Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2024
NAME OF PROVIDER OR SUPPLIER: Continuing Healthcare of Cuyahoga Falls		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42734 Based on medical record reviews, observations, review of self-reported incident, review of resident concern log, review of resident council minutes, policy review, resident interview, ombudsman interview and staff interviews, the facility failed to timely and fully address residents expressed concerns with care and treatment and environmental issues. This directly affected eighteen Residents (#9, #10, #11, #19, #27, #30, #31, #32, #40, #47, #48, #49, #52, #54, #55, #56, #58, and #62), with the potential to affect all resident residing on the 300 hall. The census was 59. Findings include: On 12/17/24 from 1:45 P.M. to 2:10 P.M. a resident meeting was held with Resident #32, Resident #40, Resident #47 and Resident #62 attending. The residents revealed concerns with the facility's lack of response to expressed concerns. The residents stated they consistently had issues with call light response times, dietary issues, missing laundry and the turnover of staff. Resident #32 had an issue with his light not working and reported it weeks prior. Resident #40 had voiced concerns about the temperature of the shower room on the memory care unit. Resident #62 stated he reported missing clothing. All four residents stated no inventory lists were completed for them. They also stated the Ombudsman or Advocate numbers were not displayed. 1. Review of the medical record for Resident #62 revealed an admitted [DATE]. Diagnoses included rectal fistula, protein-calorie malnutrition and insomnia. Resident #62 was cognitively intact. Review on 12/17/24 at 5:42 P.M., with Minimum Data Set (MDS)/ Licensed Practical Nurse (LPN) #417 of Resident #62's hard chart revealed no inventory sheet. However, MDS/LPN #417 came back 15 minutes later with a copy of an inventory sheet dated 10/07/24, with the resident's name at the top and a nurse's signature at the bottom with a note that said, came from hospital in only hospital gown on person. There was no resident signature though the form had a line for a resident signature and a date. Review of a Self-Reported Incident #253370 dated 10/25/24 for misappropriation of clothing revealed Resident #62 reported clothing missing after a hospital visit in October. The former social worker wrote a statement dated 10/25/24 stating Resident #62 was upset because the facility administration had not responded to his prior report of missing clothing (no dates specified). The investigation included taking Resident #62 to the laundry room to view all of the missing laundry, none of which were his. The staff searched the male resident rooms, but no clothes were found. An undated handwritten list of missing items was in the report along with a longer typed list of items dated 11/23/24. The facility unsubstantiated the allegation. (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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/16/24 at 11:00 A.M. with Resident #62 revealed he was still upset with management because they never took an inventory upon admission and did not do an inventory when the Ombudsman initially asked them to after the SRI was created. He said management observed the Ombudsman return at a later date and the facility staff rushed to his room to complete one. Interview on 12/18/24 at 12:15 P.M., with the Ombudsman revealed there was no inventory list in his chart when she came to investigate the first time, including the blank one with the nurse's signature. The Ombudsman stated that when she came back a couple of weeks later to check, she had to create the list with the facility. She was frustrated there was no resolution or replacement of any clothes for Resident #62. Interview on 12/18/24 at 4:40 P.M., with Unit Manager #50 revealed she completed the blank inventory sheet on the day of the admission. When asked why it was not included in the SRI investigation with the other lists, she could not say. Interview on 12/18/24 at 5:15 P.M., with the Administrator and the Director of Maintenance (DM) #401 (oversees laundry also) revealed DM #401 stated nursing should do inventory sheets upon admission and names should be marked on clothing. The Administrator added that's the problem. Review of the concern log from October 2024 revealed no concern listed about Resident #62's missing clothing before or after the SRI was reported. Review of the inventory sheets for Resident #9, Resident #48, Resident #56 and Resident #58 revealed they were blank or missing from the chart. 2. Review of the medical record for Resident #40 revealed an admitted [DATE]. Diagnoses included urinary tract infection, paresthesia of skin and diabetes. She was cognitively intact. Interview on 12/18/24 at 5:15 P.M. with the Administrator and DM 401 revealed DM #401 was aware of the water temperature in the shower room on the Memory Care unit was around 80 degrees Fahrenheit. Interview on 12/18/24 at 5:15 P.M., with DM #401 revealed he was aware the water in the shower room ran in the eighties. He stated he did not have a temperature log as they were switching forms. Observation on 12/18/24 around 6:15 P.M., revealed DM #401 tested the water temperature in the shower room stating it was 86 degrees Fahrenheit. Review of the Resident Council minutes from 11/27/24 and an entry from the concern log on 11/27/24 revealed Resident #40 noted the shower room water was often not warm enough. There was no resolution noted. 3. Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included diabetes, chronic obstructive pulmonary disease and Parkinson's Disease. He was cognitively intact. Interview on 12/17/24 at 1:45 P.M., with Resident #32 revealed he had complained of the string on his light above his bed not working weeks ago. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the concern log for November revealed an entry on 11/20/24 about Resident #32's pull string needing replaced. There was no resolution noted. 4. Observation by another surveyor starting the morning of 12/16/24 during the screening process of the survey revealed hallway lights were flickering on the 300 hallway. Interview on 12/16/24 at 9:26 P.M., with Maintenance Assistant #405 revealed the parts to replace the lights were $40/piece but corporate did not want to pay for them. Review of the concern log entry on 12/03/24 by Resident #19 and #49 revealed complaints of flickering lights. There was no resolution noted. 5. Review of the concern logs from August through December revealed 45 entries from various residents about dietary issues, missing laundry, maintenance issues, housekeeping issues and care issues. There were no resolutions noted for any of them. Review of the Concern and Complaint log from 07/31/24 through 12/12/24 revealed multiple complaints, made by residents, regarding staffing. On 09/25/24, Resident #11 complained about medication administration and assistance with toileting. Resident #14 complained that she was often left alone in the bathroom and the aides were not doing their rounds. On 11/01/24, Resident #52 complained about not enough staffing to provide his care. On 11/05/24, Resident #11 complained about nursing issues again. On 11/26/24, Resident #31 complained about not getting assistance with her hearing aids. On 11/27/24, Resident #40 complained about the aides not getting residents up early enough for church services on Sunday. On 12/12/24, Residents #10, #19, #27, #47, #49, and #55 all complained about nursing concerns. Interview on 12/16/24 at 10:12 A.M., with the Administrator revealed no resolutions had been made and confirmed the Concern logs were blank regarding resolutions. Review of Resident Council minutes from 07/31/24, 08/28/24, 09/25/24, 10/30/24 and 11/27/24 revealed the following staffing concerns. On 07/31/24 Resident #47 stated her call light was not always placed close to her. Residents #30, #40, and #54 stated the aides were using their personal, privately bought, body wash and personal hygiene products for other residents. On 08/28/24 and 09/25/24, several residents had personal care concerns. They were told they will be addressed on an individual basis. The residents were reminded to voice their concerns at the time instead of waiting for Resident Council. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/24, several residents had personal care concerns. They were told they will be addressed on an individual basis. The residents were reminded to voice their concerns at the time instead of waiting for Resident Council. Many residents stated they were not receiving ice water because the aides are not filling up the unit ice bucket. On 11/27/24, many residents stated they were not receiving ice water because the aides are not filling up the unit ice bucket. Residents were not receiving the correct size incontinent briefs. Resident #40 stated her aide is not getting her up and dressed early enough for Sunday church services. Interview with the Administrator on 12/18/24 at 3:00 P.M., verified there were no resolutions noted on the concern log for the above examples and multiple entries on various dates including 11/20/24, 12/03/24, 12/09/24, 12/12/24 and 12/15/24. The Administrator did not provide additional information. Review of the policy titled Operations Policies and Procedures: Complaints/Grievance Process, dated June 2019, revealed the facility would take immediate action to prevent further potential violation of any resident right while the alleged violation was being investigated. This deficiency represents non-compliance investigated under Complaint Number OH00160016.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observations, resident record review, resident interview, staff interviews, and facility policy review, the facility failed to ensure physician orders were followed and implemented. This affected two (#46 and #62) of six residents reviewed for physician orders. The facility census was 59. Findings include: 1. Review of the medical record for Resident #46 revealed an admitted [DATE]. Diagnoses included dementia, anxiety disorder, Alzheimer's disease, muscle weakness, and difficulty walking. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and required substantial to maximum assistance from staff for transfers. Review of the physician orders for December 2024 revealed active orders to encourage the resident to elevate feet throughout day for every shift for bilateral edema to feet. Interview on 12/16/24 at 1:44 P.M., with Resident #46's family member revealed the resident was recently started on a blood thinner for a blood clot in her leg and stated they were not elevating her leg. Observation on 12/17/24 at 2:07 P.M., of Resident #46 sitting in her wheelchair with no leg rest or feet elevated in dining area, still eating lunch. Observation on 12/18/24 at 9:16 A.M., of Resident #46 sitting in her wheelchair with no leg rest or feet elevated in the dining room. Observation on 12/18/24 at 10:52 A.M., of Resident #46 sitting in her wheelchair with no leg rest or feet elevated in the common area during an activity. Observed the Resident#46's left foot appeared swollen. Interview on 12/18/24 at 10:54 A.M., with Registered Nurse (RN) #304 verified there was some swelling in Resident #46's left foot. RN #304 stated they had been encouraging the resident to elevate her feet when she was in bed but it would help to have her feet elevated while in the wheelchair. RN #304 stated therapy could evaluate her for leg rests. RN #304 stated she had never seen Resident #46's feet elevated or her wheelchair with leg rest, although this was her second time at the facility. Observation on 12/18/24 at 2:23 P.M., of Resident #46 sitting in her wheelchair with no leg rest or feet elevated in the dining area eating lunch. Interview on 12/18/24 at 2:51 P.M., with Certified Nurse Aid (CNA) #425 stated there was only one leg rest found in Resident #46's room and that her left foot was swollen. CNA #425 stated they tried to encourage her to elevate her feet but had not attempted yet today. Observation on 12/18/24 at 5:04 P.M., of Resident #46 observed sitting in her wheelchair with no leg rest or feet elevated in dining area. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42011 2. Review for Resident #62's medical record revealed an admitted [DATE]. Diagnoses included cutaneous abscess of perineum, rectal abscess, Crohn's disease, and rectal fistula. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was cognitively intact. Resident #62 had medically complex conditions including ulcerative colitis, Crohn's, and inflammatory bowel disease. Resident #62 received antibiotics and received intravenous (IV) medication. Review of the care plan for Resident #62 dated 10/07/24 revealed Resident #62 was to be on Enhanced Barrier Precautions (EBP) as evidence by a peripherally inserted central catheter (PICC) and an open wound. Review of the physician orders for Resident #62 dated 10/23/24 revealed orders for PICC line dressing change, change PICC line dressing every five days and as needed. Interview and observation on 12/17/24 at 8:38 A.M., with Resident #62 revealed Resident #62's PICC line was located in Resident #62's left upper arm and dated 11/25/24. Drainage was visible on the dressing and the edges of the dressing was lifting. Resident #62 revealed he never refused his PICC line dressing changes and revealed he had to ask them last time to change the PICC dressing, stating, they never even offer. Interview on 12/17/24 at 8:50 A.M., with Licensed Practical Nurse (LPN) #457 revealed Resident #62 never refused PICC line dressing changes. Observation on 12/17/24 at 1:19 P.M., with LPN #457 of Resident #62's PICC line revealed Resident #62's PICC line was located in Resident #62's left upper arm. LPN #457 confirmed the dressing covering the PICC line was dated 11/25/24. There was visible brownish colored drainage on the dressing covering the wound and the edges of the dressing was lifting on all four sides. Review of the medication administration record (MAR) with LPN #457 confirmed LPN #457 signed off the PICC line dressing change on the MAR as completed on 12/03/24, 12/08/24, and 12/13/24 at 7:00 A.M.; LPN #457 stated, Maybe he wasn't in his room, sometimes when we are really busy I sign off the treatment before I do it. LPN #457 confirmed the PICC line dressing did not get changed as scheduled or after 11/25/24 and she signed the MAR reflecting it did get changed. LPN #457 repeated when we were really busy she signed off the treatment before she did them, and confirmed Resident #62 did not refuse the treatment, she did not offer it.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observations, resident record review, and staff interviews, the facility failed to ensure physician ordered pressure relieving devices were in place to prevent pressure ulcers. This affected one (#21) of two residents reviewed for pressure sores. The facility census was 59. Findings include: Review of Resident #21's medical record revealed an admitted [DATE] and re-admitted [DATE], with diagnoses including: displaced fracture of the neck of the right femur, muscle weakness, and aftercare following joint replacement surgery. Review of the 5-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was alert with cognition impairment. Review of the MDS assessment revealed Resident #21 was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 12/09/24 revealed Resident #21 had a fracture and was at risk for increased pain, limited ambulation, and further injury related to a right femur fracture. Interventions included abductor pillow to maintain hip precautions as ordered, use positioning devices for proper body alignment as ordered, and sleep with pillow between legs. Review of the physician orders dated 05/03/23 revealed an order to float heels every shift. Review of the progress note dated 11/16/24 at 2:40 A.M., revealed Resident #21 was admitted to the hospital with a right femur fracture. Review of the progress note dated 11/19/24 at 2:48 P.M., revealed Resident #21 returned from the hospital via stretcher. Observation on 12/16/24 at 9:29 A.M., revealed Resident #21 lying in bed asleep. Resident #21 was observed to not have floating heel protectors in place. Interview and observation on 12/16/24 at 9:30 A.M., with Certified Nurse Assistant (CNA) #449 revealed Resident #21 had a fall that resulted in a broken hip. CNA #449 revealed Resident #21 had pain and was limited in his mobility. CNA #449 revealed she was not aware of the orders for heel protectors. Observation during interview with CNA #449 verified Resident #21 was in bed without heel protectors in place. Interview and observation on 12/16/24 at 2:54 P.M., with Licensed Practical Nurse (LPN) #463 revealed Resident #21 had a fall that resulted in a hip fracture. LPN #463 revealed Resident #21 was always in pain and stayed in bed due to limited mobility. LPN #21 revealed Resident #21 was to have heel protectors in place to prevent pressure ulcers due to current orders to remain in bed. Observation during interview with LPN #463 verified Resident #21 was in bed without heel protectors in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview and observation on 12/17/24 at 2:08 P.M., with LPN #457 revealed Resident #21 had an order to float heels as a prevention mechanism to prevent pressure ulcers. LPN #457 revealed Resident #21 was to have heel protectors in place at all times. Observation at the time of the interview with LPN #457 confirmed Resident #21's heel protectors were not in place as ordered. Random observations during the annual survey period dated 12/16/24 through 12/19/24 revealed Resident #21 did not have heel protectors in place. Resident #21 remained in bed for the duration of the annual survey.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51067 Based on medical record review, observation, staff interview, and review of policy, the facility failed to ensure foot care was provided as needed. This affected two (#15 and #41) of two residents reviewed for non-pressure wounds. The facility census was 59. Findings include: 1. Review of Resident #41's medical record revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, idiopathic peripheral autonomic neuropathy, cellulitis of unspecified part of limb, and erythema intertrigo. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #41 was dependent for dressing, toilet use, transferring, putting on and taking off footwear and was unable to walk. Resident #41 had no skin ulcers, wounds, or other skin problems identified at the time of the assessment. Review of the care plan dated 02/24/23 revealed Resident #41 had diabetes mellitus and was at risk for diabetic related complications. Interventions included to use a draw sheet or lifting device to move resident, use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface, monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration (skin softening and breaking down due to moisture) et cetera (etc) to physician (MD) and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Further review of the care plan revealed identification of behaviors or the resident refusing care. However, there was no documentation in the progress notes or medical record of Resident #41 refusing care. Observation on 12/16/24 at 10:28 A.M. revealed Resident #41 sitting in bed with his right foot exposed and a dressing to the right anterior side of the foot, dated 11/07/24. Interview and observation on 12/16/24 at 1:30 P.M., with Unit Manager/Licensed Practical Nurse (UM/LPN) #434, verified the dressing on Resident #41's foot was dated 11/07/24. UM/LPN #434 removed the old dressing, revealing brown dried drainage on the bandage and an opened area on the foot. Further review of the medical record revealed no orders for treatment to the right foot or documentation of the 11/07/24 dressing. Review of the weekly skin assessments from 11/01/24 to present revealed no concerns identified related to Resident #41's right lateral foot. There were no further assessments of Resident #41's feet. Review of the policy titled Nursing Policies and Procedures Subject: Wound Evaluation, dated June 2019, stated the facility was to evaluate wounds during dressing changes. Evaluation should be performed on admission, weekly, and on discovery. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Nursing Policies and Procedures Subject: Wound Documentation, dated June 2019, revealed on admission and/ or discovery, the nurse initiates the wound documentation process. 42011 2. Review for Resident #15's medical record revealed an admitted [DATE]. Diagnoses included dementia, type two diabetes mellitus, muscle weakness and difficulty in walking. Review of the quarterly MDS assessment dated [DATE] revealed Resident #15 used a walker for mobility, required substantial/maximum assistance with putting on and taking off footwear and was dependent for personal hygiene. Review of the physician orders for Resident #15 revealed an order dated 03/29/24 to cleanse bilateral feet with soap and water, pat dry and apply Aquaphor every shift. The treatment was scheduled at 7:00 A.M. and 7:00 P.M. Observation on 12/18/24 at 8:17 A.M., revealed Resident #15 was sitting in a chair in the lounge sleeping. Resident #15 had no socks on, and her shoes were removed and sitting next to her feet on the floor. Resident #15's feet appeared very dry and flaky. Review on 12/19/24 1:55 P.M., of the medication administration and treatment administration records (MAR/TAR) for Resident #15 for December 2024 with RN #427 confirmed the treatments to cleanse Resident #15's bilateral feet with soap and water, pat dry and apply Aquaphor every shift was signed as completed twice daily. RN #427 revealed, We don't do that, that was when we had carpet. They all had the order in the spring. We just need to get it discontinued, we only did it for a few weeks after it was written. I don't know why the nurses still sign it off, I am guilty too, I just sign it but I will get it discontinued. Observation on 12/19/24 at 2:00 P.M., of Resident #15's right foot with RN #427 confirmed Resident #15's right foot was dry, had flaking skin over the entire foot and the heel had a large crack through it. Interview on 12/19/24 between 2:17 P.M. and 2:53 P.M., with the Director of Nursing (DON) revealed if nurses sign the physician orders off on the MAT/TAR as completed, they should be doing it. The DON confirmed he looked at Resident #15's right foot and verified the dry flaky skin and the cracked heel. The DON confirmed there were no other treatments to Resident #15's feet except to cleanse bilateral feet with soap and water pat dry and apply Aquaphor every shift.

