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	03/03/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, interview with the staff, and review of the facility policy, the facility failed to knock on the door before entering the room of Resident #26. This affected one resident (Resident #26) of five residents observed during medication administration.Findings Include:Review of the medical record revealed Resident #26 was admitted to the facility on [DATE]. Diagnoses included schizoaffective disorder, visual loss, mood disorder, psychosis, prediabetes, toxic effect of carbon monoxide, cocaine dependence, major depressive disorder, homelessness, adult failure to thrive and post-traumatic stress disorder.Observation on 02/25/26 at 9:00 A.M. revealed Licensed Practical Nurse (LPN) #133 prepared the medication for Resident #26 at the medication cart in the hallway and then walked right into his room without knocking on the door. An interview at this time with LPN #133 verified she had not knocked on the door or waited for a response before entering the room of Resident #26.Review of the facility policy titled, Privacy-Resident ' s Right for, dated 06/19 revealed the facility staff would provide the resident with his/her right to privacy and security. The staff would knock on doors for permission to enter.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure the bathroom of Resident #10 was maintained in a safe, comfortable manner. This affected one resident (Resident #10) of eight residents observed for environment.Findings Include:Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, severe protein calorie malnutrition, peripheral vascular disease, hypertension, depression, chronic kidney disease, and left eye blindness.Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #10 had moderately impaired cognition, no psychosis, and no behaviors. The assessment stated the resident required setup or clean-up assistance for toileting and she was occasionally incontinent of urine and always continent of bowel.Observation on 02/25/26 at 11:10 A.M. revealed in the bathroom of Resident #10 there were two softball size holes in the wall where the baseboard was missing under the sink exposing the interior of the wall.Observations on 02/26/26 at 10:15 A.M. with Director of Support Services #132 revealed two soft ball size holes in the wall of the bathroom for Resident #10. An interview at this time revealed he was not aware of the holes in the wall, and he could not fix something he did not know about. He stated he did not do environmental rounds.On 02/26/26 at 12:45 P.M. an interview with the Administrator revealed the facility did not perform regular environmental round however they did walk around the building daily and noticed when things needed fixed.This deficiency represents non-compliance investigated under Complaint Number 2743199.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview, the facility failed to ensure accurate acquiring, receiving, dispensing, and administering of Resident #32's eye drops. This affected one resident (Resident #32) of three reviewed for administering medication per physician's orders.Findings Include:Review of the medical record revealed Resident #32 was admitted to the facility on [DATE]. Diagnoses included heart failure, protein-calorie malnutrition, nontraumatic subdural hemorrhage, Wernicke's encephalopathy, macular degeneration, cataracts, diverticulosis, alcohol abuse, fatty liver, hypothyroidism, pancreatitis, and adrenal gland disorder.Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #32 had intact cognition.Further review of the medical record revealed Resident #32 had cataract surgery on 02/25/26.Review of the post operation orders dated 02/25/26 revealed Resident #32 was to start Prednisone 1.0 percent (%) ophthalmic drops with instructions to administer four drops in the left eye once daily for post cataract surgery until 03/04/26, Ketorolac Tromethamine ophthalmic 0.5% drops with instructions to administer one drop to the left eye four times daily for post eye surgery until 03/03/36, and Moxifloxacin ophthalmic 0.5% drops with instructions to administer one drop in the left eye three times daily until 03/01/26.Review of the February 2026 medication administration record (MAR) revealed Resident #32 had not received his Prednisone, Ketorolac, or Moxifloxacin eye drops on 02/25/26 at 4:00 P.M. and 8:00 P.M. and on 02/26/26 at 8:00 A.M.On 02/25/26 at 2:15 P.M. an interview with Resident #32 revealed he was to start eye drops two hours after surgery. He stated the office did not send the drops with him, but he gave the paperwork to the staff.On 02/26/26 at 9:35 A.M. an interview with the Director of Nursing revealed the facility did not get the eye drops in for Resident #32 the night before and someone called the pharmacy to have them drop shipped this morning.On 02/26/26 at 9:50 A.M. an interview with Resident #32 revealed he had not had any of his eye drops yet. He stated he was told by the nurse his eye drops were delivered around 4:00 PM last night [indicating 02/25/26] and whoever signed for them did not place them in the medication