| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365826 | A. Building<br>B. Wing | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Continuing Healthcare of Cuyahoga Falls | 300 East Bath Road<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to report an injury of unknown origin to the State Agency for Resident #18. This affected one (Resident #18) of three residents reviewed for reporting alleged violations. The facility census was 55. Findings include:Review of the medical record of Resident #18 revealed an admission date of 06/07/22 with diagnoses including cerebral infarction (stroke), diabetes mellitus, hypertension, heart failure and need for personal assistance. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18's cognition was intact, he had no behaviors and had an impairment on one side of his body. Review of the nursing progress note dated 01/05/26 at 6:38 P.M. by Licensed Practical Nurse (LPN) #602 for Resident #18 revealed during breakfast an aide had noted he had swelling to the right side of his face. She stated she assessed him and noted his right top eye lid was swollen, resident cheeks were swollen and reddened. LPN #602 asked Resident #18 how he sustained the swollen and reddened eye and cheeks and he stated he did not know and he was not in pain. LPN #602 updated the Director of Nursing (DON) and the physician and received new orders. The nursing progress note did not state what the new orders were. Review of the progress note dated 01/06/26 by Nurse Practitioner (NP) #607 for Resident #18 revealed he was found to have a scab by his right eyebrow with swelling around his right eye and down into his cheek. She stated he was started on Clindamycin (antibiotic) 300 milligrams three times a day for seven days. NP #607 stated his face appeared less swollen and there was no pain or itching per the resident. It was noted Resident #18 was having some difficulty with vision out of his right eye due to the swelling of his eyelid. NP #607 stated Resident #18 had facial cellulitis (painful facial redness, swelling and warmth that is caused by bacteria entering through skin breaks or dental infections. Causes are usually skin trauma including cuts, scratches, insect bites, animal bites; dental infections or infection conditions such as acnes or boils). Interview on 03/30/26 at 9:33 A.M. with LPN #602 revealed she was on duty on 01/05/26 and was the nurse who assessed Resident #18's right eye. She stated an aide came to her and stated his eye had a scab and was swollen. She stated she spoke to Resident #18 who stated he did not know what had happened to his eye. She stated she updated NP #607 and the DON. LPN #602 stated NP #602 had ordered an antibiotic and would see the resident the following day. LPN #602 stated facility management had not interviewed her related to what had happened to Resident #18's eye and she had not performed an investigation as to how he had the scab or swelling. LPN #602 denied asking other staff how Resident #18 obtained the injury to his face. Interview on 03/30/26 at 9:36 A.M. with Resident #18 revealed he could recall that he had a scab and swelling to his right eye previously, a few months ago. He stated he could not remember how it had happened as his memory was bad because he had three strokes. Resident #18 stated he could not remember if he had ever been physically or verbally abused. Interview on 03/30/26 at 10:50 A.M. with the Administrator revealed she was not made aware of the area to Resident #18's right eye and possible injury of unknown origin. She stated she had not reported it to the State Agency or investigated the possibility of an injury of unknown origin. Interview on 04/08/26 at 2:01 P.M. with NP #607 revealed on 01/05/26 LPN #602 had<br>(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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| Continuing Healthcare of Cuyahoga Falls | 300 East Bath Road<br>Cuyahoga Falls, OH 44223 |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | called and described Resident #18's face to her. She stated she had started an antibiotic and then assessed him on her next visit which was 01/06/26. NP #607 stated she is not aware of what happened to Resident #18's face just that he had a scab above his eyebrow, his right eyelid was swollen as well as his cheeks. She stated Resident #18 did not have a history of cellulitis or injuries. Review of the facility policy titled, Abuse, Neglect, and Exploitation Prohibition, revised October 2024, defined injury of unknown course as a physical injury observed on a resident where the cause or origin could not be readily determined or explained. The policy stated the facility would conduct a timely investigation of any alleged injuries of unknown origin. The investigation should include gathering evidence, interviewing witnesses, conducting surveys as indicated, reviewing medical records and examining relevant documentation. The investigation findings would then be documented on appropriate state forms as applicable. This deficiency represents non-compliance investigated under Complaint Number 2963714. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Continuing Healthcare of Cuyahoga Falls | 300 East Bath Road<br>Cuyahoga Falls, OH 44223 |

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|---|---|
| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to investigate an injury of unknown origin for Resident #18. This affected one (Resident #18) of three residents reviewed for investigation. The facility census was 55. Findings include:Review of the medical record of Resident #18 revealed an admission date of 06/07/22 with diagnoses including cerebral infarction (stroke), diabetes mellitus, hypertension, heart failure and need for personal assistance. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18's cognition was intact, he had no behaviors and had an impairment on one side of his body. Review of the nursing progress note dated 01/05/26 at 6:38 P.M. by Licensed Practical Nurse (LPN) #602 for Resident #18 revealed during breakfast an aide had noted he had swelling to the right side of his face. She stated she assessed him and noted his right top eye lid was swollen, resident cheeks were swollen and reddened. LPN #602 asked Resident #18 how he sustained the swollen and reddened eye and cheeks and he stated he did not know and he was not in pain. LPN #602 updated the Director of Nursing (DON) and the physician and received new orders. The nursing progress note did not state what the new orders were. Review of the progress note dated 01/06/26 by Nurse Practitioner (NP) #607 for Resident #18 revealed he was found to have a scab by his right eyebrow with swelling around his right eye and down into his cheek. She stated he was started on Clindamycin (antibiotic) 300 milligrams three times a day for seven days. NP #607 stated his face appeared less swollen and there was no pain or itching per the resident. It was noted Resident #18 was having some difficulty with vision out of his right eye due to the swelling of his eyelid. NP #607 stated Resident #18 had facial cellulitis (painful facial redness, swelling and warmth that is caused by bacteria entering through skin breaks or dental infections. Causes are usually skin trauma including cuts, scratches, insect bites, animal bites; dental infections or infection conditions such as acnes or boils). Interview on 03/30/26 at 9:33 A.M. with LPN #602 revealed she was on duty on 01/05/26 and was the nurse who assessed Resident #18's right eye. She stated an aide came to her and stated his eye had a scab and was swollen. She stated she spoke to Resident #18 who stated he did not know what had happened to his eye. She stated she updated NP #607 and the DON. LPN #602 stated NP #602 had ordered an antibiotic and would see the resident the following day. LPN #602 stated facility management had not interviewed her related to what had happened to Resident #18's eye and she had not performed an investigation as to how he had the scab or swelling. LPN #602 denied asking other staff how Resident #18 obtained the injury to his face. Interview on 03/30/26 at 9:36 A.M. with Resident #18 revealed he could recall that he had a scab and swelling to his right eye previously, a few months ago. He stated he could not remember how it had happened as his memory was bad because he had three strokes. Resident #18 stated he could not remember if he had ever been physically or verbally abused by staff. Interview on 03/30/26 at 10:50 A.M. with the Administrator revealed she was not made aware of the area to Resident #18's right eye and possible injury of unknown origin. She stated she had not reported it to the State Agency or investigated the incident as an injury of unknown origin. Interview on 04/08/26 at 2:01 P.M. with NP #607 revealed on 01/05/26 LPN #602 had called and described Resident #18's face to her. She stated she had started an antibiotic and then assessed him on her next visit which was 01/06/26. NP #607 stated she is not aware of what happened to Resident #18's face just that he had a scab above his eyebrow, his right eyelid was swollen as well as his cheeks. She stated Resident #18 did not have a history of cellulitis or injuries. Review of the facility policy titled, Abuse, Neglect, and Exploitation Prohibition, revised October 2024, defined injury of unknown course as a physical injury observed on a resident where the cause or origin could not be readily determined or explained. The policy stated the facility would conduct a timely investigation of any alleged injuries of unknown origin. The investigation should include gathering evidence, interviewing witnesses, conducting surveys as indicated, reviewing medical records and examining relevant<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 365826 | A. Building<br>B. Wing | 04/10/2026 |

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| Continuing Healthcare of Cuyahoga Falls | 300 East Bath Road<br>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.