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42730

Based on observations, resident record review, and staff interviews, the facility failed to ensure a resident with limited range of motion from a fractured hip was provided with positioning device to prevent dislocation of hip. This affected one (#21) of six residents reviewed for accidents. The facility census was 59.

Findings include:

Review of Resident #21's medical record revealed an admitted [DATE] and re-admitted [DATE], with diagnoses including: displaced fracture of the neck of the right femur, muscle weakness, and aftercare following joint replacement surgery.

Review of the 5-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was alert with cognition impairment. Resident #21 was dependent on staff for activities of daily living (ADLs).

Review of the care plan dated 12/09/24 revealed Resident #21 had a fracture and was at risk for increased pain, limited ambulation, and further injury related to a right femur fracture. Interventions included abductor pillow to maintain hip precautions as ordered, use positioning devices for proper body alignment as ordered, and sleep with pillow between legs.

Review of the progress note dated 11/15/24 at 11:12 A.M., revealed Resident #21 had an unwitnessed fall and was found on the floor by staff. Resident #21 received orders to be transported to the emergency room via stretcher due to right hip pain.

Review of the progress note dated 11/16/24 at 2:40 A.M., revealed Resident #21 was admitted to the hospital with a right femur fracture.

Review of the progress note dated 11/19/24 at 2:48 P.M., revealed Resident #21 returned from the hospital via stretcher.

Review of the progress note dated 11/19/24 at 5:31 P.M., revealed Resident #21 received orders to be placed on strict dislocation precautions that included having a pillow between his legs and staying in place at all times.

Review of the physician orders dated 12/06/24 revealed an order for Resident #21 to sleep with pillow between his legs.