cart, so they do not know where they were at. He mentioned he better not get an infection in his eye.On 02/26/26 at 10:10 A.M. an interview with Licensed Practical Nurse #135 revealed she had not administered the eye drops to Resident #32 yet and she was going to do that now that they found them.On 02/26/26 at 10:25 A.M. an interview with Licensed Practical Nurse #101 revealed the eyedrops for Resident #32 were delivered the night before [02/25/26] around 4:00 P.M. by the hospital pharmacy, not their normal pharmacy. She stated the staff member who received the medication placed them in the wrong medication cart. The nurse working had not known they had been delivered so they were never started. She verified Resident #32 had just received his first eye drops on 02/26/26 at 10:20 A.M. and they were not given as order even after they were delivered.On 02/26/26 at 3:00 P.M. an interview with Surgery Staff #300 revealed Resident #32 was in the office the day before for cataract surgery and they were not aware they were to send the prescriptions with him when he left. She stated they sent them to the pharmacy they had on file. She stated the facility called them for the prescription and that was when they realized they sent the prescription to his old pharmacy they had on file. She stated when they realized the mistake they had the prescription filled at the hospital pharmacy and the lead nurse took them personally to the facility and dropped them off around 4:00 to 4:30 P.M. on 02/25/26.This deficiency represents non-compliance investigated under Complaint Number 2747670.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, review of the facility menus, interview with staff, and review of facility policy, the facility failed to follow the lunch menu for the residents. This affected all 63 residents in the facility who received their meals from the dining room. The facility census was 63.Findings Include:Review of the menu for 02/25/26 revealed the facility was to serve a corn dog, cheesy mashed potatoes, mixed vegetables, white bread and yellow cake for lunch.Observation of meal service on 02/25/26 at 11:40 A.M. revealed [NAME] #130 was serving corn dogs, regular mashed potatoes, mixed vegetables and vanilla pudding. There was no cheese in the mashed potatoes, no bread was given to the residents and they did not have yellow cake.On 02/25/26 at 12:15 P.M. an interview with [NAME] #130 revealed she did not make the mashed potatoes cheesy and there was not a reason why she did not. She stated they did not have the yellow cake, so they were serving pudding instead and verified they forgot to give the residents bread.On 02/25/26 at 4:15 P.M. an interview with Corporate Dietary Manager #128 stated she was not aware they did not serve cheesy potatoes or bread for the lunch meal. She stated she did know they had not made the yellow cake and substituted the pudding. She sated the cook the night before did not make the cake so they could not serve it. She verified they did have the yellow cake in stock to make; it just was not made.Review of the facility policy titled, Menus, dated 06/2019 revealed menus would be planned to meet the nutritional needs and preferences of the residents and were in accordance with the recommended dietary allowances of the Food and Nutritional Board of National Research Council, National Academy of Sciences. It noted the facility would make appropriate substitutions when items on the menu were not available and to record these substitutions and keep the records on file with the menus. Substitutions offered were to be similar in nutritional values to the food being offered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, and review of facility policy, the facility failed to maintain a safe sanitary kitchen. This affected all 63 residents who ate their meals from the facility kitchen. The facility census was 63.Findings Include: Observations of the kitchen with Corporate Dietary Manager #128 on 02/25/26 at 10:10 A.M. revealed the following concerns:a. There were two 50-gallon trash cans with no lids on them. b. The utensil drawer with the scoops and ladles had a red, sticky substance spilled down inside the drawer with the scoops and ladles laying in it.c. The stainless stain shelf under the steam table had food and a yellow liquid spilled on it.d. There were three three-tiered red food carts which were soiled with food debris and a white liquid dried on them.e. Two-large tubs of rice crispy cereal were not labeled as to when they were opened.f. Two five-pound packages of semi frozen tubes of hamburger were in the stainless stain sink soaking in warm water.g. The dry storage had several pieces of cardboard and paper littering the floor.h. In the refrigerator there was a small square stainless steel pan with something white and hard in it without a label as to identify it or when it was made, a bag of lettuce open to air with no date when opened, a bag of bacon bits was observed as not dated when opened, and the Reach-In refrigerator #2 had a large round container and three pitchers of a red liquid with no date or identifying label.Interviews with Corporate Dietary Manager #128 throughout the tour of the kitchen verified the above findings.Observation on 02/25/26 at 12:15 P.M. revealed the two five-pound tubes of hamburger were still in the sink defrosting in stagnant cool water.Observation on 02/25/26 at 2:35 P.M. with Corporate Dietary Manager #128 revealed the two five-pound tubes of hamburger were out of the water just sitting on the sink, they were cool to touch. [NAME] #130 took the temperature of the hamburger, with Corporate Dietary Manger #128 and Dietary Manager #131 watching, which revealed the temperature of the first tube was 57.8 degrees Fahrenheit (F) and the second roll was 49.8 degrees F. Corporate Dietary Manager #128 verified the temperature was not safe and told Dietary Manager #131 they had to throw the meat away because it was not safe to consume. Dietary Manager #131 asked what they were supposed to do for supper because he did not have any more hamburger to use, she stated they would just have to make meatless spaghettis sauce.Review of the facility policy titled, Food Safety in Receiving and Storage, dated 08/12/19 revealed food would be received and stored by methods to minimize contamination and bacteria growth. It stated to place food that was repackaged on a leak-proof, pest-proof, non-absorbent, sanitary container with a tight-fitting lid and label both the container and its lid with the common name of the contents and the date it was transferred to the new container.Review of the facility policy titled, Sanitation and Food Safety in Food Service. dated 06/2019 revealed the Nutrition/Culinary Service Director (NSD) would assume responsibility for the food safety and sanitation of the Nutrition Culinary Department. The NSD developed, implemented, and monitored a cleaning schedule that assigned specific cleaning responsibilities to specific individuals.

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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, review of the medical record, interview, and review of facility policies, the facility failed to maintain appropriate infection control while administering medication to Resident #21 and #26 and failed to ensure feces-soiled linens were properly contained during care for Resident #20. This affected three residents (Resident #20, #21, and #26) of eight observed for infection control and medication administration.Findings Include:1. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE]. Diagnoses included schizoaffective disorder, visual loss, mood disorder, psychosis. Prediabetes, toxic effect of carbon monoxide, cocaine dependence, major depressive disorder, homelessness, adult failure to thrive and post-traumatic stress disorder.Observation of medication administration on 02/25/26 at 9:00 A.M. revealed Agency Licensed Practical Nurse (LPN) #133 popped an Amlodipine 5 milligram (mg) tablet out of the card into her bare hand and placed the tablet into the medication cup. LPN #133 was stopped by the surveyor and an interview at this time with LPN #133 verified she touched the tablet with her bare hands and planned to administer the medications to the resident.2. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, atrial fibrillation, heart failure, depression, and cerebral infarction.Observation of medication administration on 02/25/25 at 9:05 A.M. revealed Licensed Practical Nurse (LPN) #127 poured an Aspirin 81 milligrams from the bottle into her bare hand and placed it into a medication cup then she popped a Carvedilol 25 milligrams and Eliquis 5.0 milligrams from the cards into her bare hand and placed the tablets into the medication cup. LPN #127 was stopped by the surveyor and an interview at this time with LPN #127 verified she touched the tablets with her bare hands and planned to administer the medications to the resident.3. Review of the medical record revealed Resident #20 was admitted to the facility 02/20/26. Diagnoses included chronic obstructive pulmonary disease, solitary pulmonary nodule, anxiety disease, and respiratory failure.Observation during the initial tour on 02/25/26 at 8:42 A.M. revealed the door was open on the room of Resident #20 and Certified Nursing Assistant #109 was brushing the resident's hair. There was a hand towel and a blue disposable pad lying directly on the floor and both were heavily soiled with feces. An interview at this time with Certified Nursing Assistant #109 verified the feces soiled items should not have been placed directly on the floor without a barrier down or in a plastic bag.Review of the facility policy titled, Laundry Services, dated 02/2022 revealed the purpose of the policy was to ensure adequate and clean supply of linens and to ensure occupation hazard safety for laundry service employes. Soiled linens should be handled as little as possible with minimal agitation to prevent gross microbial contamination of air and persons handling the linens. Standard precautions would be used by clinical staff handling the linens. All soiled linen would be bagged or placed in carts at the location where the resident was cared for. It further stated linens saturated in blood or body fluids should be placed in a biohazard bag.