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|---|---|
| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | documentation. The investigation findings would then be documented on appropriate state forms as applicable. This deficiency represents non-compliance investigated under Complaint Number 2963714. |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure Resident #56's immediate discharge was documented accurately and included in the medical record. This affected one resident (Resident #56) of one resident reviewed for discharge. The facility census was 55. Findings Include:Resident #56 was admitted to the facility on [DATE] with diagnoses including vascular dementia severe without behavioral disturbance, major depressive disorder, alcohol dependence with alcohol induced persisting dementia, anxiety disorder, restlessness and agitation, and generalized anxiety disorder. The resident was transported to the hospital on [DATE] with no information regarding if the resident was admitted , transferred, or discharged .Review of the physician's orders for Resident #56 revealed on 01/29/26 and order was written for Depakote 125 milligrams (mg) (an anticonvulsant used as a mood stabilizer) three capsules given three times a day for vascular dementia, 02/01/26 an order was written for Zyprexa (an antipsychotic medication) 5 mg twice a day for vascular dementia, 02/23/26 an order was written for Ativan (an antianxiety medication) 1 mg four times a day for vascular dementia, 02/25/26 an order was written for Rexulti (an antipsychotic medication used to treat major depressive disorder, schizophrenia, or agitation associated with dementia due to Alzheimer's disease) 1 mg daily for vascular dementia, and an order was written on 01/30/26 for the resident to reside on the secured unit.Review of the quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 03/07/26, revealed Resident #56 was severely cognitively impaired. He exhibited behaviors of hallucinations, delusions, physical behaviors directed towards others for one to three days of the assessment period. He also exhibited behavioral symptoms not directed toward others for one to three days. He rejected care and wandered for one to three days of the assessment period. The resident required maximum assistance of staff for all personal care except eating.Review of the nursing progress notes from admission through discharge revealed Resident #56 exhibited increased agitation since admission. He wandered into other residents room putting clothes and other items in the toilets and exhibited exit seeking behaviors. The resident would become very aggressive and refuse medications. When staff redirected the resident from other residents rooms he would become very agitated and be very confused, spoke in a loud voice, and appeared more confused. On 12/16/25 at 7:14 A.M. Licensed Practical Nurse (LPN) #582 documented in the nursing progress notes Resident whipped his [NAME] out and urinated on the floor and wall. Staff intervened and provided redirection and assistance. And ensured the area was clean and disinfected. Incident was reported to nursing management. This behavior continued throughout his admission. Staff would find Resident #56 in female residents rooms, naked, and engaging in inappropriate sexual behavior on the female resident's bed. He would defecate in the hallways and attempt to rub feces on other residents. On 12/19/25 the resident was transferred for a psychiatric evaluation as the nurse practitioner said the facility was unable to manage his behaviors. The behaviors exhibited were anxiety, aggression, exit seeking, and being sexually aggressive with females on the secured unit as well as towards staff. The facility readmitted Resident #56 on 01/15/26 where he was placed on one to one supervision and placed on an unsecured unit due to a Covid-19 outbreak on the secured unit. Upon arrival the resident again started wandering into female residents rooms. On 01/19/26 the facility was again able to return to the secured unit where he remained on one to one supervision. His exit seeking behaviors continued as did entering female residents rooms. Resident #56 was again transferred for psychiatric evaluation 01/21/26 when the resident demonstrated combative behavior and aggression resulting in a self-inflicted injury. The resident was then transferred to a local emergency room (ER) for treatment. Upon return to the facility the resident continued his behaviors of wandering into female resident rooms insisting they were his wife, difficulty redirecting his behaviors, inappropriate urinating and defecating, and<br>(continued on next page) |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | becoming more physically aggressive with staff and other residents. On 03/07/26 at 8:30 P.M. LPN #587 documented in the nursing progress notes that Resident #56 was observed in the hallway with his genitals exposed and refusing staff redirection to put his clothes on. LPN #587 and an aide attempted multiple times to get the resident to put on his underwear but without success. Resident #56 became physically aggressive towards LPN #587 and ripped her shirt off and pulled her hair out. The resident proceeded into a female resident's room (Resident #42), still naked, said this was his wife and forcefully attempted to get into the resident's bed. The female resident woke up and fell out of bed while attempting to get away from Resident #56. Emergency services was contacted due to the resident's behaviors and both residents were transferred to the ER for evaluation. No further documentation was found in the nursing progress notes regarding where Resident #56 discharge. No interdisciplinary team notes discussing the resident's behaviors were noted during Resident #56's stay in the facility.Interview with the Administrator and the Assistant Director of Nursing (ADON) on 03/30/26 at 10:50 A.M. revealed Resident #56 like to derobe sometimes according to the Administrator. He would urinate on tables on the secured unit. He thought all the female residents on his unit were his wife. The Administrator said she did not consider Resident #56 going into other residents rooms naked from the waist down and claiming the resident was his wife then trying to get in bed with them is a behavior that would be thought of as sexually inappropriate. This incident occurred on 03/07/26 and resident was transported from the facility by Emergency Medical Services. The ADON confirmed Resident #56 did not return to the facility. The ADON stated Resident #56 had scared Resident #42 and she fell out of bed attempting to get away from him. Resident #42 was also transferred to the ER for evaluation. Interview with the Administrator on 04/01/26 at 5:30 P.M. regarding accepting Resident #56 as a resident revealed the facility's former Admissions/Marketer Director informed her she did not need to conduct an on-site review of Resident #56. The Administrator said she was hesitant as most facilities do not transfer good residents but the Admissions Director was adamant the Administrator not complete an on-site visit. The Administrator said she was aware the facility had transferred the resident from had resided on a secured all male unit. The Administrator said he never touched anyone but he did have behaviors. The resident would urinate in inappropriate places, wandered, and slept very little. The resident missed his wife and thought every female in the facility was her. As time went on Resident #56 became more aggressive. When asked why the facility readmitted him after psychiatric services transferred him for a psychiatric evaluation because the facility was unable to provide for his behavioral needs on 12/19/25 and remained hospitalized until 01/15/26, the Administrator said she felt the facility could deal with his behaviors on the secured unit. The Administrator said when Resident #56 returned to the facility in January 2026, they were unable to readmit him to the secured unit due to the unit being quarantined for Covid-19. They assigned one to one supervision for him. His behaviors of wandering continued while he was on the regular units. The Administrator said they did have several families emailing her about Resident #56 saying the facility should discharge him. The Administrator said staff did not inform her of the residents' concerns regarding Resident #56. Upon his return to the secured unit the Administrator said Resident #56's wife asked if the facility was planning on discharging him and the Administrator informed her there was no plan to discharge him. Then on 03/07/26 Resident #56 was wandering the unit naked from the waist down. The staff were unable to redirect him and the resident attacked LPN #587 and tore her braid off her head and ripped her shirt. The Administrator said she then issued an emergency discharge due to his inappropriate behaviors placing himself and others at risk for harm. The Administrator said she did not know what happened after they discharged him.Review of the discharge notice for Resident #56, dated 03/09/26, revealed the facility inaccurately identified the resident would be discharged home. The notice stated if less than 30 days were listed as the discharge date then he was given an immediate discharge as the resident's behaviors endangered the safety of the individuals in the home. The notice indicated the resident and his wife had the right to appeal the discharge. Information was provided on how to reach both the<br>(continued on next page) |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | facility Ombudsman and the Administrator. Review of Resident #56's electronic health record revealed no information regarding an immediate discharge had been issued or