Observation on 12/16/24 at 9:29 A.M., revealed Resident #21 lying in bed asleep. Resident #21 was observed to not have a pillow between his legs.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview and observation on 12/16/24 at 9:30 A.M., with Certified Nurse Assistant (CNA) #449 revealed Resident #21 had a fall that resulted in a broken hip. CNA #449 revealed Resident #21 had pain and was limited in his mobility. CNA #449 revealed Resident #21 was to have a pillow in place between his legs while in bed. Observation during interview with CNA #449 verified Resident #21 was in bed without a pillow in between his legs. Interview and observation on 12/16/24 at 2:54 P.M., with Licensed Practical Nurse (LPN) #463 revealed Resident #21 had a fall that resulted in a hip fracture. LPN #463 revealed Resident #21 was always in pain and stayed in bed due to limited mobility. LPN #21 revealed Resident #21 was to have a pillow in between his legs. Observation during interview with LPN #463 confirmed Resident #21 was in bed without a pillow in between his legs. A follow-up interview on 12/17/24 at 2:06 P.M., with CNA #449 revealed staff nurses were responsible to ensure Resident #21's pillow was in place between his legs due to pain and limited mobility. Interview and observation on 12/17/24 at 2:08 P.M., with LPN #457 revealed Resident #21 was to have hip pillows in place at all times. Observation at the time of the interview with LPN #457 verified Resident #21's pillows were not in place between his legs as ordered. Random observations during the annual survey period dated 12/16/24 through 12/19/24 revealed Resident #21 did not have a pillow between his legs. Resident #21 remained in bed for the duration of the annual survey.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, resident interview and staff interview, the facility failed to ensure potentially hazardous chemicals and medicated treatments were kept in a secured area where residents residing in the Memory Care Unit did not have access. This had the potential to affect 14 (#1, #7, #12, #15, #16, #35, #37, #43, #44, #50, #52, #57, #59, and #60) who were identified by the facility as being independently mobile of the 17 residents residing in the Memory Care Unit. In addition, the facility failed to ensure a resident at risk for choking was supervised and monitored during meals. This affected one (#50) of ten residents observed for dining in the memory care unit. The facility census was 59. Findings include: 1. Observation on 12/16/24 at 12:39 P.M. of the Memory Care Unit revealed a large dining area. Next to the dining area was an open kitchenette area with multiple kitchen cabinets. Observation revealed none of the cabinets were secured. Residents were observed sitting in the dining area and wandering throughout the unit including the kitchenette area. Observation of the unsecured cabinets within reach of residents in the kitchenette area, as they were opened, revealed three boxes of unopened Binax now COVID 19 tests, one opened Inteli swab COVID 19 test with one of the two tests missing, partially used body cleanser, body spray, and plastic silverware. In the second lower cabinet opened was partially used cans of Lysol spray, Clorox spray, and air sanitizer. In the unsecured drawer by the sink was a bottle of liquid baby powder, coffee creamer, condiments, car keys, and nasal swabs. The next drawer had a hairbrush stored with silverware. Observation and interview on 12/16/24 at 12:50 P.M. with Registered Nurse (RN) #427 verified all items in the cabinets in the kitchenette area. RN #427 confirmed residents frequently wander in the kitchenette area and residents have full access to all cabinets and drawers in the kitchenette area and none were locked or secured. Observation on 12/18/24 at 8:18 A.M. of the treatment cart located in the secured Memory Care Unit located across from dining room was unlocked. Observation revealed no staff were present or within view of the area/cart. The treatment cart had five drawers with multiple treatment items including dressings, lotions, medicated creams, tinactin spray, multiple containers of nyamycin powder, hemorrhoid ointments, diclofenac cream, zinc ointment, and antibiotic ointments. Observation and interview on 12/18/24 at 8:24 A.M. revealed RN #702 exited a resident room at the end of a hall. RN #702 confirmed the treatment cart was left unsupervised and unsecured in the residential living area. RN #702 confirmed there was only one other staff member in the Memory Care Unit and she was unsure where that staff member was. RN #702 verified the treatment cart was unlocked where residents were noted actively wandering and she did not notice the cart was left unlocked. 2. Review of Resident #50's medical record revealed an admitted [DATE]. Diagnoses included muscle weakness, dysphagia oropharyngeal phase, and dementia. Additional diagnoses dated 10/08/24 included fracture of the sternum, multiple fractures of ribs, and on 12/08/24 other symptoms and signs concerning food and fluid intake were added. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the quarterly MDS dated [DATE] revealed Resident #50 was severely cognitively impaired. Resident #50 had impairment on both sides of upper extremities and impairment on one side lower extremity. Resident #50 used a walker and required set up or clean up assist with meals. Review of the physician orders dated 09/09/22 revealed Resident #50 was to receive a regular diet, mechanical soft texture, and regular thin consistency liquids. Review of the care plan for potential risk for nutrition initiated on 03/18/24 and revised on 12/13/24 for Resident #50 revealed Resident #50 was to be monitored for chewing and swallowing difficulty that may trigger speech therapy consult-notifying nursing or dietitian. Review of the progress note dated 10/06/24 at 9:29 A.M. for Resident #50 completed by Licensed Practical Nurse (LPN) #447 revealed Resident #50 had a choking incident and had to have the Heimlich maneuver performed. Resident #50 was sent out via 911. Review of the progress note dated 10/06/24 at 9:30 A.M., completed by LPN #434, for Resident #50 revealed a change of condition was identified: Resident (#50) choked during breakfast. Resident was eating breakfast and choking on her food. Review of the progress note dated 10/06/24 at 9:54 P.M., completed by LPN #437 for Resident #50 revealed the nurse called the hospital for an update on the resident. Resident #50 was admitted for a sternum fracture. The resident's nurse stated that the resident will get a chest x-ray in the A.M., and she is able to swallow and take her medications now. Review of the progress note dated 10/08/24 at 4:52 P.M., completed by Director of Nursing (DON), for Resident #50 revealed the resident returned to the facility. Record review of the physician order dated 10/08/24 revealed an order for Speech Therapy (ST) and patient to be seen three times a week for four weeks addressing cognition and swallowing. Interview on 12/19/24 at 8:38 A.M. with Certified Nursing Assistant (CNA) #425 revealed she had to try to still get residents up for breakfast. CNA #425 revealed there were not enough staff to do it all, one nurse and one aide, there was not enough to care for everyone. CNA #425 then left to care for Resident #37. Registered Nurse (RN) #427 also left the dining room again. Observation revealed Resident #50 was sitting in a chair in the dining room with a plate of scrambled eggs and a dry piece of toast. No staff were present to assist or observe Resident #50 with her meal. Observation revealed Resident #50 had multiple broken/missing teeth and multiple caries. Resident #50 revealed she had trouble chewing her food due to missing teeth in front and on both sides. Interview and observation on 12/19/24 at 8:41 A.M. with RN #427 revealed RN #427 was sitting behind the nurses station. RN #427 verified she was unable to see Resident #50 in the dining room due to the wall blocking the view to where Resident #50 was sitting in the corner eating her breakfast unattended in the dining room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 12/19/24 at 9:30 A.M. with the DON revealed he would expect staff to monitor Resident #50 during meals. The DON confirmed Resident #50 did have a care plan specific to monitoring for chewing and swallowing. Phone interview on 12/19/24 at 12:42 P.M. with ST #703 revealed Resident #50 becomes distracted easily when eating. ST #703 revealed she would recommend Resident #50 was observed during meals.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39968 Based on observations, staff interviews, review of nursing schedules, review of Self-Reported Incidents (SRI), review of personnel files, review of concern logs, review of resident council minutes, and review of the facility assessment, the facility failed to provide sufficient nursing staff to meet the total care needs of the residents and failed to provide adequate nursing coverage on each shift. This had the potential to affect all 59 resident in the facility. The facility census was 59. Findings include: 1. Review of an SRI, dated 09/17/24, revealed Certified Nursing Assistant (CNA) #600 was found to be sleeping in an empty resident bed and had eaten several bags of snacks and chips. Resident #4 stated an STNA (State tested Nursing Assistant) came into her room, pulled the privacy curtain and pulled her blind down. CNA #600 then proceeded to lay down in the bed, the other bed in her room (bed B), and ate and drank all night. Resident #4 stated I could hear her crunching all night. CNA #600 was suspended pending the investigation. Review of CNA #600's personnel file revealed she was terminated on 09/20/24 due to a disciplinary occurrence on 09/17/24 regarding conduct and customer service. The Director of Nursing (DON) signed and witnessed the document. Interview on 12/17/24 at 3:10 P.M. with the DON confirmed there was only one nurse on duty that evening and CNA #600 no longer worked at the facility. 2. Observations on 12/18/24 at 2:32 P.M. revealed several residents in the common area on the Memory Care Unit, sitting in chairs and wheelchairs. The assigned CNA was in the shower room with a resident and the nurse was not on unit. Activity Aide #402 was on the unit painting resident fingernails. Observation on 12/18/24 at 2:33 P.M. noted an active call light for Resident #12. The call light was answered at 2:40 P.M. by the CNA when she exited the shower room. Review of the nursing schedule for 12/18/24 for the Memory Care Unit revealed one nurse and two CNA's were scheduled to be on the unit. 3. Observation on 12/18/24 at 4:37 P.M. found a resident sitting in chair with no socks or shoes on. Interview with Registered Nurse (RN) #605 confirmed the resident had no socks or shoes on. She stated there are not enough staff, and she can't get everything done. She only had one aide, all day, back in Memory Care. RN #605 stated when the aide was helping residents, RN #605 can pass medications, but RN #605 has to stop when there is no aide on the floor. RN #605 was unable to provide incontinence care with no aide on the floor to assist her with meeting the needs of the residents. Interview on 12/18/24 at 4:45 P.M. with CNA #425 reported the resident was up when she started her shift, with no socks on then, just shoes. She took the shoes off the resident. She stated it's too much in memory care with just one aide. She told the DON and Administrator, and they say it's a number thing. The census is low, but these people need more care, and CNA #425 stated she can't get everything done. Needing to assist residents with toileting every two hours leaves residents unattended and leads to more falls. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the nursing schedule for 12/18/24, for the Memory Care Unit revealed one nurse and two CNA's were scheduled to be on the unit. 4. Observation on 12/19/24 at 8:20 A.M. of meal service in the Memory Care Unit revealed Social Worker Designee (SWD) #453 was observing Business Office Manager (BOM) #410 passing the breakfast trays in the Memory Care Dining Room. No other staff were present. After serving the breakfast trays, SWD #453 and BOM #410 left the Memory Care Unit. Observation revealed BOM #410 did not open any milk cartons or offer a glass or straw to the residents for their milk. Residents observed unattended in the dining room were Residents #5, #7, #13, #15, #16, #44, #50, #57, #59, and #60. Observation and interview on 12/19/24 at 8:32 A.M. of the dining room with RN #427 revealed the kitchen did not provide the residents cups for milk, they provide coffee cups only except for two residents, Residents #13 and #52 who received thickened liquids. RN #427 confirmed staff did not open the milk for residents. Observation revealed residents did not open or drink the milk. Resident #60 stated, I can't open it, so I will just leave it. Observation on 12/19/24 at 8:34 A.M. revealed Resident #37 walking down the hall towards the dining room in the Memory Care Unit in a shirt saturated in urine to her armpit and pants that were saturated front and back with urine. Resident #37 had a strong urine odor. Observation revealed RN #427 was feeding one resident. RN #427 revealed there was only one other staff member in the Memory Care Unit, and she was assisting another resident. Interview on 12/19/24 at 8:38 A.M. with CNA #425 revealed she had to try to still get residents up for breakfast. CNA #425 revealed there were not enough staff to do it all, one nurse and one aid, and there was not enough to care for everyone. CNA #425 then left to care for Resident #37. RN #427 also left the dining room again. Observation revealed Resident #50 was sitting in a chair in the dining room with a plate of scrambled eggs and a dry piece of toast. No staff were present to assist or observe Resident #50 with her meal. 5. Interview on 12/19/24 at 8:38 A.M. with CNA #425 stated the family of Resident #52 wants him to wake up on his own and it varies, he is usually up between 10:00 A.M. and 12:00 P.M. CNA #425 stated she will save his breakfast tray and warm it up. She will check to see when Resident #52 is up and walking around his room. CNA #425 stated Residents #35 and #46 were awake and in their rooms as well. She was unable to get them up, to bring them down to breakfast because she was the only aide on the unit. Review of the nursing schedule for 12/19/24 for the Memory Care Unit revealed one nurse and two CNA's were scheduled to be on the unit. 6. Review of Resident Council minutes from 07/31/24, 08/28/24, 09/25/24, 10/30/24 and 11/27/24 revealed the following staffing concerns: On 07/31/24, Resident #47 stated her call light was not always placed close to her. Residents #30, #40, and #54 stated the aides were using their personal, privately bought, body wash and personal hygiene products for other residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 08/28/24 and 09/25/24, several residents had personal care concerns. They were told they will be addressed on an individual basis. The residents were reminded to voice their concerns at the time instead of waiting for Resident Council. On 10/30/24, several residents had personal care concerns. They were told they will be addressed on an individual basis. The residents were reminded to voice their concerns at the time instead of waiting for Resident Council. Many residents stated they were not receiving ice water because the aides are not filling up the unit ice bucket. On 11/27/24, many residents stated they were not receiving ice water because the aides are not filling up the unit ice bucket. Residents were not receiving the correct size incontinent briefs. Resident #40 stated her aide is not getting her up and dressed early enough for Sunday church services. Review of the Concern and Complaint logs from 07/31/24 through 12/12/24 revealed multiple complaints made by residents regarding staffing. On 09/25/24, Resident #11 complained about medication administration and assistance with toileting. Resident #14 complained that she was often left alone in the bathroom and the aides were not doing their rounds. On 11/01/24, Resident #52 complained about not having enough staffing to provide his care. On 11/05/24, Resident #11 complained about nursing issues again. On 11/26/24, Resident #31 complained about not getting assistance with her hearing aids. On 11/27/24, Resident #40 complained about the aides not getting residents up early enough for church services on Sunday. On 12/12/24, Residents #10, #19, #27, #47, #49, and #55 all complained about nursing concerns. Interview on 12/16/24 at 10:12 A.M. with the Administrator revealed no resolutions had been made to residents expressing concerns. 7. Review of the Facility Assessment, updated 08/13/24, was based on the Average Daily Census of 60 residents. The facility census was 59. It asserted a ratio of one nurse for every 20 residents is required on the day shift, approximately three nurses, and one nurse for every 30 residents was required on the night shift, approximately two nurses. Review of nursing schedules for 10/03/24 through 10/15/24 revealed on 10/07/24 and 10/14/24 there were only two nurses scheduled for the day shift, 7:00 A.M. to 7:00 P.M. Only one nurse was scheduled for the following night shifts, 7:00 P.M. to 7:00 A.M., on 10/03/24, 10/04/24, 10/05/24, 10/06/24, 10/08/24, 10/09/24, 10/10/24, 10/11/24, 10/13/24, 10/14/24, and 10/15/24. Interview on 12/16/24 at 10:12 A.M. with the Administrator verified the staff schedules were not staffed according to the facility assessment. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	This deficiency represents noncompliance investigated under Complaint Numbers OH00160172 and OH00160016.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review and staff interview, the facility failed to ensure an as needed psychotropic medication was stopped after 14 days of ordering. This affected one (#52) of five residents reviewed for medication. The facility census was 59. Findings include: Review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease with early onset, anxiety disorder, insomnia, and dementia. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #52 had impaired cognition. Review of the physician orders for December 2024 revealed active order for Ativan oral tablet 0.5 milligrams (mg) (Lorazepam). Give 0.5 mg by mouth every 4 hours as needed for anxiety with a start date of 11/11/24. Interviews on 12/17/24 at 4:21 P.M. and 5:22 P.M., with the Director of Nursing (DON) verified there was no stop date for the as needed Ativan and should have been after 14 days. The DON stated he called hospice agency (who ordered the Ativan originally) and hospice will discontinue the medication because the resident has not needed the medication outside of the routine order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, staff interview, medical record review, and review of manufacturer's guidelines, the facility failed to ensure the medication error rate did not exceed five percent (%). The facility had three medication errors of 25 opportunities for an error rate of 12%. This affected two (#31 and #32) of four residents reviewed for medication administration. The facility census was 59 residents. Findings include: 1. Review for Resident #31's medical record revealed an admitted [DATE]. Diagnoses included muscle wasting, hypocalcemia, and [NAME] syndrome (an immune system illness). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #31 was cognitively intact. Review of the care plan dated 01/06/23 revealed Resident #31 was at risk for constipation related to decreased mobility and medication use. Interventions included to administer medications as ordered. Review of the physician orders for Resident #31 for December 2024 revealed an order for Miralax oral powder 17 gram (gm)/scoop. Give 1 scoop by mouth in the morning every other day related to [NAME] syndrome. An additional order included calcium tablet 600-200 milligram (mg) unit, (Calcium-Vitamin D). Give 1 tablet by mouth two times a day for hypocalcemia. Observation on 12/17/24 at 8:11 A.M., with Licensed Practical Nurse (LPN) #701 during medication administration for Resident #31 revealed calcium tablet 600-200 mg unit was not available for administration. LPN #701 confirmed the calcium was not available. LPN #701 then poured Miralax oral powder into the cap, half way to the fill line, then poured it into a cup to serve. LPN #701 verified that was the complete dose to be administered. The surveyor read the instructions on the container with LPN #701 which included 17 gms would be the full cap (to the top of the white line). Concurrent interview with LPN #701 verified she prepared the wrong dose of Miralax for administration to Resident #31. 2. Review for Resident #32's medical record revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus. Review of the quarterly MDS dated [DATE] revealed Resident #32 was cognitively intact and had diabetes mellitus. Review of the care plan for Resident #32 dated 10/08/24 revealed Resident #32 was at risk for hypo/hyperglycemia related to diabetes mellitus. Interventions included to administer diabetes medication as ordered by the doctor. Review of the physician orders for December 2024 for Resident #32 revealed Humalog subcutaneous solution cartridge 100 units/milliliter (ml) (Insulin Lispro) inject four units subcutaneous (SQ) three times a day, give with Humalog subcutaneous solution as per sliding scale three times a day related to type two diabetes mellitus with other circulatory complications. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/18/24 11:35 A.M., with LPN #415 during Resident #32's administration of Humalog (Insulin Lispro) revealed LPN #415 set the Kwikpen at 12 units (four units for the routine dose and eight units per the sliding scale result). Continuous observation revealed LPN #415 did not prime the Kwikpen prior to setting the dose. LPN #415 showed the surveyor the 12 units set on the Kwikpen and confirmed she was ready to administer the dose. When asked about priming, LPN #415 revealed, You don't need to with a Kwikpen then asked the surveyor, Why, are you supposed to? LPN #415 confirmed she never primed the Kwikpen and confirmed she would have administered the insulin injection if the surveyor had not intervened. Review of the manufacturer's guidelines titled, Use of the Insulin Lispro, revised July 2023, revealed to always use a new needle for each injection and prime before each injection. Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime the pen before each injection, you may get too much or too little insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2024
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Cuyahoga Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 300 East Bath Road Cuyahoga Falls, OH 44223	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42011 Based on observation, staff interview, and review of policy, the facility failed to ensure medications were stored in a secure manner. This affected six (#4, #25, #27, #40, #41, and #60) and had the potential to affect 19 additional residents (#1, #3, #7, #12, #15, #16, #17, #21, #26, #29, #35, #37, #43, #44, #49, #50, #52, #57, and #59) identified by the facility as being cognitively impaired and independently mobile. The facility census was 40. Findings include: 1. Observation on 12/16/24 at 9:20 A.M., revealed 11 pills left unattended in a medication cup at the bedside table for Resident #41. Certified Nursing Assistant (CNA) #462 was present providing incontinence care for Resident #41. Interview and observation on 12/16/24 at 9:24 A.M., with Licensed Practical Nurse (LPN) #463 confirmed the 11 pills were left unattended in a medication cup at the bedside table for Resident #41 and confirmed the medications were not administered to Resident #41 per the physician orders. 2. Observation on 12/16/24 at 9:36 A.M., revealed four pills in a medication cup left unattended at the bedside table for Resident #25. Interview with LPN #463, at the time of the observation, confirmed the four pills in medication cup that was to be administered to Resident #25 was left on the table and not administered per the physicians orders. 3. Observation on 12/16/24 at 9:36 A.M., revealed Resident #4 was sitting up in a wheelchair in her room. Observation revealed a small white oval shaped pill on the floor next to the window in her room. A large white pill was observed under the bed side table, an additional half white oval shaped pill was on the other side of the room in front of the sink, a half oval shaped pill was on the floor in front of the entrance door and an additional oval shaped white pill was near the wheel of the bed. Interview at the time of the observation, with LPN #701, confirmed all five pills lying throughout the room on the floor of Resident #4's room and revealed the pills wouldn't have been from today because she doesn't give the resident her pills in her room. LPN #701 stated the large white pill was a potassium supplement and the remainder of the white pills were escitalopram 10 milligrams (mg). LPN #701 confirmed Resident #4 was unable to self administer medications. Observation on 12/16/24 at 10:28 A.M., while walking up Cascade hall, a small round pill was observed left on the floor. Interview with LPN #701, at the time of the observation, confirmed the pill and revealed it was a Topiramate used for epilepsy. LPN #701 revealed she did not know who the pill belonged to. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation on 12/16/24 at 10:33 A.M., revealed a medication cup on Resident #27's table in his room with four large white pills and 3 capsules in the cup. Interview at the time of the observation, with LPN #701 revealed she left the pills for Resident #27 to take with his meal but he must have left them and went on to therapy. 5. Observation on 12/16/24 at 1:03 P.M., in the Memory Care Unit revealed Resident #60 had a large opened bag of Halls cough drops sitting on her nightstand. Interview with Registered Nurse (RN) #427, at the time of the observation, confirmed the Halls were left unsecured on Resident #60's nightstand. RN #427 confirmed no medications should be left unsecured in the Memory Care Unit. Interview on 12/18/24 at 10:33 A.M. with Director of Nursing (DON) confirmed at the times of the observations on 12/16/24, Residents #41, #25, #27, and #60 did not have orders or assessments completed to self administer medications. The DON confirmed medications should never be left at a bedside unsecured/unattended at any time. 6. Observation on 12/18/24 at 9:49 A.M., outside of the room belonging to Resident #40, revealed a red/burgundy colored pill in an oval form, located on the floor. Interview on 12/18/24 at 9:51 A.M., with LPN #415 confirmed and verified the loose pill on the floor in the hallway located outside of Resident #40's room. Review of the policy titled, Medication Administration and Management, revised June 2019, revealed only authorized medical and licensed nursing staff will administer medications ordered by the physician. (The residents right to self-administer medications will be respected following the Medication Self Administration Policy) Home medications must have a written order from the admitting or attending physician for use by the resident and home medications must be kept on the medication cart with the residents current medications. Remain with the patient/resident until he/she has swallowed the medication. This deficiency represents non-compliance investigated under Complaint Number OH00160172.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51067 Based on observations, medical record review, policy review, resident interview and staff interview, the facility failed to arrange an Maxillary Oral Surgeon consult as ordered. This affected one (#2) of one resident reviewed for dental services. The facility census was 59. Findings included: Review of Resident #2's medical record revealed an admitted [DATE], with diagnoses including: unspecified dementia, gastroesophageal reflux disease, and hypertensive heart disease without heart failure. Review of the quarterly Minimum Data Set (MDS) assessment completed on 10/07/24 revealed Resident #2 had no broken or loosely fitting full or partial dentures or mouth or facial pain, discomfort or difficulty chewing. Review of care plan initiated on 10/02/18, revealed Resident #2 had potential for dental concerns and was at risk for increased pain and infections as evidenced by own teeth, poor dentition, and rejections of assistance with oral hygiene. Interventions included observe for pain, excessive bleeding, et cetera (etc) and report to physician (MD), observe for signs and symptoms of infection, for example, swollen glands, fever, redness, etc. and report to MD, and observe to ensure food texture is appropriate. Review of the dental consent form dated 08/05/24 revealed Resident #2 had a dental visit and was referred to a maxillary oral surgeon for sedation and extraction of ten teeth. Review of a progress note dated 09/13/24 revealed a note stating working on oral surgeon referral. Further review of the medical record revealed no additional follow up from the 09/13/24 note or evidence of an appointment being arranged for Resident #2 to be seen by an oral surgeon. Observation on 12/17/24 at 1:30 P.M., revealed Resident #2 sitting at the dining room table attempting to eat lunch. Lunch consisted of shredded beef, cubed potatoes, pudding and gelatin. Resident #2 consumed approximately 25 percent of the gelatin and pudding. Concurrent interview with Resident #2 revealed she was unable to eat the solid foods due to mouth pain. Interview on 12/17/24 at 1:30 P.M., with Certified Nursing Assistant (CNA) #449 revealed she made Resident #2 a peanut butter and jelly or bread and butter sandwich with her lunch to assist her with eating foods that are tolerable. Interview on 12/18/24 at 2:59 P.M., with Medical Records Staff (MRS) #452 revealed she was responsible for scheduling ancillary appointments, including oral surgeons, and associated transportation. MRS #452 denied she was made aware by social services to schedule an oral surgeon appointment for Resident #2 and verified no appointment had been arranged for the resident. Review of the policy titled Ancillary Policy, dated January 2024, revealed the facility was to assist residents in obtaining routine and 24-hour emergency dental care.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observations, resident interviews, staff interviews, job description review, review of resident diet order list, and review of personnel files, the facility failed to ensure adequate and appropriate dietary staff to meet the dietary needs of the residents. This had the potential to affect all residents except one resident (#45) who received nothing by mouth. The facility census was 59. Findings include: Interview on 12/16/24 at 9:00 A.M. with Resident #21 revealed his breakfast meal had not arrived, and he was hungry. Resident #21 revealed his breakfast, lunch, and dinner meal were late daily. Interview and observation on 12/16/24 at 9:10 A.M. with Resident #11 revealed she had not received her breakfast meal. Resident #11 revealed all her meals arrived late every day. Resident #11 revealed her lunch always arrived after 2:30 P.M. and her dinner always arrived after 6:30 P.M. Review of the mealtimes revealed for lunch dining room opened at 11:15 A.M. The tray line began at 12:00 P.M., the [NAME] unit received lunch at 12:15 P.M., the Buckeye unit at 12:30 P.M. and Cascade unit at 12:45 P.M. At the bottom of the mealtimes revealed please allow five to 10 minutes grace period on halls and noted to be revised on 05/16/24. Observation of lunch in the main dining room on 12/16/24 at 12:01 P.M. revealed six residents and Certified Nurse Assistant (CNA) #406 sitting in the dining room. By 12:13 P.M., there were eight residents in the dining room. Observation on 12/16/24 at 12:26 P.M., revealed lunch nor beverages were served. At this time, interviews with Residents #20, # 24, #39, #47, #49, #54, #55, and #56 revealed lunch was late. All residents stated they were usually in the dining room by 11:30 A.M. and the aides were supposed to be in the dining room serving beverages. The residents stated the kitchen was always late with meals. Observation on 12/16/24 at 12:37 P.M. revealed lunch trays had not arrived at the Buckeye Trail Unit. Observation on 12/16/24 at 12:38 P.M. revealed CNA #406 to bring out the beverage cart and start offering beverages to the residents in the dining room. Interview on 12/16/24 at 12:40 P.M. with CNA #462 and Licensed Practical Nurse (LPN) #457 verified the lunch meal trays had not arrived to the Buckeye Trail Unit and were late. Interview with CNA #462 and LPN #457 revealed the meals, breakfast, lunch and dinner, were always late. LPN #457 revealed the kitchen did not have enough staff to meet the needs of the residents and to produce efficient results. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 12/16/24 at 12:42 P.M. with CNA #406 stated typically lunch was served at 11:30 A.M., but there had been a lot of issues with kitchen staff. CNA #406 stated they can't stop people from quitting or being unhappy with their job. CNA #406 stated lunch was on time when the kitchen was staffed but it had been unstable since the core group left. CNA #406 verified lunch today was running late and she had to make the beverage cart because the residents were sitting. CNA #406 stated the kitchen staff were still working on lunch. CNA #406 stated the kitchen staff usually made the beverage cart, but she will help with what she can even if outside of her scope. Observation on 12/16/24 at 12:57 P.M. noted CNA #406 to bring out and start serving dessert. At this time, CNA #406 stated it was upside-down cake and they were still waiting for lunch. Observation and interview on 12/16/24 at 1:03 P.M. revealed lunch trays had not arrived at Buckeye Trail, Cascade Valley, and [NAME] Hills, the 3 units that made up the facility census of 59. LPN #303 confirmed the lunch trays had not arrived and stated, The meals are always late. Observation on 12/16/24 at 1:28 P.M. revealed the lunch cart arrived, and CNA #406 started serving the dining room. During an interview on 12/17/24 at 10:35 A.M. with Dietary Manager (DM) #454 he stated he started on 12/02/24. DM #454 stated staffing in the kitchen was low and he was trying to put staff in the kitchen. DM #454 stated on 12/16/24, the cook called off and a dietary aide was in a car accident. DM #454 stated there was a laundry aide that does both the kitchen and laundry and the maintenance men had helped in the kitchen. DM #454 stated prior to his start at the facility, the Administrator used to cook in the kitchen. Interview on 12/18/24 at 8:54 A.M. with Maintenance Assistant (MA) #405 stated he helped out in the kitchen when there was a call off or staff had quit. MA #405 stated he only did the dishes and delivered the hall carts. Interview on 12/18/24 at 8:56 A.M. with Director of Maintenance (DOM) #401 stated he has helped in the kitchen only in emergencies and he helped cook and do the dishes. DOM #401 stated he had no formal training but has helped out in the kitchen at other nursing homes and cooked at home. Interview on 12/18/24 at 9:02 A.M. with Laundry Aide (LA) #455 stated he helped out in kitchen usually with call offs. LA #455 stated he would work a few hours in the kitchen which included doing the dishes, sweeping/mopping floors, and help with food preparation. Review of job description for the cook revealed under required education and experience revealed preferred ServSafe Certification and 2 or more years experience as a cook in a restaurant or institution. Review of the personnel file for DOM #401 revealed a hire date of 08/22/24. Review of the application under previous employment included maintenance, maintenance director, scale techician but no listed dates or time frames. There was no noted history related to food service or restaurant work. Observation on 12/18/24 at 4:44 P.M. revealed nine residents in the dining room. Staff were observed offering beverages to residents. (continued on next page)

