cream. She said facility used to have sofas, baby dolls, cribs but they were removed when new management started. Observation on 10/08/25 at 10:25 A.M. revealed AA #406 arrived on secure unit. Sip & Chat started at 10:36 A.M. which included giving residents coffee. Five residents attended activity. The Daily Chronicle was passed out at 10:37 A.M. At 10:38 A.M. LPN #351 brought two more residents to the activity. At 10:45 A.M. AA #406 read the Daily Chronicle followed by a resident reading a few paragraphs. At 11:05 A.M. AA #406 played music. At 11:31 A.M. residents that smoke were taken outside to smoke.Observation on 10/08/25 at 1:45 P.M. on secured memory care unit revealed music playing in large common area and the television was on in the smaller sitting area. Observation at 2:51 P.M. revealed residents coloring and doing a word search. The planned activity of basketball trivia and game was not being done.Interview on 10/08/25 at 2:52 P.M. with LPN #351 revealed the activities calendar is often not followed and she is not sure why. She revealed residents do ask her why they are not doing activities that are posted on the calendar.Interview on 10/08/25 at 2:54 P.M. with AA #406 revealed she thought the residents would enjoy coloring and the word search over the basketball activity. She said they did not do the planned manicure activity today because they did that on Monday.Interview and observation on 10/09/25 at 3:08 P.M. with AA #407 revealed she started working at the facility about two weeks ago. She said activities are divided by the secure memory unit and the non-secured unit and an activity assistant is assigned to each unit. AA #407 is assigned to the non-secure unit. She revealed she does not think there were enough activities on the secured memory care unit and that the calendar was not being followed. Observation of activity closet revealed numerous supplies and AA #407 feels they have enough supplies. Interview on 10/09/25 at 3:48 P.M. with Activity Director (AD) #388 revealed that Sip and Chat is coffee and talking, Sittercise is exercises in chairs, Freshen-Up is helping residents to the bathroom before lunch and the Hydration Station is passing out water or juice to encourage residents to drink. Observation on 10/14/25 at 8:56 A.M. through 11:05 A.M. on secured memory care unit revealed multiple residents in the common area. Two residents were watching television. Review of the October activities calendar revealed Sip & Chat was scheduled for 9:45 A.M. and Craft was scheduled for 10:30 A.M. Sip & Chat started at 10:00 A.M. At 10:25 A.M. AA #406 was reading the Daily Chronicle, followed by Sittercise which involved playing music and doing stretches in chairs. At 11:00 A.M. residents were still listening to music. No observation of the Craft activity being done at 10:30 A.M.Review of October activity calendar for the secured memory care unit for 10/16/25 revealed that Bingo was scheduled for 2:30 P. M. Observation at 2:40 P.M. on secured memory unit revealed no activities being done. Interview on 10/16/25 at 2:40 P.M. with Registered Nurse (RN) #338 revealed residents that are able and wanted to go off unit were taken to bingo on non-secure unit. She does not think there are enough activities on the secure unit. She revealed she does not think Hydration Station should be considered an activity and the activity calendar is not being followed. RN #338 revealed if facility had more activities it would help with the

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	365826	A. Building B. Wing	11/19/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to ensure Resident #55 blood sugar was monitored appropriately. This affected one resident (Resident #55) of three residents reviewed for quality of care. Facility census was 56. Resident #55 was admitted to the facility on [DATE] and had diagnoses including heart failure, type 2 diabetes, atrial fibrillation (abnormal heart rhythm), and low back pain. Resident #55 had an order dated 06/20/25 for a Dexcom G7 Sensor (a wearable continuous blood sugar monitor) for blood sugars every ten days. Review of the Medication Administration Record (MAR) for 08/01/2025 to 08/31/25 revealed on 08/20/25 Resident #55 did not receive the Dexcom G7 Sensor due to being out of the facility without medications and on 08/30/25 nothing was indicated on the MAR; the entry was blank. Review of the MAR for 09/01/25 to 09/30/25 revealed on 09/09/25 and 09/29/25 Resident #55 did not receive the Dexcom G7 Sensor. Resident #55 was not administered the Dexcom G7 Sensor from 08/20/25 to 09/18/25. Review of the progress notes revealed no documentation indicating any further attempts were made to administer the Dexcom G7 Sensor to Resident #55. Interview on 10/07/25 at 10:23 A.M. with the Director of Nursing (DON) #335 verified the above findings. Review of the policy titled Nursing Policies and Procedures: Administration of Drugs dated 06/2019 revealed the following: the facility will administer medications as prescribed by the physician, medications must be administered according to physician orders, all medications must be recorded on the resident's MAR, medications should be administered as scheduled, and if a medication is not given an explanatory note should be entered. This deficiencies represents non-compliance investigated under Complaint Number 2624366.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident #22 received treatment to maintain vision. This affected one resident (Resident #22) of three residents reviewed for vision. The facility census was 56. Review of Resident #22's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic diastolic heart failure, type 2 diabetes mellitus, morbid obesity, asthma, insomnia, major depressive disorder, dry eyes syndrome of bilateral lacrimal glands and bilateral combined forms of age-related cataract.Review of an annual Minimum Data Set (MDS) 3.0 assessment completed on 08/01/25 revealed Resident #22 was alert and oriented with intact cognition. Further review revealed Resident #22 vision was severely impaired.Record review revealed Resident #22 was seen by the eye care consultant on 03/18/25 and recommended following up with ophthalmologist of facility choice for cataract evaluation. Interview on 09/24/25 at 3:57 P.M. with Resident #22 revealed she is unable to see due to having cataracts in both eyes. Resident #22 revealed cataract surgery was recommended by a ophthalmologist but an appointment has not been scheduled.Interview on 09/25/25 at 3:14 P.M. with Receptionist #323 who revealed she had trouble finding an ophthalmologist that took Resident #22 insurance and can accept bariatric patients. Receptionist #323 provided documentation of eight ophthalmologist offices she had contacted during 07/2025 with no further evidence the appointment had been scheduled.