that the resident's wife had received any information about why the discharge was issued.Interview with the Administrator on 04/02/26 at 3:15 P.M. regarding Resident #56's immediate discharge and the electronic health record not having any information regarding the discharge, revealed the Administrator stating the information was in the record. After reviewing the electronic health record with the Administrator she confirmed there was no documentation regarding the resident's discharge. The Administrator returned to her office and then immediately returned and provided a folder with the information she and Former Social Worker (FSW) #609 had worked on together regarding the immediate discharge. The Administrator provided a copy of the certified mail they sent to Resident #56's wife dated 03/09/26 and received by the wife on 03/11/26. The Administrator provided an undated note and unsigned noted that a detailed voicemail was left for the social worker at the facility where Resident #56 was admitted and informed him they would not be able to have the resident return to the facility as an emergent discharge for the safety of the facility's other residents who resided on Resident #56's unit. The resident's wife was notified of the emergent discharge of her husband as the resident was a safety risk to the other residents as he thinks all the women are his wife. The note stated the wife felt he would do better on an all male secured unit. Review of the immediate discharge notice sent to Resident #56's wife was dated 03/09/26. The discharge location was listed as the family home. The reason for the discharge was for the safety of individuals in the home being endangered. The contact information for the Ombudsman and the Administrator were provided. A copy of the notice was sent to the Office of General Counsel, Ohio Department of Health via email as well as a copy to the Ohio State Long-Term Care Ombudsman. The Administrator confirmed she did not document the information or scan the discharge notice into Resident #56's electronic health record.Review of the facility's Discharge/Transfer policy, last revised in June 2025, revealed the common discharge/transfer rationale was due to medical improvement; voluntary discharge or transfer; a medically emergent transfer, transfer to another healthcare facility for a higher level of care or specialized equipment; the transfer or discharge for resident welfare, and the resident's needs cannot be met in the facility; if the resident has failed, after reasonable and appropriate notice, to pay for ( or to have paid under Medicare or Medicaid) a stay at the facility; or if the resident has behavioral issues than cannot be safely managed in the current setting that endanger other individuals in the facility. When unplanned discharges occur the facility should provide as much specific information as possible in the discharge notice to notify the resident or why he/she is being discharged and how the discharge meets discharge criteria. The information must be documented in the resident's electronic health record.This deficiency represents non-compliance under Complaint Number 2968354. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident assessments were accurately completed. This affected three (Residents #18, #42 and #48) of seven residents reviewed for assessments. The facility census was 55. Findings include:1. Review of the medical record for Resident #18 revealed an admission date of 06/07/22 with diagnoses including cerebral infarction (stroke), diabetes mellitus, hypertension, heart failure and need for personal assistance.<br><br>Review of the fall risk assessment dated [DATE] for Resident #18 revealed he had fall in the previous three months.<br><br>Review of the fall investigation dated 12/11/25 at 5:00 P.M. for Resident #18 revealed he was observed laying on the floor next to his bed. Resident #18 had attempted to transfer from the wheel chair to the bed without staff assistance and fell on the floor. He had no injuries noted on the investigation.<br><br>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18's cognition was intact, he had no behaviors and had an impairment on one side of his body. On section J1800 of the assessment, facility staff had documented Resident #18 did not have any falls since admission or the prior MDS assessment. His last MDS was noted to be completed on 10/06/25.<br><br>Interview on 03/30/26 at 10:50 A.M. with the Administrator verified the MDS dated [DATE] for Resident #18 was incorrect under section J as he had a fall without injury on 12/11/25 that should have been documented.<br><br>2. Review of the medical record for Resident #42 revealed an admission date of 11/14/25 with diagnoses including Alzheimer's disease, chronic kidney disease and hypertension.<br><br>Review of the facility fall investigations from 11/27/25 through 02/25/26 for Resident #42 revealed she had falls on 12/18/25 at 9:00 A.M. which resulted in a skin tear, on 12/26/25 at 9:30 A.M. which resulted in a head injury, 01/05/26 at 11:30 A.M. with no injury and on 01/07/26 at 11:45 A.M. with no injury.<br><br>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #42 had no falls documented on section J1800 for the question had she had any falls since admission or the prior MDS assessment. Her last MDS was completed on 11/26/25.<br><br>Interview on 03/29/26 at 11:47 A.M. with Licensed Practical Nurse (LPN) #525 verified the MDS dated [DATE] for Resident #42 was incorrect under section J as she four falls since her admission MDS on 11/26/25 and one of those falls she sustained a head injury and should have been documented under major injury.<br><br>3. Resident #48 was admitted to the facility on [DATE] with diagnoses including bullous pemphigoid, morbid obesity, asthma, generalized anxiety disorder, major depressive disorder, heart disease, high blood pressure, and neuromuscular dysfunction of the bladder.<br><br>Review of the physician's orders for Resident #48 revealed an order dated 08/27/24 to monitor for potential complications of an indwelling urinary catheter (a tube inserted into the bladder to allowing (continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | urine to flow into a drainage bag) such as redness, signs and symptoms of infection, obstruction, bladder spasms, blood tinged urine, or leakage around the catheter. Catheter care is to be completed daily and an as needed basis. Urinary output was to be monitored daily.<br><br>Review of the annual comprehensive Minimum Data Set (MDS) 3.0 assessment for Resident #48, dated 01/02/26, revealed the resident was cognitively intact, has an indwelling foley catheter and is always incontinent of urine.<br><br>Interview with Registered Nurse (RN) #19 on 04/08/26 at 10:00 A.M. confirmed Resident #48 MDS assessment was inaccurately coded as always incontinent of urine in the bowel and bladder section. Resident #48 is always continent of urine due to having a foley catheter. |

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|---|---|---|---|
| | 365826 | A. Building<br>B. Wing | 04/10/2026 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure dependent residents received showers as scheduled. This affected one (Resident #18) of three residents reviewed for showers. The facility census was 55. Findings include:Review of the medical record of Resident #18 revealed an admission date of 06/07/22 with diagnoses including cerebral infarction (stroke), diabetes mellitus, hypertension, heart failure and need for personal assistance. Review of Resident #18's care plan dated 06/07/22 revealed he had self-care deficit with his activities of daily living and needed total assistance of one staff member for bathing. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18's cognition was intact, he had no behaviors and had an impairment on one side of his body. He needed substantial to maximum assistance from staff for showers and bathing. Review of Resident #18's showers under the task section of the electronic record and shower sheets provided by the facility from dates 01/01/26 through 03/31/26 revealed he had not received showers as scheduled. Resident #18 was to receive two showers a week on Tuesdays and Fridays. The facility documentation revealed he had not received showers on 01/02/26, 01/06/26, 02/24/26, 03/03/26 and 03/27/26. Interview on 03/30/26 9:36 A.M. with Resident #18 revealed he was admitted to the facility because he had three strokes and could not remember things. Interview on 04/02/26 at 3:15 P.M. with the Administrator verified there were no other shower sheets or shower documentation available for Resident #18. Review of the facility policy titled, Activities of Daily Living-Highest Level of Functioning, revised on January 2026, revealed the facility would support each resident in maintaining or improving their highest practicable level of function related to activities of daily living based on the resident's needs, preferences and goals. This deficiency represents non-compliance investigated under Complaint Number 2962348. |