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	365826	A. Building B. Wing	12/23/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 12/18/24 at 4:48 P.M. with DM #454 stated the cook walked out and he had to finish preparing dinner. Observation on 12/18/24 at 5:26 P.M., all residents in the dining room were served dinner. Review of the mealtimes for dinner revealed the dining room opens at 4:00 P.M., the tray line starts at 4:45 P.M., Buckeye unit received meals at 5:00 P.M., Cascade unit received meals at 5:15 P.M., and [NAME] unit receive meals at 5:30 P.M. Review of the resident diet order list revealed Resident #45 had a physician order to receive nothing by mouth. This deficiency represents non-compliance investigated under Master Complaint Number OH00160817, and Complaint Numbers OH00160172, OH00160146, and OH00160016.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39969 Based on observations, resident interviews, staff interviews, review of resident diet order list and policy review, the facility did not ensure food was held at appropriate temperatures while on the steam table and served at palatable temperatures. This affected seven residents on pureed (#13, #36 #52) and/or mechanical soft (#4, #15, #19, #50) diets respectively. Additionally, interviews with four residents (#11, #19, #33, #40) voiced concerns that the food was served cold. The facility census was 59. Findings include: Interviews on 12/16/24 from 9:00 A.M. to 3:00 P.M. with Residents #11, #19, #33, and #40 stated the food was served cold. Observation on 12/19/24 at 11:38 A.M., Dietary [NAME] (DC) #407 washed his hands and then obtained food temperatures of the food on the steam table for tray line meal service. Continuous observation revealed the temperature of the ground baked ziti was 120 degrees Fahrenheit (F), pureed baked ziti was 120 degrees F, and the pureed beets were 130 degrees F. Concurrent interview with DC #407 verified the temperatures and stated the items would heat up while on the steam table. Observation on 12/19/24 at 12:58 P.M. of the test tray with Dietary Manager (DM) #454, revealed the temperature of the baked ziti was 111 degrees F and the diced beets were 108.8 degrees F. Both items were flavorful but were cold. Coinciding interview with DM #454 verified the food temperatures. DM #454 stated yesterday was his first food committee meeting and the residents complained about the taste of the food as well as the food temperatures being cold. Review of the undated policy titled, Safe Food Temperatures, revealed it was the policy of the facility that food temperatures would be maintained at acceptable levels during food storage, preparation, holding, serving, delivery, cooling and reheating. The steam table may not be used to reheat food. Hold hot foods at 140 degrees F or higher during meal service (on the tray line). Hold cold foods at 40 degrees F or lower during meal service (on the tray line). Maintain and serve hot beverages at 140 degrees F or higher. This deficiency represents non-compliance investigated under Master Complaint Number OH00160817 and Complaint Numbers OH00160146, and OH00160016.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observation, policy review, resident interviews, and staff interviews, the facility failed to ensure a clean and sanitary kitchen. This had the potential to affect all residents except one resident (#45) who received nothing by mouth. The facility census was 59. Findings include: 1. Observations during the tour of the kitchen on [DATE] from 9:33 A.M. to 9:56 A.M., with the Administrator revealed: observed in the walk-in cooler the two light fixtures were heavily dusty, there was a black substance on the ceiling near the fans and on the silver parts around the fan. There was also a black substance/spots on the wall around the door that led to the walk-in freezer; observed on a clean rack on the bottom shelf was a black bucket with plastic cups that were clear colored but were very cloudy. There was a four slotted silverware container with spoons in two of the slots that had water spots and the other two slots were empty with crumbs; the dry storage room floor entry way was heavily soiled; observed the back side of the steam table was heavily soiled and dusty. The coffee urn sat on a table behind the steam table and the bottom shelf of this table had boxes of coffee filters and coffee. This shelf had dried coffee stains; observed under the sink where the juice machine was located was a large white dried stain and a sticky, brown substance on the shelf; and the ice machine next to the sink, observed inside on the bottom portion of the silver part that the ice comes down had a tannish substance along it. Interview on [DATE] between 9:33 A.M. to 9:56 A.M., the Administrator verified the above findings. Follow-up visit to the kitchen on [DATE] at 11:15 A.M., observed the toaster on the preparation table next to the blender was heavily caked with crumbs inside, on the knobs, and unclean on the outside of the toaster. Interview on [DATE] at 11:28 A.M. with Dietary Manager (DM) #454 verified the observation. Review of the resident diet order list revealed Resident #45 had a physician order to receive nothing by mouth. Review of the policy titled Sanitation and Food Safety in Food Service, revised [DATE], revealed the nutrition/culinary services director (NSD) will assume responsibility for the food safety and sanitation of the Nutrition Culinary Department. (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