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	365826	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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	365826	A. Building B. Wing	11/19/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure Resident #44 was free from significant medication error. This affected one resident (Resident #44) of three residents reviewed for medications. Findings include:Review of Resident #44's medical record revealed the resident was admitted on [DATE] with diagnoses including multiple sclerosis, epilepsy, seizures, essential hypertension, major depressive disorder, localization-related symptomatic epilepsy and epileptic syndrome with complex partial seizers. Review of the physician order dated 10/30/24 with a revised date of 08/04/25 revealed Resident #44 was prescribed Valtoco 10 milligrams (mg) 1 spray alternating nostrils every 24 hours as needed for seizures. Review of the nurse progress note dated 08/04/25 revealed nurse spoke to Nurse Practitioner (NP) to get a new prescription for the Valtoco seizure medications.Review of the nurse progress notes dated 09/11/25 revealed Resident #44 had a seizure. Nurse notified NP, received an order to send the resident to the emergency room and called resident's family.Review of the Medication Administration Record (MAR) for September 2025 revealed Resident #44 did not receive Valtoco on 09/11/25.Review of hospital notes dated 09/11/25 through 09/14/25 revealed Resident #44 presented to the Emergency Department (ED) for complaints of seizure. Resident #44 was not given seizure medication at the nursing home but received Versed 5 mg by Emergency Medical Services (EMS). Resident was admitted for urinary tract infection, lactic acidosis and seizures. Resident was somnolent upon admission to ED. She had an EKG showing sinus tachycardia. Neurology was consulted and an EEG was ordered. Keppra, Locasamine, and Zonisamide were given for seizure disorder. Further review revealed hospital recommended for social services to follow-up with the facility for polypharmacy compliance. Resident was discharged back to the facility on [DATE].Review of Concern Report dated 09/11/25 revealed residents emergency seizure mediation was on site. Resolution included ordering medication once resident returned from the hospital. Investigation results were reported to resident and family.Review of Resident #44 hospital discharge record dated 09/15/25 revealed the resident was discharged with an order to continue Valtoco 10 milligrams intranasally as needed for seizures.Review of nurse progress note dated 09/16/25 by Director of Nursing (DON) #335 revealed Valtoco was on back order per the pharmacy. DON #335 received a new order for intramuscular (IM) Ativan PRN for seizures until Valtoco was delivered.Review of New Prescription Summary from the pharmacy dated 09/16/25 revealed Valtoco 10 mg was delivered to facility on 09/16/25.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had moderate cognitive impairment and received anticonvulsant medication.Review of Care Plan dated 09/24/25 revealed Resident #44 was on anticonvulsant therapy. Interventions included the administration of anticonvulsant medications as ordered by physician.Interview on 09/23/25 at 9:05 A.M. with Resident #44's family member revealed the Administrator told her the seizure medication had not been reordered.Interview on 09/25/25 at 12:43 P.M. with DON #335 revealed the facility changed pharmacy providers on 08/01/25 and the previous pharmacy had picked up all medications. Resident #44 needed a new prescription due to medication being a controlled substance. DON #35 revealed it is the nurse's responsibility to order medications. DON #335 revealed on 09/16/25 Valtoco 10 mg was on back order at the pharmacy and a prescription for Ativan was ordered as an alternative until Valtoco could be delivered.Interview on 09/30/25 at 2:08 P.M. with Licensed Practical Nurse (LPN) #352 revealed Valtoco 10 mg was not available on 09/11/25 and Resident #44 was not given any medication by mouth due to her having a seizure. LPN #352 revealed EMS gave Resident #44 a shot and she stopped seizing for a few seconds, but then started seizing again and was taken to the hospital. Interview on 09/25/25 at 5:30 P.M. with the Administrator revealed Resident #44 did not have Valtoco available for administration from 08/01/25 through 09/16/25.Review of facility policy Administration of Drugs with a revised date of 06/2019 revealed medications must be administered in accordance with the written orders of the ordering/prescription physician.This deficiency represents non-compliance investigated under Complaint Number 2644009, 2624366, and 2618865.