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| Continuing Healthcare of Cuyahoga Falls | 300 East Bath Road<br>Cuyahoga Falls, OH 44223 |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure to audiology services and intervention were implemented properly. This affected two (Residents #21 and #32) of three residents reviewed for audiology services. The facility census was 55. Findings include: 1. Review of the medical record for Resident #21 revealed an admission date of 05/01/23 with diagnoses including diabetes mellitus, hypertension, depression and anxiety. Review of the care plan dated 01/04/22 for Resident #21 revealed she had a communication problem related to a mild hearing deficit and had bilateral hearing aids. Staff were to assist the resident with inserting and removing hearing aids and consult audiology as indicated. Review of Resident #21's physician orders revealed she had an order dated 08/06/25 for staff to insert hearing aids every morning and remove them at night. Her hearing aides were to be stored in the medication cart. Review of the nursing progress notes for Resident #21 revealed on 12/01/25 at 11:57 A.M. her hearing aids were lost and the social worker was requesting another pair. On 12/12/25 at 12:52 P.M. Resident #21's hearing aids arrived at the facility and were available for her to use. On 02/24/26 at 9:29 A.M. it was documented that Resident #21's hearing aids needed repaired. On 03/06/26 at 9:01 A.M. it was again documented that Resident #21's hearing aids were not working properly and the nurse practitioner and social worker were notified. On 03/07/26 at 5:44 A.M. the nurse had documented the hearing aids were broken. Review of the care plan meeting dated 01/26/26 held with facility staff, Resident #21 and her representative revealed the representative had asked about Resident #21's hearing aids. The note stated they would follow-up with the nursing staff. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #21 had adequate hearing with hearing aids. Resident #21 had intact cognition and had no behaviors. Review of the audiology visit on 04/01/26 and list of residents revealed Resident #21 was not seen by the audiologist. Observation and interview on 04/07/26 at 11:58 A.M. with Resident #21 and Licensed Practical Nurse (LPN) #525 revealed there was a wire that had come out of the right hearing aid. LPN #525 pushed the wire back into the hearing aid and asked if the resident would try them to see if they worked. Resident #21 stated she would try, however, was concerned she would not be able to hear as she had excessive wax in her ears and needed to be seen by the audiologist. Resident #21 stated she had not seen the audiologist in a long time and had wanted to see him on his last visit. Resident #21 stated she knew the audiologist was in the facility on 04/01/26 but did not have a visit. After LPN #525 placed the hearing aids in resident's bilateral ears, Resident #21 stated she thought they were working. Resident #21 stated to this surveyor and LPN #525 that the nursing staff did not place her hearing aids in daily as ordered. Interview on 04/07/26 at 12:39 P.M. with the Administrator verified the previous social worker made the audiology appointments for the facility. She stated the social worker no longer worked at the facility and there was no one covering until the new social worker started. The Administrator stated the last visit by the audiologist was on 04/01/26 and Resident #21 was not seen. Review of the facility policy titled, Ancillary Services Policy and Procedures, undated, revealed the facility would assist residents in obtaining routine audiology services. 2. Resident #32 was admitted to the facility on [DATE] with diagnoses including a right ilium fracture, a motor vehicle accident with injuries, chronic obstructive pulmonary disease (COPD), major depressive disorder, acute pain due to trauma, bipolar disorder with psychotic features, anxiety disorder, history of malignant carcinoid tumor of bronchus and lung, malignant neoplasm of the bladder, and a urostomy (a surgical opening created in the abdominal wall to divert urine outside the body when the bladder is removed, commonly due to cancer or injury). Review of the physician's orders for Resident #32 revealed an order dated 02/13/26 for audiology to evaluate and treat. Review of Resident #32's quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 01/05/26, revealed the resident was moderately cognitively impaired, had adequate hearing and did not need hearing aides, and was independent for personal care. Review of<br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #32's nursing progress notes revealed Assistant Director of Nursing (ADON) documented on 02/13/26 at 4:38 P.M. Resident #32 returned to the facility from a doctor's appointment her sister had taken her to. The physician discontinued two medications and ordered audiology to assess her. Review of the audiology visits for the residents since 09/11/24 revealed the audiologist had not examined Resident #32 during any of the visits. The most recent audiologist visit was 04/01/26. Resident #32 was not examined by the audiologist. Interview with Resident #32's sister (Family #596) on 03/29/26 at 2:25 P.M. revealed the resident was supposed to see the facility audiologist in January 2026 but for some reason they did not see her. The facility said they would have the audiologist see her on 02/11/26 but again they did not examine her. The facility said the audiologist went to the resident's former facility to see her. The facility told them they would arrange an emergency appointment with audiology. Three weeks later an appointment had still not been scheduled. On 02/13/26 Family #596 brought the resident back to the facility after a physician's appointment and gave the facility an order for audiology to see the resident as she needed her ears flushed as she was having difficulty hearing. On 02/19/26 the facility said Debrox ear drops were ordered to be given weekly but they were never administered. Family #596 said she has repeatedly met with the Administrator, the ADON, and the Ombudsman but nothing ever changes. Family #596 said she had to make an appointment with an audiologist outside of the facility to have the resident's ears flushed and now she can finally hear again. Interview with the ADON on 04/01/26 at 5:28 P.M. revealed the facility audiologist was here today and she will provide a list of who was seen. The ADON confirmed Resident #32 has never seen the audiologist since she was admitted . The ADON said it was possible Resident #32's sister had taken the resident to an outside provider as she does that a lot. Interview with the Administrator on 04/07/26 at 12:39 P.M. revealed no staff were currently covering the audiology services or any other ancillary services since Former Social Worker (FSW) #609 left. Review of the facility's undated Ancillary Services Policy and Procedures revealed the facility assists residents in obtaining routine and 24-hour emergency dental care as well as routine vision, audiology, and podiatry care. All coordination efforts, appointments and resident or representative notifications are to be documented in the resident's medical record. This deficiency represents non-compliance investigated under Complaint Number 2968354. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure all doors of the secured unit remained in functioning order and failed to ensure Resident #18 was accurately assessed for risk of falls. This affected 17 residents (Residents #3, #10, #12, #16, #19, #24, #25, #28, #30, #38, #40, #42, #46, #47, #49, #51, and #53) of 17 residents residing on the secured unit and one resident (Resident #18) of three residents reviewed for falls. The facility census was 55. Findings Include:1. Observation of the secured unit on 03/29/26 at 1:57 P.M. revealed there were three entry and exit points. The Assistant Director of Nursing (ADON) was present during the observation and confirmed there were three entry and exit points to the unit. The door leading to the secured unit and dining room/kitchen area opened without having to push on the door for 15 seconds prior to opening. The door alarmed when opened but did not require a code be entered or a button to push to allow the door to open automatically. No staff members were located at the door to ensure residents were not able to leave the unit without staff knowledge. The ADON confirmed the secured unit door should be secured and the doors should not open immediately and that there was no one monitoring the door.<br><br>Interview with Director of Support Services (DoSS) #559 on 03/29/26 at 3:35 P.M. revealed he discovered the doors leading on/off the secured unit were not working properly on 03/24/26. He placed a call to a local door repair company and they sent him a new customer form. After he submitted it he realized the company only serviced garage doors. On 03/26/26 DoSS #559 contacted a different company with a request for service and they contacted him via email on 03/27/26 with questions regarding the repairs. The Administrator said she was unaware the doors to the secured unit were not working properly. She said the facility would do whatever they need to do to have it repaired and while they are waiting for the repairs they would assign and employee to sit at the door to ensure no resident could leave the unit unsupervised. DoSS #559 said the doors must have stopped working properly recently as he monitors them weekly. He said they recently had a power surge and he felt that was what had caused the doors to malfunction.<br><br>Interview with Anonymous Employee (AE) #604 on 03/30/25 at 4:00 P.M. confirmed the doors leading to the secured unit had not been working properly for awhile and had notified the facility that they were not working. AE #604 said she had heard the facility was now stationing an employee at the door to ensure residents were not able to leave the unit without supervision.