42011

2. Review of Resident #55's medical record revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, muscle weakness, difficulty in walking, gastroesophageal reflux disorder, and heart failure.

Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively intact. Resident #55 required set up or clean up assist with meals and was independent with ambulation.

Observation on [DATE] at 9:56 A.M., revealed Resident #55 had a refrigerator in his room. Observation of the refrigerator revealed multiple food items including dairy, milk products, cottage cheese, yogurt, pudding snacks, multiple types of cheese and sodas. The shelving unit in the refrigerator had multiple spills. There was no thermometer available, and the bottom of the refrigerator had a liquid spill with brown and pink particles floating and a thick slime floating on top. The refrigerator had a foul odor. Per Resident #55 he tried to clean it when he could but he had no cleaning supplies.

Interview on [DATE] at 10:10 A.M. with Housekeeper #421 revealed housekeepers did not clean refrigerators.

Observation on [DATE] at 11:11 A.M., with the Director of Nursing (DON), of Resident #55's refrigerator in his room confirmed the contents, spills, odor and slime with the food inside the refrigerator. The DON stated housekeepers were to clean refrigerators. The DON confirmed the food/drinks in Resident #55's refrigerator were unsafe to consume. Resident #55 revealed to the DON he tried to clean it and told them it needed cleaned.

3. Review for Resident #1's medical record revealed a readmitted [DATE]. Diagnoses included vascular dementia and Alzheimer's disease.

Review of the quarterly MDS dated [DATE] revealed Resident #1 was severely cognitively impaired. Resident #1 had no impairment of the upper or lower extremities and used a walker for mobility.