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	11/19/2025

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Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and policy review the facility failed to ensure medications were labeled, unexpired, and stored in an appropriate manner. This had the potential to affect all residents served from two of two storage rooms, two of two treatment carts, and two of three medication carts available for medication storage in the facility.Findings include:1.Observation of the facility medication storage rooms and [NAME] Unit treatment cart on 09/30/25 at 9:51 A.M. to 10:27 A.M. with the Assistant Director of Nursing revealed the following:The medication storage room in the [NAME] Unit contained (1) bottle of Children's Flonase 0.38fl oz expired on 04/2025 and (4) Zyno Medical administration sets (tubing used for intravenous (IV) medication) expired on 01/25/25.The [NAME] treatment cart contained (15) packets Procure triple antibiotic ointment 0.9 grams and an opened (1) DermaRite 4x4 xeroform gauze (medicated gauze used in wound treatment).The medication storage room in the Cascade Unit contained an opened box of Monject filter needles (a needle used to withdraw medications from glass ampules) expired on 07/01/25 and ICU Medical sterile caps expired on 11/01/24 (1) and 01/01/25 (2). The above findings were verified with the ADON at the time of observation. Review of the policy titled Nursing Policy and Procedure: Medication Storage dated 11/24 revealed medications that are in containers without secure or contaminated are to be removed from inventory and disposed of according to procedure, and all expired medications will be removed from supply and destroyed. 2. Observation of the medication carts and treatment carts on 09/30/25 at 11:28 A.M. to 12:06 P.M. with the Director of Nursing (DON) revealed the following:The [NAME] Unit medication cart contained Assure blood glucose control high and low expired on 02/23/25, (28) Hyoscyamine 0.125 milligrams (mg) (to treat stomach disorders) PRN (as needed) expired on 09/25/25, (4) tramadol (a narcotic pain reliever) 50mg expired 08/15/25.The Cascade unit treatment cart contained a small piece of opened xeroform gauze, a box of expired Dynamerx iodine prep pads (for skin), opened (1) DermaRite 4x4 xeroform gauze, opened (2) DermaRite 4x4 hydrogel gauze (medicated gauze used for wound care), and opened (1) DermaGinate/AG 4x8 dressing (a medicated dressing used for wound care).The above findings were verified with the DON at time of observation. Review of the policy titled Nursing Policy and Procedure: Medication Storage dated 11/24 revealed medications that are in containers without secure or contaminated are to be removed from inventory and disposed of according to procedure, and all expired medications will be removed from supply and destroyed.

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	11/19/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and facility policy, the facility failed to provide food at appetizing temperatures. This had the potential to affect 55 of 56 residents as the facility identified Resident #17 as receiving no food by mouth. Facility census was 56.Findings include:Review of Resident Council dated 06/26/25 revealed complaint that Certified Nursing Assistants (CNA) are only passing their assigned resident trays which results in food sitting for a long time. There was no evidence of the resolution to the council minutes following the June 2025 meeting.Interview on 09/24/25 at 3:32 P.M. with Resident #56 revealed she usually eats meals in her room and food is not always warm.Interview on 09/24/25 at 9:30 A.M. with Resident #55 revealed the dining room is not open so he usually eats in his room and the food is sometimes not warm.A test tray was plated on 09/23/25 at 6:13 P.M. and arrived on the Buckeye Hall at 6:17 P.M. Test tray was completed at 6:34 P.M., after all room trays were served. The food was not at the appropriate temperature. The pasta was 122.4 degrees Fahrenheit (F), the raspberry applesauce was 61 degrees F. Temperatures were verified with Dietary Manager #393. Each food item was tasted and the pasta was lukewarm. Both the pasta and raspberry applesauce tasted appetizing.Interview on 09/23/25 at 6:46 P.M. with the Dietary Manager #393 and Administrator joining the interview revealed they checked the food temps in the kitchen and plated everything fast, and the issue with hall trays being passed was because it took over 20 minutes to pass out 13 trays. Dietary Manager #393 revealed she asked everyone to help and there was just no sense of urgency with the other staff. Dietary Manager #393 revealed she was aware of issues with cold food. Review of facilities Nutrition Services Policy not dated revealed that food temperatures would be maintained at acceptable levels during food storage, preparation, holding, serving, delivery, cooling and reheating.This deficiency represents non-compliance investigated under Complaint Number 2624366.