<br><br>Review of the secured unit's invoice and repair information dated 04/02/26 revealed on 03/31/26 a service call was requested by the facility as a door kept going into alarm and would not reset. Upon arrival at the facility the vendor met with DoSS #559 who took the vendor to the secured care unit that had three double door systems he wanted checked. The vendor found the double door system had only one lock on it with a push button reentry. The facility said they were not able to reset it and it would go into alarm mode all the time. The vendor inspected the door and found the lock was off on an angle causing the egress and armature to make good connections with the lock. This was due to the lock only having three screws in the mounting plate because the lock was misaligned and too far from the door by over 1/4 of an inch. The lock was realigned and six screws were placed in the lock mounting plate which pulled the lock to be at the correct angle. The egress wheel was also broken so the wheel was replaced and the egress adjusted. The system was tested several times and was function properly. The report indicated the doors were in rough shape and should be replaced because they are rubbing in the center of the doors and do not always close properly.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview with the Administrator on 04/07/26 at 5:23 P.M. revealed she had not received a copy of the invoice and repair information until this day. She was not aware the vendor recommended replacing the doors to the secured unit.<br><br>Review of the facility secured unit census revealed Residents #3, #10, #12, #16, #19, #24, #25, #28, #30, #38, #40, #42, #46, #47, #49, #51, and #53 resided on the secured unit.<br><br>Review of the facility's Maintenance Requests policy, last revised January 2025, revealed all maintenance requests must be submitted through the systems electronic program tracker. Urgent or emergency issues (power outages, water leaks, Heating Ventilation Air Conditioning (HVAC) failure, safety hazards) must also be reported directly by phone or radio to the Department of Special Services or the Administrator in addition to entering them into the system. The electronic system serves as the facility's official log for all maintenance requests. The request must include the date, time, location, and a description of the issue. The DoSS will assign a priority level (Emergency, High, Routine) within the system. Emergency requests must be responded to immediately, high priority requests within 24 hours, and routine requests within three to five days. Once the repair is completed the DoSS or designee will close the request in the electronic record and document the corrective action taken and when it was completed. If the work cannot be completed within the expected timeframe, the delay and anticipated timeline must be documented in the system.<br><br>Review of the work orders submitted to the facility's electronic system from December 28, 2025 through March 30, 2026 revealed no orders indicating the doors to the secured unit were not functioning properly.<br><br>Review of the facility's Dementia Care policy, last revised December 2021, revealed providing care and services for residents living with dementia or dementia-like symptoms is an integral part of the person-centered care environment. This environment supports quality of life, meaningful relationships, and positive engagement. The necessary person-centered care and services that reflect the resident's goals, choices, and preferences while maximizing their dignity autonomy, privacy, socialization, independence, choice and safety. Staff providing care to residents with dementia or dementia-like symptoms are provided with training related to the management of dementia and will have competencies and skills to support the resident with dementia through the implementation of individualized approaches to cart that are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress of loss of abilities. Residents with dementia or dementia-like symptoms may reside in a secured/locked area, if available in the facility, when clinical evaluation indicates the resident would benefit from such an environment and the resident, his or her family, and/or the resident representative have been provided information to make an informed decision regarding the care and services afforded in the secured/locked area to address the clinical and psychosocial/behavioral needs of the resident.<br><br>2. Review of the medical record for Resident #42 revealed an admission date of 11/14/25 with diagnoses including Alzheimer's disease, chronic kidney disease and hypertension.<br><br>Review of the facility fall investigations from 11/27/25 through 02/10/26 for Resident #42 revealed she had falls on 12/18/25 at 9:00 A.M. which resulted in a skin tear, on 12/26/25 at 9:30 A.M. which resulted in a head injury, on 01/05/26 at 11:30 A.M. with no injury and on 01/07/26 at 11:45 A.M. with no injury.<br><br>Review of the fall risk assessment dated [DATE] for Resident #42 revealed nursing staff had<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | documented she had no history of falling in the previous three months. Due to the inaccuracy of the answer to the question, the assessment stated Resident #42 was not at risk for falls.<br><br>Interview on 03/29/26 at 11:47 A.M. with Licensed Practical Nurse (LPN) #525 verified the fall risk assessment dated [DATE] for Resident #42 was incorrect. She verified Resident #42 had fallen four times during the assessment period and was at high risk for falls.<br><br>This deficiency represents non-compliance investigated under Complaint Numbers 2801663 and 2962348. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received pain medications as ordered. This affected one (Resident #21) of one reviewed for pain management. The facility census was 55. Findings include:Review of the medical record for Resident #21 revealed an admission date of 05/01/23 with diagnoses including diabetes mellitus, hypertension, depression and anxiety. Review of the care plan dated 01/04/22 for Resident #21 revealed she had alteration in comfort related to arthritis. Staff were to administer medications as ordered. Review of the physician's orders for Resident #21 revealed an order for Tramadol 50 milligrams (mg) three times a day for pain dated 12/27/25. Review of the narcotic logs for Resident #21 for February 2026 revealed she had utilized her last Tramadol 50 mg pill on 02/13/26 at 6:00 P.M. and had not received another Tramadol 50 mg pill until 02/17/26 at 2:00 P.M. Review of the Medication Administration Record (MAR) for February 2026 revealed Resident #21 received Tramadol 50 mg three times a day, one in the morning, one at 3:00 P.M. and one at 8:00 P.M. On 02/14/26 in the morning it was noted the Tramadol was not administered, on 02/14/26 at 3:00 P.M. the Tramadol was not administered, on 02/14/26 at 8:00 P.M. the Tramadol was administered, on 02/15/26 in the morning the Tramadol was administered, on 02/15/26 at 3:00 P.M. the Tramadol was administered, on 02/15/26 at 8:00 P.M. the Tramadol was not administered, on 02/16/26 in the morning the Tramadol was not administered, and on 02/16/26 at 3:00 P.M. the Tramadol was not administered. Review of the nursing progress notes for Resident #21 revealed on 02/14/26 at 8:50 A.M. the nurse stated she was waiting on the Tramadol 50 mg from the pharmacy for the resident. She stated the nurse practitioner was made aware of the missed dose. On 02/14/26 at 6:01 P.M. the nurse stated she was waiting on the Tramadol 50 mg as it was on hold until available. Nurse Practitioner was made aware of missed dose. There were no progress notes stating the Nurse Practitioner gave the order to hold the Tramadol 50 mg for Resident #21. On 02/16/26 at 2:35 A.M. the nurse stated the Tramadol 50 mg was on order. On 02/16/26 at 8:48 A.M. the nurse stated the Tramadol 50 mg was on order. There was no documentation on 02/15/26 related to the Tramadol 50 mg medication not being available or the physician being updated. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #21 had intact cognition and had no behaviors. Interview on 03/29/26 at 10:03 A.M. with Resident #21 revealed she did not always get her medications as ordered. She stated she either did not get her medications or they were late at times. Interview on 04/07/26 at 2:44 P.M. with Pharmacist #608 revealed the facility had received Tramadol 50 mg for Resident #21 on 01/31/26 with the amount of 30 pills and on 02/16/26 with 30 pills. She stated there was no Tramadol sent by the pharmacy during the time frame of 01/31/26 through 02/16/26 except for those two dates. Interview on 04/08/26 at 1:48 P.M. with the Interim Director of Nursing (DON) verified Resident #21 did not receive her Tramadol as ordered on the dates listed above. She also verified the Tramadol was not available in the facility between 02/14/26 through 02/16/26 for Resident #21 until 8:00 P.M. even though the nursing staff stated they had given the medication on 02/14/26 at 8:00 P.M., on 02/15/26 in the morning and on 02/15/26 at 3:00 P.M. Review of the facility policy titled, Medication Administration and Management, revised June 2019, revealed the nursing staff would administer medications as ordered by the physician. Review of the facility policy titled, Pain Management, revised November 2025, revealed the nursing staff would administer medications as ordered by the physician. Medication unavailability wound be documented. This deficiency represents non-compliance investigated under Complaint Number 2968354. |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to provide the necessary dementia care and treatment to maintain the safety and well being residents on the dementia unit. This affected Resident #56 and had the ability to affect all 17 residents residing on the secured unit (Residents #3, #10, #12, #16, #19, #24, #25, #28, #30, #38, #40, #42, #47, #46, #49, #51, and #53). The facility census was 55. Findings Include:Resident #56 was admitted to the facility on [DATE] with diagnoses including vascular dementia severe without behavioral disturbance, major