Observation on [DATE] at 1:07 P.M., with Director of Admissions (DOA) #441 of Resident #1's refrigerator, located in the resident's room on the Memory Care Unit, revealed the refrigerator temperature was 44 degrees Fahrenheit (F). Inside the refrigerator were multiple food items including a container of ham salad with an expiration date of [DATE] and a yogurt with an expiration date of [DATE]. There was no temperature tracking log observed on or near the refrigerator. Resident #1 was observed sitting in a chair in her room. Resident #1 stood and ambulated independently. Resident #1 revealed she ate the food items from her refrigerator. DOA #441 confirmed the expired food items in Resident #1's refrigerator and stated the Certified Nursing Assistants (CNA) and housekeeping should routinely clean the resident's refrigerator and dispose of expired food items.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Refrigerators and Freezers, created [DATE], revealed the facility would ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Acceptable temperature ranges were 35 degrees F to 40 degrees F for refrigerators and less than 0 degrees F for freezers. Monthly tracking sheets for all refrigerators and freezers would be posted to record temperatures. For residents with a personal refrigerator, staff would place a portable thermometer in the refrigerator and the temperature of that refrigerator would be recorded by housekeeping personnel. Supervisors would be responsible for assuring food items in pantry, refrigerators, and freezers were not expired or post perish dates.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, resident interview, staff interview, record review, and review of policy, the facility failed to ensure accurate documentation reflecting care and treatment provided. This affected two (#15 and #62) of three residents reviewed for wound care. The facility census was 59. Findings include: 1. Review for Resident #62's medical record revealed an admitted [DATE]. Diagnoses included cutaneous abscess of perineum, rectal abscess, Crohn's disease, and rectal fistula. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was cognitively intact. Resident #62 had medically complex conditions including ulcerative colitis, Crohn's, and inflammatory bowel disease. Resident #62 received antibiotics and received intravenous (IV) medication. Review of the care plan for Resident #62 dated 10/23/24 revealed the resident was on IV - peripherally inserted central catheter (PICC) antibiotics related to peritoneal abscess. Interventions included to observe dressing. Change dressing and record observations of site. Review of the physician orders for Resident #62 dated 10/23/24 revealed orders for PICC line dressing change, change PICC line dressing every five days and as needed. Review of the Medication Administration Record (MAR) for Resident #62 from 11/23/24 through 12/17/24 revealed the PICC line dressing changes were scheduled to be completed on 11/23/24, 11/28/24, 12/03/24, 12/08/24, and 12/13/24 at 7:00 A.M. Further review revealed each date was signed as completed, with the exception of 11/28/24. Review of the nursing note for Resident #62 dated 11/25/24 at 3:23 P.M., completed by Registered Nurse (RN) #412, revealed the physician was notified of leakage at the resident's PICC line site. The dressing was changed to the site. Review of the nursing note for Resident #62 dated 11/28/24 at 12:56 P.M., completed by RN #412, revealed PICC Line Dressing Change: Change PICC Line dressing every five days and as needed; PICC line dressing was changed on 11/25/24. Interview and observation on 12/17/24 at 8:38 A.M., with Resident #62 revealed Resident #62's PICC line was located in Resident #62's left upper arm and dated 11/25/24. Drainage was visible on the dressing and the edges of the dressing was lifting. Resident #62 revealed he never refused his PICC line dressing changes and revealed he had to ask them last time to change the PICC dressing, stating, they never even offer. Interview on 12/17/24 at 8:50 A.M., with Licensed Practical Nurse (LPN) #457 revealed Resident #62 never refused PICC line dressing changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365826	A. Building B. Wing	12/23/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/17/24 at 1:19 P.M., with LPN #457 of Resident #62's PICC line revealed Resident #62's PICC line was located in Resident #62's left upper arm. LPN #457 confirmed the dressing covering the PICC line was dated 11/25/24. There was visible brownish colored drainage on the dressing covering the wound and the edges of the dressing was lifting on all four sides. Review of the MAR with LPN #457 confirmed LPN #457 signed off the PICC line dressing change on the MAR as completed on 12/03/24, 12/08/24, and 12/13/24 at 7:00 A.M.; LPN #457 stated, Maybe he wasn't in his room, sometimes when we are really busy I sign off the treatment before I do it. LPN #457 confirmed the PICC line dressing did not get changed as scheduled after 11/25/24 and she signed the MAR reflecting it did get changed. LPN #457 repeated when really busy, she signed off the treatment before she did them. LPN #457 confirmed Resident #62 did not refuse the dressing changes and further verified she did not complete the dressing changes but documented they had been done. 2. Review of Resident #15's medical record revealed an admitted [DATE]. Diagnoses included dementia, type two diabetes mellitus, muscle weakness and difficulty in walking. Review of the quarterly MDS assessment dated [DATE] revealed Resident #15 used a walker for mobility, required substantial/maximum assistants with putting on and taking off footwear and was dependent for personal hygiene. Review of the physician orders for Resident #15 revealed an order dated 03/29/24 to cleanse bilateral feet with soap and water pat dry and apply Aquaphor every shift. The treatment was scheduled at 7:00 A.M. and 7:00 P.M. Observation on 12/18/24 at 8:17 A.M., revealed Resident #15 was sitting in a chair in the lounge sleeping. Resident #15 had no socks on, and her shoes were removed and sitting next to her feet on the floor. Resident #15's feet appeared very dry and flaky. Review on 12/19/24 1:55 P.M. of the MAR and treatment administration record (TAR) for Resident #15 for December 2024, with RN #427, confirmed the treatments to cleanse Resident #15's bilateral feet with soap and water, pat dry and apply Aquaphor every shift was signed as completed twice daily. RN #427 revealed, We don't do that. That was when we had carpet. They all had the order in the spring. We just need to get it discontinued, we only did it for a few weeks after it was written. I don't know why the nurses still sign it off, I am guilty too, I just sign it but I will get it discontinued. RN #457 verified treatments were documented as completed, even though they had not been done. Interview on 12/19/24 between 2:17 P.M. and 2:53 P.M., with the Director of Nursing (DON) revealed if nurses sign the physician orders off on the MAT/TAR, they should be doing it. The DON confirmed he looked at Resident #15's right foot and verified the dry flaky skin and the cracked heel. The DON confirmed there was no other treatment to Resident #15's feet except to cleanse bilateral feet with soap and water pat dry and apply Aquaphor every shift. Review of the policy titled, Documentation - Licensed Nurse, revised June 2019, revealed the nursing staff will be responsible for recording care and treatment, observations and assessments and other appropriate entries in the resident clinical record. The qualified nursing staff notes the time, date, and dosage of all medications and treatments at the time they are administered and initials the note on the medication and/or treatment record. Entries are factual and objective, do not document an action before it took place, do not document an action that did not take place.