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	11/19/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review the facility failed to ensure appropriate infection control procedures were followed. This affected three residents (Resident #18 Resident #20, and Resident #52) out of three residents reviewed for infection control procedures. The facility census was 56.1.Review of Resident #20's medical record revealed an admission date of 10/01/21. Diagnoses included dementia, dysphagia, psoriatic arthritis, essential hypertension, neuromuscular dysfunction of bladder, anxiety and colostomy. Review of Resident #20's physician order dated 12/16/24 for Enhanced Barrier Precautions (EBP) revealed orders for protective personal equipment (PPE): gloves/gown during high-contact resident care activities. Review of Resident #20 Care Plan dated 04/22/25 revealed resident was at risk for malnutrition and weight loss and required the use of an ostomy. Review of Resident #20 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident required setup or clean-up assistance with eating but was dependent on all other ADL areas. Resident's Brief Interview for Mental Status (BIMS) score was zero, which indicated severe cognitive impairment. Observation on 09/23/25 at 12:33 P.M. of Resident #20 room revealed an EBP sign observed on door. The room revealed a strong odor of feces. Resident #20 was asking for help repeatedly and was difficult to understand, but said she had not been changed in two days. Resident #20's hospital gown was stained brown and wet from the ostomy bag leaking. Resident #20's call light was wrapped around bed frame and out of reach for resident and the resident said she could not reach call light. After surveyor intervention, the call light was pressed at 12:38 P.M. and Certified Nursing Assistant (CNA) #354 answered call light at 12:44 P.M. Interview on 09/23/25 at 12:44 P.M. with CNA #354 revealed she had changed Resident #20 45 minutes prior. CNA #354 at this time checked the ostomy bag and it was leaking from the top. CNA #354 went to get nurse to assist. At 12:55 P.M. Unit Manager (UM) #337 entered room, left the room to get supplies and returned with supplies. Observation of CNA #354 and UM #337 wearing gloves while changing ostomy bag and resident. Observation and interview on 09/23/25 at 1:04 PM of UM #337 leaving Resident #20 room with gloves on her hands. UM #337 revealed she did not wear a gown while changing the resident but should have since the resident was on EBP. Review of facilities Enhanced Barrier Precautions Policy dated 03/24 revealed: When EBP are indicated, EBP should be employed for the following high-contact resident care activities: Dressing, bathing/showering, transferring, providing hygiene, changing briefs, assisting with toileting, device care, and wound care. 2. Review of Resident #18's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses include congestive heart failure, coronary artery disease, acute transverse myelitis (a nerve disease), and diabetes type two. (continued on next page)

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	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18 was cognitively intact, dependent on staff for toileting, and was frequently incontinent of bowel and bladder. Observation of incontinence care for Resident #18 with Certified Nurse Assistant (CNA) #364 and CNA #373 was made on 09/25/24 at 2:35 P.M. Supplies were already gathered before entering the resident room. After hand hygiene was completed and gloves donned a bedside table was moved next to the bed and supplies including a basin, pack of wipes, a towel and multiple washcloths were set down on top of it, the table was not cleaned or was a barrier placed before supplies were set down. During perineal care CNA #364 took the pack of wipes from the bedside table and placed them directly on top of Resident #18's bed. Before resident was turned to the right-side CNA #364 removed gloves and donned a new pair without any hand hygiene. Interview with CNA #364 on 09/25/25 at 2:56 P.M. verified the above findings. Review of the policy titled Perineal Care, dated 12/23 revealed perineal care will be provided in a manner that reduces the risk of infection and soiled gloves should be removed before applying a clean brief followed by hand hygiene before donning new gloves. 3.Review of Resident #52's medical record revealed they were admitted to the facility on [DATE]. Diagnoses include sepsis, mild neurocognitive disorder, schizoaffective disorder, diabetes mellitus type two, chronic obstructive pulmonary disease (a lung disorder), and anxiety disorder. Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #52 was cognitively impaired and required moderate to maximal assistance for activities of daily living. Review of the physician order dated 09/28/25 revealed Resident #52 had an order to clean the left lateral ankle with normal saline and then apply a dry dressing every shift and as needed. Observation of wound care for Resident #52 with Licensed Practical Nurse (LPN) #350 on 09/29/25 at 3:00 P.M. revealed supplies were gathered prior to the procedure. Hand hygiene was completed prior to the procedure starting. Supplies were set onto the bedside table without the table being cleaned or a barrier placed before supplies were set down the procedure. The wound care procedure was then completed. Interview with LPN #350 on 09/29/25 at 3:05 P.M. verified the bedside table was not cleaned or a barrier placed before supplies were set on it. Review of the policy titled Nursing Policies and Procedures Dressing Change: Wound dated 06/2019 revealed the facility will follow general infection control principles during dressing changes. This deficiency represents non-compliance investigated under Complaint Number 2624366.