depressive disorder, alcohol dependence with alcohol induced persisting dementia, anxiety disorder, restlessness and agitation, and generalized anxiety disorder. The resident was transported to the hospital on [DATE] with no information regarding if the resident was admitted , transferred, or discharged .Review of the physician's orders for Resident #56 revealed on 01/29/26 and order was written for Depakote 125 milligrams (mg) (an anticonvulsant used as a mood stabilizer) three capsules given three times a day for vascular dementia, 02/01/26 an order was written for Zyprexa (an antipsychotic medication) 5 mg twice a day for vascular dementia, 02/23/26 an order was written for Ativan (an antianxiety medication) 1 mg four times a day for vascular dementia, 02/25/26 an order was written for Rexulti (an antipsychotic medication used to treat major depressive disorder, schizophrenia, or agitation associated with dementia due to Alzheimer's disease) 1 mg daily for vascular dementia, and an order was written on 01/30/26 for the resident to reside on the secured unit.Review of the quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 03/07/26, revealed Resident #56 was severely cognitively impaired. He exhibited behaviors of hallucinations, delusions, physical behaviors directed towards others for one to three days of the assessment period. He also exhibited behavioral symptoms not directed toward others for one to three days. He rejected care and wandered for one to three days of the assessment period. The resident required maximum assistance of staff for all personal care except eating.Review of the nursing progress notes from admission through discharge revealed Resident #56 exhibited increased agitation since admission. He wandered into other residents room putting clothes and other items in the toilets and exhibited exit seeking behaviors. The resident would become very aggressive and refuse medications. When staff redirected the resident from other residents rooms he would become very agitated and be very confused, spoke in a loud voice, and appeared more confused. On 12/16/25 at 7:14 A.M. Licensed Practical Nurse (LPN) #582 documented in the nursing progress notes Resident whipped his [NAME] out and urinated on the floor and wall. Staff intervened and provided redirection and assistance. And ensured the area was clean and disinfected. Incident was reported to nursing management. This behavior continued throughout his admission. Staff would find Resident #56 in female residents rooms, naked, and engaging in inappropriate sexual behavior on the female resident's bed. He would defecate in the hallways and attempt to rub feces on other residents. On 12/19/25 the resident was transferred for a psychiatric evaluation as the psychiatric practitioner said the facility was unable to manage his behaviors. The behaviors exhibited were anxiety, aggression, exit seeking, and being sexually aggressive with females on the secured unit as well as towards staff. The facility readmitted Resident #56 on 01/15/26 where he was placed on one to one supervision and placed on an unsecured unit due to a Covid-19 outbreak on the secured unit. Upon arrival the resident again started wandering into female residents rooms. On 01/19/26 the facility was again able to return to the secured unit where he remained on one to one supervision. His exit seeking behaviors continued as did entering female residents rooms. Resident #56 was again transferred for psychiatric evaluation 01/21/26 when the resident demonstrated combative behavior and aggression resulting in a self-inflicted injury. The resident was then transferred to a local emergency room (ER) for treatment. Upon return to the facility the resident continued his behaviors of wandering into female resident rooms insisting they (continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | were his wife, difficulty redirecting his behaviors, inappropriate urinating and defecating, and becoming more physically aggressive with staff and other residents. On 03/07/26 at 8:30 P.M. LPN #587 documented in the nursing progress notes that Resident #56 was observed in the hallway with his genitals exposed and refusing staff redirection to put his clothes on. LPN #587 and an aide attempted multiple times to get the resident to put on his underwear but without success. Resident #56 became physically aggressive towards LPN #587 and ripped her shirt off and pulled her hair out. The resident proceeded into a female resident's room (Resident #42), still naked, said this was his wife and forcefully attempted to get into the resident's bed. The female resident woke up and fell out of bed while attempting to get away from Resident #56. Emergency services was contacted due to the resident's behaviors and both residents were transferred to the ER for evaluation. No further documentation was found in the nursing progress notes regarding where Resident #56 went. No interdisciplinary team notes discussing the resident's behaviors were noted during Resident #56's stay in the facility.Review of Resident #56's care plans revealed a care plan was initiated on 12/04/25 for behaviors and was last revised on 02/01/26. The care plan was for behaviors and the resident was at risk for further episodes and injury. This was evidenced by the resident wandering in and out of resident rooms, removing clothing from other residents room and wearing it, placing paper towels in the toilets, and urinating on the floor. The interventions were to encourage him to attend social activities, explain things in a way he can understand, medication as ordered, monitor labs, chart behaviors, observe for early warning signs of behavior, and consult with psychiatric services as ordered. A second care plan was initiated on 12/04/25 for Mood/Behavior as resident has a history of alteration in mood or exhibition of behavioral symptoms related to Alzheimer's dementia, depression and psychosis with the same interventions as listed under the behaviors care plan. The Mood/Behavior care plan was not revised during Resident #56's stay at the facility. No risks or interventions were noted regarding the resident entering female residents rooms naked, insisting the resident was his wife, attempting to get into bed with the female residents, or making the resident one to one supervision upon his readmission to the facility on [DATE].Review of the referral progress notes and dementia care plan from the referring facility Resident #56 was transferred from prior to admission to the current facility revealed the behaviors the resident exhibited at the referring facility were the same behaviors he exhibited as he demonstrated at the current facility.Review of the facility census revealed Residents #3, #10, #12, #16, #19, #24, #25, #28, #30, #38, #40, #42, #47, #46, #49, #51, and #53 resided on the secured dementia unit.Interview with Anonymous Employee (AE) #600 on 03/29/26 at 1:12 P.M. revealed the Administrator tends to ignore staff concerns. Earlier in March 2026 they had a resident with behaviors. He was a man who would go into other residents rooms naked. AE #600 was told several times the Ombudsman was involved with the situation. The female residents were afraid of the naked resident. The Administrator kept brushing off staff concerns until a female resident fell and has not walked since the fall. The naked male ripped a nurses' shirt and pulled her hair. EA #600 confirmed the naked man was Resident #56 and he no longer resides in the facility.Interview with the Administrator and the Assistant Director of Nursing (ADON) on 03/30/26 at 10:50 A.M. revealed Resident #56 like to derobe sometimes according to the Administrator. He would urinate on tables on the secured unit. He thought all the female residents on his unit were his wife. The Administrator said she did not consider Resident #56 going into other residents rooms naked from the waist down and claiming the resident was his wife then trying to get in bed with them is a behavior that would be thought of as sexually inappropriate. This incident occurred on 03/07/26 and resident was transported from the facility by Emergency Medical Services. The ADON confirmed Resident #56 did not return to the facility. The ADON stated Resident #56 had scared Resident #42 and she fell out of bed attempting to get away from him. Resident #42 was also transferred to the ER for evaluation. The ADON stated Resident #42 is not ambulating like she used to and spends most of her time in a wheelchair but is starting to perk up a bit. The Administrator stated Resident #42 had perked up due to Resident #56 no longer residing in the facility.Interview with the Administrator on<br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 04/01/26 at 5:30 P.M. regarding accepting Resident #56 as a resident revealed the facility's former Admissions/Marketer Director informed her she did not need to conduct an on-site review of Resident #56. The Administrator said she was hesitant as most facilities do not transfer good residents but the Admissions Director was adamant the Administrator not complete an on-site visit. The Administrator said she was aware the facility had transferred the resident from had resided on a secured all male unit. The Administrator said he never touched anyone but he did have behaviors. The resident would urinate in inappropriate places, wandered, and slept very little. The resident missed his wife and thought every female in the facility was her. As time went on Resident #56 became more aggressive. When asked why the facility readmitted him after psychiatric services transferred him for a psychiatric evaluation because the facility was unable to provide for his behavioral needs on 12/19/25 and remained