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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** 42011 Based on observation, staff interview, record review, and review of policies, the facility failed to ensure infection control practices were maintained during a sterile peripherally inserted central catheter (PICC) line dressing change. This affected one (#62) of one resident reviewed for infection control with intravenous access care. The facility census was 59. Findings include: Review for Resident #62's medical record revealed an admitted [DATE]. Diagnoses included cutaneous abscess of perineum, rectal abscess, Crohn's disease, and rectal fistula. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was cognitively intact. Resident #62 had medically complex conditions including ulcerative colitis, Crohn's', and inflammatory bowel disease. Resident #62 received antibiotics and received IV medication. Review of the care plan for Resident #62 dated 10/07/24 revealed Resident #62 was to be on Enhanced Barrier Precautions as evidence by a peripherally inserted central catheter (PICC) and an open wound. Review of the physician orders for Resident #62 dated 10/23/24 revealed orders for PICC line dressing change, change PICC line dressing every five days and as needed. Observation on 12/17/24 at 1:19 P.M., of Licensed Practical Nurse (LPN) #457 complete a sterile dressing change to Resident #62's PICC line revealed Resident #62 was sitting in a chair in his room. On Resident #62's doorway was an Enhanced Barrier Precaution (EBP) sign. LPN #457 confirmed the PICC line was located in Resident #62's left upper arm. LPN #457 confirmed the dressing covering the PICC line was dated 11/25/24. There was visible brownish colored drainage on the dressing covering the wound and the edges of the dressing was lifting on all four sides. LPN #457 did not donn an isolation gown prior to or during any of the procedure. LPN #457 removed the old dressing from the PICC line site, disposed of the old dressing and the gloves then opened the sterile dressing change kit and donned the gloves without washing her hands after removing the old soiled dressing. LPN #457 then cleansed the wound and applied a new sterile dressing. LPN #457 verified she did not donn a gown during the dressing change and revealed she thought she was supposed to but was not sure. LPN #457 verified she did not wash her hands after removing the soiled dressing and before donning the sterile gloves. LPN #457 verified the dressing was dated 11/25/24. Interview on 12/17/24 at 1:40 P.M., with Director of Nursing (DON) revealed the nurse was required to apply an isolation gown while completing a dressing change to a PICC line and confirmed the nurse should absolutely wash their hands after removing a soiled dressing and before donning sterile gloves which are required to do a PICC line dressing change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Enhanced Barrier Precautions (EBP), dated March 2024, revealed EBP is an infection control intervention designed to reduce the transmission of multi drug resistant organisms (MDRO) and employs targeted gown and glove use during high contact resident care activities for targeted residents. EBP are indicated for residents with wounds and or indwelling medical services even if the resident is not known to be infected or colonized with MDRO. Review of the policy titled, Dressing Change: Wound, dated June 2019, revealed to wash hands before and after donning gloves. Put on gloves, remove old dressing, remove gloves and wash hands. Put on clean gloves then cleanse the wound.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observations, resident interviews, family interviews, staff interviews, review of resident council minutes, and policy review, the facility failed to ensure a clean, functional and sanitary environment. This had the potential to affect all 59 residents. The facility census was 59. Findings include: Observation on 12/16/24 at 9:00 A.M of Resident #21 over the bed light revealed a light that was unable to be turned on due to no string or pull cord to operate it. Interview on 12/16/24 at 9:00 A.M., with Resident #21 revealed the light above his bed had not been in working order for 8 weeks and no one would fix it due to electricity concerns and/or hazards. Interview on 12/16/24 at 9:03 A.M. with Licensed Practical Nurse (LPN) #303 revealed housekeeping did not clean the resident rooms or common areas often. LPN #303 revealed housekeeping staff typically swept and mopped the areas that were visible from the hallways. Interview and observation on 12/16/24 at 9:10 A.M., with Resident #11 revealed housekeeping staff never cleaned her room. Resident #11 revealed sometimes the Certified Nursing Assistants (CNAs) attempted to straighten up, but they were busy meeting the needs of the residents. Observation during the interview with Resident #11 revealed a foul odor located in her bathroom. Observation of the bathroom revealed a toilet with brown stains located around the toilet seat and base of toilet. The brown stains appeared smeared and crusted. Observation on 12/16/24 at 9:15 A.M. of the cascade valley and buckeye trails units revealed multiple flickering lights on the ceilings. Interview on 12/16/24 at 9:26 A.M. with the Maintenance Assistant (MA) #405 revealed the lights were $40 a piece to replace but corporate was too cheap to replace it or they didn't want to pay for it. MA #405 confirmed and verified the flickering lights throughout the facility units. Interview on 12/16/24 at 9:30 A.M., with CNA #415 revealed housekeeping staff did not clean the resident rooms. CNA #415 confirmed and verified Resident #21 room was dirty and his fall floor mat was dirty with brown footprints located on the surface. CNA #415 also confirmed and verified Resident #11 bathroom with brown smear stains and foul odors. Interview on 12/16/24 at 9:51 A.M., with Housekeeper (HSKPR) #421 revealed she cleaned resident rooms every other day. However, she did not clean the residents rooms if the residents remained in the room. HSKPR #421 revealed she did not touch or clean resident bathroom shower curtains or privacy curtains. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and observation on 12/16/24 at 10:03 A.M., with MA #405 revealed the facility utilized an electronic system, TELS, to monitor facility and residents needs as it related to completing issues related to the environment. MA #405 revealed he did not have access to this system; therefore, he could not fix any issues that he was not aware of. MA #405 confirmed and verified Resident #21's over the bed light and pull cord was not in working order. Observation on 12/16/24 at 10:23 A.M., on the Memory Care Unit, revealed a floor strip located in the dining room that was lifting and peeling from one end to the other. The floor strip was approximately 16 feet long and 3 inches wide and corroded with dirt. Observation on 12/16/24 at 10:32 A.M., revealed a strong odor of urine on the Memory Care Unit. Interview on 12/16/24 at 10:36 A.M. with HSKPR #418 revealed there was one housekeeper assigned per unit. HSKPR #418 revealed the strong odors of urine was a daily issue, but it was usually cleared by mid-shift. HSKPR #418 confirmed and verified the strong odor of urine. Observation on 12/16/24 at 11:12 A.M. of Resident 23's bathroom revealed there was no soap in the dispenser and the bathroom has a pervasive odor of urine. Interview on 12/16/24 at 11:17 A.M. with CNA #462 revealed there was no soap in Resident #23's bathroom and there was a strong odor of urine in her bathroom. Interview on 12/17/24 at 9:15 A.M., with Resident #18's wife, revealed Resident #18's floors were covered with crumbs, trash cans had garbage overflowing onto the floor, and the toilet ring caulking was peeling. Interview with Resident #18's wife revealed he had been without hand soap for quite some time and the room had smells of urine. Observation and interview on 12/17/24 at 9:44 A.M. with Resident #53 revealed his shower curtain had splattered reddish brown stains covering the entire curtain. Resident #53 revealed he had wounds that bleed constantly, and it occurred two weeks ago after showering. Resident #53 revealed he requested a replacement shower curtain for the past two weeks. Interview on 12/17/24 at 9:44 A.M. with LPN #463 confirmed and verified Resident #53 shower curtain. Observation on 12/17/24 at 9:52 A.M. of Resident #18's room and bathroom was confirmed with LPN #463. Interview on 12/17/24 at 1:32 P.M. with Resident #53 revealed that he's been without hand soap in his bathroom for approximately three weeks and he's had to use body wash as a substitute when washing his hands. Interview on 12/17/24 at 1:36 P.M. with HSKPR #430 verified Resident #53's bathroom had no hand soap. Interview on 12/17/24 at 1:38 P.M. with HSKPR #430 verified Resident #18's bathroom had no hand soap. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 12/18/24 at 2:40 P.M. with MA #405 confirmed the floor strips condition and revealed the strip separated the dining room from the kitchenette on the memory care unit, and was tethered, torn, and frayed with pieces [NAME] up. Observation on 12/18/24 at 5:07 P.M., located on the Memory Care Unit, revealed an unclean unit with multiple crumbs from previous meals on the floor. Multiple tables located in the dining area were unclean with various spillage and crumbs observed. Resident #44 was observed sitting in her wheelchair bending over attempting to pick up crumbs off the floor. Observation revealed a plastic cup underneath the table with trash stuffed inside. Interview on 12/18/24 at 5:07 P.M. with CNA #425 revealed HSKPR #430 cleans the common areas once a day and the housekeeping department as a whole was not good. CNA #425 confirmed and verified the above findings located on the memory care unit. 39968 Observations on 12/18/24 at 6:00 P.M. with Maintenance Director #401 and Maintenance Assistance #405 revealed the Memory Care Shower Room shower water was not hot. The faucet was allowed to run for three minutes. The first temperature obtained was 86.1 degrees Fahrenheit. After an additional minute, the second temperature was still 86.1 degrees Fahrenheit. At 6:08 P.M., a water temperature was taken from Resident #33's shower. The faucet was allowed three minutes to run. The first temperature obtained was 110 degrees Fahrenheit. After an additional minute, the second test performed with temperature of 111 degrees Fahrenheit obtained. Interviews on 12/18/24 at 6:00 P.M. and 6:08 P.M. with Maintenance Director #401 confirmed the temperatures observation and the range for bathing was 100 to 120 degrees Fahrenheit. Review of Resident Council minutes from 11/27/24 revealed Resident #40 complained about cold water in the Memory Care Unit shower room. 42011 Observation on 12/16/24 at 9:56 A.M., revealed Resident #55 was sitting up in a chair in his room. Observation revealed there were multiple food crumbs and dried spills on the floor. The floor was sticky throughout. There was a privacy curtain pulled near the center of the room. The curtain had multiple large red/brown stains with visible substance sticking to the curtain. The window blinds had thick filmy dust on each blind. The walls had dried drippings of spills. The refrigerator was sitting on a piece of broken wood, the right front corner was sunk into the broken wood. In front of the refrigerator on the floor was multiple food/drink spills that also had paper items unable to be picked up because they were stuck to the floor. The sink located near the refrigerator had food particles covering the drain, the drain also had a thick black film. The bottom of the sink had multiple wet food crumbs and stains. The bathroom floor had a large amount of dirt and grime build up in all corners and floor edging. The floor was dirty and sticky. The toilet bowl had a thick ring around the inside of the bowl. The shower was dirty with black mold on all the corners of the shower. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Resident #55, at the time of the observation, stated he has never seen a housekeeper in his room, he tried to clean when he could but he had no cleaning supplies. Resident #55 stated he was frustrated, he had asked for help with cleaning his room several times and did not like living in the environment but he was unable to clean the room himself. Interview with Certified Nursing Assistant (CNA) #406 , at the time of the observation and resident interview, verified the appearance in the room. Observation on 12/16/24 at 11:11 A.M., with Director of Nursing (DON) of Resident #55's room confirmed the appearance of the room including the refrigerator, the food and paper stuck to the floor, the privacy curtain covered in a substance unknown, the window blinds covered in a thick filmy dust, the sink with a black substance covering the drain and multiple food particles, the bathroom floor with dirt and grime build up, the dirty toilet bowl and the mold in the shower used by the resident. The DON revealed he would not stay in that room. Observation on 12/17/24 at 4:43 P.M. with Maintenance Director #401 revealed he was also the Housekeeping Supervisor. Observation of Resident #55's room with Maintenance Director #401 confirmed the sink located near the refrigerator still had food particles covering the drain, the drain also had a thick black film. The bottom of the sink had multiple wet food crumbs and stains. The shower was dirty with black mold on all the corners of the shower. Maintenance Director #401 revealed the sink appeared clogged and he was not aware of the concerns. Maintenance Director #401 confirmed it appeared to be black mold in the shower and revealed housekeeping should be checking rooms [NAME] and the problem was housekeepers kept calling off, and they were not cleaning as well as they should be. Review of the policy titled, General Resident Area Cleaning/Disinfecting dated February 2022, revealed routine cleaning of inpatient areas while the patient is admitted , focuses on the patient zones, and aims to remove organic material and reduce microbial contamination to provide a visually clean environment. Routine cleaning was daily including high touch areas, floors and handwashing sinks. Resident restrooms and toilets clean and disinfect daily and floors under normal conditions should be cleaned daily. This deficiency represents non-compliance investigated under Master Complaint Number OH00160817, and Complaint Numbers OH00160146 and OH00160016.