hospitalized until 01/15/26, the Administrator said she felt the facility could deal with his behaviors on the secured unit. The Administrator said when Resident #56 returned to the facility in January 2026, they were unable to readmit him to the secured unit due to the unit being quarantined for Covid-19. They assigned one to one supervision for him. His behaviors of wandering continued while he was on the regular units. The Administrator said they did have several families emailing her about Resident #56 saying the facility should discharge him. The Administrator said she was unaware the female residents were barricading their doors to prevent him from entering their rooms as they were afraid of him. The Administrator said staff did not inform her of the residents concerns. Upon his return to the secured unit the Administrator said Resident #56's wife asked if the facility was planning on discharging him and the Administrator informed her there was no plan to discharge him. Then on 03/07/26 Resident #56 was wandering the unit naked from the waist down. The staff were unable to redirect him and the resident attacked LPN #587 and tore her braid off her head and ripped her shirt. The Administrator said she then issued an emergency discharge due to his inappropriate behaviors placing himself and others at risk for harm. Review of the facility's Dementia Care policy, last revised December 2021, revealed providing care and services for residents living with dementia or dementia-like symptoms is an integral part of the person-centered care environment. This environment supports quality of life, meaningful relationships, and positive engagement. The necessary person-centered care and services that reflect the resident's goals, choices, and preferences while maximizing their dignity autonomy, privacy, socialization, independence, choice and safety. Staff providing care to residents with dementia or dementia-like symptoms are provided with training related to the management of dementia and will have competencies and skills to support the resident with dementia through the implementation of individualized approaches to cart that are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress of loss of abilities. Residents with dementia or dementia-like symptoms may reside in a secured/locked area, if available in the facility, when clinical evaluation indicates the resident would benefit from such an environment and the resident, his or her family, and/or the resident representative have been provided information to make an informed decision regarding the care and services afforded in the secured/locked area to address the clinical and psychosocial/behavioral needs of the resident.This deficiency represents non-compliance investigated under Complaint Number 2801663. |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, policy review, and job description review, the facility failed to ensure Resident #21 and Resident #32 received ancillary services timely. This affected two residents (Residents #32 and #21) of four residents reviewed for medically related social services. The facility census was 55. Findings Include:1. Resident #32 was admitted to the facility on [DATE] with diagnoses including a right ilium fracture, a motor vehicle accident with injuries, chronic obstructive pulmonary disease (COPD), major depressive disorder, acute pain due to trauma, bipolar disorder with psychotic features, anxiety disorder, history of malignant carcinoid tumor of bronchus and lung, malignant neoplasm of the bladder, and a urostomy (a surgical opening created in the abdominal wall to divert urine outside the body when the bladder is removed, commonly due to cancer or injury).<br><br>Review of the physician's orders for Resident #32 revealed an order dated 02/13/26 for audiology to evaluate and treat.<br><br>Review of Resident #32's quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 01/05/26, revealed the resident was moderately cognitively impaired, had adequate hearing and did not need hearing aides, and was independent for personal care.<br><br>Review of Resident #32's nursing progress notes revealed Assistant Director of Nursing (ADON) documented on 02/13/26 at 4:38 P.M. Resident #32 returned to the facility from a doctor's appointment her sister had taken her to. The physician discontinued two medications and ordered audiology to assess her.<br><br>Review of the audiology visits for the residents since 09/11/24 revealed the audiologist had not examined Resident #32 during any of the visits. The most recent audiologist visit was 04/01/26. Resident #32 was not examined by the audiologist.<br><br>Interview with Resident #32's sister (Family #596) on 03/29/26 at 2:25 P.M. revealed the resident was supposed to see the facility audiologist in January 2026 but for some reason they did not see her. The facility said they would have the audiologist see her on 02/11/26 but again they did not examine her. The facility said the audiologist went to the resident's former facility to see her. The facility told them they would arrange an emergency appointment with audiology. Three weeks later an appointment had still not been scheduled. On 02/13/26 Family #596 brought the resident back to the facility after a physician's appointment and gave the facility an order for audiology to see the resident as she needed her ears flushed as she was having difficulty hearing. On 02/19/26 the facility said Debrox ear drops were ordered to be given weekly but they were never administered. Family #596 said she has repeatedly met with the Administrator, the ADON, and the Ombudsman but nothing ever changes. Family #596 said she had to make an appointment with an audiologist outside of the facility to have the resident's ears flushed and now she can finally hear again.<br><br>Interview with the ADON on 04/01/26 at 5:28 P.M. revealed the facility audiologist was here today and she will provide a list of who was seen. The ADON confirmed Resident #32 has never seen the audiologist since she was admitted . The ADON said it was possible Resident #32's sister had taken the resident to an outside provider as she does that a lot.<br><br>Interview with the Administrator on 04/07/26 at 11:30 A.M. revealed the facility does not currently<br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | have a social worker or a social services designee. Former Social Worker (FSW) #609 quit on 03/16/26 when Former Director of Nursing (FDON) #595 also left the facility. They have been splitting the social service designee duties between herself, the ADON, the Business Office Manager, and therapy. The Administrator said she had previously been a licensed social worker but let her license lapse a few years ago. The facility has been accepting applications for the position but have not received many. They have received more for the DON position. The Administrator said they have an interim licensed social worker starting on 04/08/26 who they are hoping to hire if things go well. The interview continued at 12:39 P.M. when the Administrator stated no one was currently covering the audiology services or any other ancillary services since FSW #609 left.<br><br>Review of the facility's undated Ancillary Services Policy and Procedures revealed the facility assists residents in obtaining routine and 24-hour emergency dental care as well as routine vision, audiology, and podiatry care. All coordination efforts, appointments and resident or representative notifications are to be documented in the resident's medical record.<br><br>Review of the Social Services Director's (SSD) job description revealed the primary purpose of the SSD is to assist the Administrator to plan, organize, develop and direct the overall operation of the Social Services department. The SSD assists in developing and implementing policies and procedures for identifying the medically related social and emotional needs of the resident.<br><br>2. Review of the medical record for Resident #21 revealed an admission date of 05/01/23 with diagnoses including diabetes mellitus, hypertension, depression and anxiety.<br><br>Review of the care plan dated 01/04/22 for Resident #21 revealed she had a communication problem related to a mild hearing deficit and had bilateral hearing aids. Staff were to assist the resident with inserting and removing hearing aids and consult audiology as indicated.<br><br>Review of Resident #21's physician orders revealed she had an order dated 08/06/25 for staff to insert hearing aids every morning and remove them at night. Her hearing aides were to be stored in the medication cart.<br><br>Review of the nursing progress notes for Resident #21 revealed on 12/01/25 at 11:57 A.M. her hearing aids were lost and the social worker was requesting another pair. On 12/12/25 at 12:52 P.M. Resident #21's hearing aids arrived at the facility and were available for her to use. On 02/24/26 at 9:29 A.M. it was documented that Resident #21's hearing aids needed repaired. On 03/06/26 at 9:01 A.M. it was again documented that Resident #21's hearing aids were not working properly and the nurse practitioner and social worker were notified. On 03/07/26 at 5:44 A.M. the nurse had documented the hearing aids were broken.<br><br>Review of the care plan meeting dated 01/26/26 held with facility staff, Resident #21 and her representative revealed the representative had asked about Resident #21's hearing aids. The note stated they would follow-up with the nursing staff.<br><br>Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #21 had adequate hearing with hearing aids. Resident #21 had intact cognition and had no behaviors.<br><br>Review of the audiology visit on 04/01/26 and list of residents revealed Resident #21 was not seen by the audiologist.<br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and interview on 04/07/26 at 11:58 A.M. with Resident #21 and Licensed Practical Nurse (LPN) #525 revealed there was a wire that had come out of the right hearing aid. LPN #525 pushed the wire back into the hearing aid and asked if the resident would try them to see if they worked. Resident #21 stated she would try, however, was concerned she would not be able to hear as she had excessive wax in her ears and needed to be seen by the audiologist. Resident #21 stated she had not seen the audiologist in a long time and had wanted to see him on his last visit. Resident #21 stated she knew the audiologist was in the facility on 04/01/26 but did not have a visit. After LPN #525 placed the hearing aids in resident's bilateral ears, Resident #21 stated she thought they were working. Resident #21 stated to this surveyor and LPN #525 that the nursing staff did not place her hearing aids in daily as ordered. LPN #525 stated she would educate the staff on ensuring her hearing aids were placed in her ears in the morning and taken out at night.<br><br>Interview on 04/07/26 at 12:39 P.M. with the Administrator verified the previous social worker made the audiology appointments for the facility. She stated the social worker no longer worked at the facility and there was no one covering until the new social worker started. The Administrator stated the last visit by the audiologist was on 04/01/26 and Resident #21 was not seen.<br><br>Review of the facility policy titled, Ancillary Services Policy and Procedures, undated, revealed the facility would assist residents in obtaining routine audiology services. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident #32's medical record accurately reflected ostomy care. This affected one resident (Resident #32) of one resident reviewed for ostomy care. The facility census was 55. Findings Include:Resident #32 was admitted to the facility on [DATE] with diagnoses of a motor vehicle accident with multiple fractures, chronic obstructive pulmonary disease, major depressive disorder, bipolar disorder with psychotic features, obstructive and reflux uropathy, anxiety disorder, artificial openings of urinary tract status, malignant neoplasm of bladder, and history of malignant carcinoid tumor of the bronchus and lung. Review of the physician's orders dated 09/12/25 revealed Resident #32 was to have urostomy care on day shift every three days. Staff are to remove the bag and wafer, cleanse the site with normal saline, observe for any abnormalities of the skin/ostomy, apply skin prep to the stoma border, allow the areas to dry, then apply a new wafer and bag. Interview with Family Member (FM) #596, the sister and Power of Attorney for Resident #32, on 03/29/26 at 2:25 P.M. revealed the resident has a urostomy (a surgical opening for draining urine from the body) but the facility does not know how to provide care for it. The facility is supposed to check and empty the urostomy bag every two hours. The facility does not clean the bag and it smells. She provides the supplies for her sister's care and labels them for the date they need to be changed and places them in her sister's closet. Every three days the bag is supposed to be replaced. But the staff still does not change it. Review of the March 2026 Medication Administration Record (MAR) for Resident #32 revealed on 03/29/26 Licensed Practical Nurse (LPN) #576 had changed the urostomy bag in the morning. Observation of Resident #32's urostomy bag on 03/29/26 at 2:35 P.M revealed the bag in placed was soiled in appearance. The bag was stained a dirty yellowish brown. This was observed by two surveyors and FM #596. LPN #576 documented she had changed the ostomy bag that morning. Interview with ADON on 04/01/26 at 5:28 P.M. confirmed nurses should not document a task has been completed if it has not been done. This deficiency represents non-compliance investigated under Complaint Number 2968354. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observation, interview, record review, and policy review, the facility failed to ensure all doors of the secured unit remained in functioning order. This affected 17 residents (Residents #3, #10, #12, #16, #19, #24, #25, #28, #30, #38, #40, #42, #46, #47, #49, #51, and #53) of 17 residents residing on the secured unit. Findings Include:Observation of the secured unit on 03/29/26 at 1:57 P.M. revealed there were three entry and exit points. The Assistant Director of Nursing (ADON) was present during the observation and confirmed there were three entry and exit points to the unit. The door leading to the Buckeye unit and dining room/kitchen area would not open even after being pressed on for over one minute. No alarms sounded while the doors were pushed on. A code had to be entered to access/leave the unit. The ADON confirmed the doors should open and alarm after being pushed on for 15 seconds in order to allow egress from the unit.Interview with Director of Support Services (DoSS) #559 on 03/29/26 at 3:35 P.M. revealed he discovered the doors leading on/off the secured unit were not working properly on 03/24/26. He placed a call to a local door repair company and they sent him a new customer form. After he submitted it he realized the company only serviced garage doors. On 03/26/26 DoSS #559 contacted a different company with a request for service and they contacted him via email on 03/27/26 with questions regarding the repairs. The Administrator said she was unaware the doors to the secured unit were not working properly. She said the facility would do whatever they need to do to have it repaired and while they are waiting for the repairs they would assign and employee to sit at the door to ensure no resident could leave the unit unsupervised. DoSS #559 said the doors must have stopped working properly recently as he monitors them weekly. He said they recently had a power surge and he felt that was what had caused the doors to malfunction.Interview with Anonymous Employee (AE) #604 on 03/30/25 at 4:00 P.M. confirmed the doors leading to the secured unit had not been working properly for awhile and had notified the facility that they were not working. Review of the secured unit's invoice and repair information dated 04/02/26 revealed on 03/31/26 a service call was requested by the facility as a door kept going into alarm and would not reset. Upon arrival at the facility the vendor met with DoSS #559 who took the vendor to the secured care unit that had three double door systems he wanted checked. The facility had a double door system with two locks on the system with push button entry. The vendor was told this door was not going into egress. After inspecting the system the vendor determined the issue was caused because egress wires were removed from the panel. The vendor placed the wire back into the panel and adjusted egress. The vendor tested the system several times and everything was functioning properly. The east double door system has one lock on the system with push button reentry. The vendor was told egress was not working on the system. The vendor again inspected the door and discovered the egress wire was missing from the panel. The wire was replaced and the system tested and worked properly. The vendor then discovered the lock was loose. The issued was caused because the lock mounting plate only had tree screws and they were backing out. Larger screw were placed into the mounting plate with two additional screws into the mounting plate to ensure the lock will not move anymore. The doors were also in rough shape and should be replaced because they are rubbing in the center of the doors and do not always close properly.Interview with the Administrator on 04/07/26 at 5:23 P.M. revealed she had not received a copy of the invoice and repair information until this day. She was not aware the vendor recommended replacing the doors to the secured unit.Review of the facility's Maintenance Requests policy, last revised January 2025, revealed all maintenance requests must be submitted through the systems electronic program tracker. Urgent or emergency issues (power outages, water leaks, Heating Ventilation Air Conditioning (HVAC) failure, safety hazards) must also be reported directly by phone or radio to the Department of Special Services or the Administrator in addition to entering them into the system. The electronic system serves as the facility's official log for all maintenance requests. The request must include the<br>(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<br>B. Wing | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Continuing Healthcare of Cuyahoga Falls | 300 East Bath Road<br>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.

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|---|---|
| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | date, time, location, and a description of the issue. The DoSS will assign a priority level (Emergency, High, Routine) within the system. Emergency requests must be responded to immediately, high priority requests within 24 hours, and routine requests within three to five days. Once the repair is completed the DoSS or designee will close the request in the electronic record and document the corrective action taken and when it was completed. If the work cannot be completed within the expected timeframe, the delay and anticipated timeline must be documented in the system.Review of the work orders submitted to the facility's electronic system from December 28, 2025 through March 30, 2026 revealed no orders indicating the doors to the secured unit were not functioning properly,This deficiency represents non-compliance investigated under Complaint Number 2962348. |