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	05/26/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, review of the facility ombudsman notification log and staff interview, the facility failed to ensure the State Long Term Care (LTC) Ombudsman Office was notified of resident discharges from the facility. This affected one resident (Resident #61) of one resident reviewed for discharge. The facility census was 56.Findings include:Review of the medical record for Resident #61 revealed an admission date of 10/07/25 with diagnoses including alcohol abuse, muscle weakness and difficulty in walking. Resident #61 was discharged from the facility on 02/19/26 to her personal residence.Review of the ombudsman notification log labeled, Ombudsman Transfer/Discharge Log for February 2026 (a monthly document sent to the State LTC Ombudsman Office to notify them of resident discharges from the facility) revealed Resident #61's discharge was not on the log.Interview with the Administrator on 05/20/26 at 2:15 P.M. verified Resident #61's discharge information was not sent to the State LTC Ombudsman Office as required.

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure Minimum Data Set (MDS) 3.0 assessments were transmitted to the Centers for Medicare and Medicaid Services (CMS) within fourteen days of completion as required. This affected one resident (Resident #18) of one resident reviewed for resident assessments. The facility census was 56.Findings include:Review of the medical record for Resident #18 revealed an admission date of 12/24/25 with diagnoses including fractured back, major depressive disorder and insomnia. Resident #18 discharged back to the community with his spouse on 02/03/26.Review of MDS assessment records for Resident #18 revealed a Discharge Return Not Anticipated assessment dated [DATE]. The assessment was noted as completed but not transmitted directly to CMS as required.Interview with MDS Nurse #998 on 05/19/26 at 10:00 A.M. verified the Discharge Return Not Anticipated assessment dated [DATE] was not transmitted to CMS within fourteen days of completion as required.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and an interview with a representative from the State Pre-admission Screening and Resident Review (PASRR) authority (The Ohio Department of Mental Health and Addiction Services), the facility failed to ensure PASRR recommendations for placement and related services were implemented and incorporated into the resident's comprehensive care plan. This deficient practice affected one resident (Resident #42) of two residents reviewed for PASRR assessments. The facility census was 56.Findings include:Review of the medical record for Resident #42 revealed an admission date of 05/19/25 with diagnoses including bipolar disorder, suicidal ideations, and seizures. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #42 was moderately cognitively impaired and independent in completing activities of daily living.Review of the Level II PASRR assessment completed by the Ohio Department of Mental Health and Addiction Services (OMHAS) dated 10/28/25 revealed Resident #42 did not require the services of a nursing facility. The assessment stated, in part, You (Resident #42) are not appropriate for continued nursing facility services. You require hands-on assistance with changing incontinence supplies only, which can be provided in an assisted living or other residential care setting. You are no longer receiving skilled rehabilitation services. Should you require such services in the future, they can be provided on an outpatient basis. It is recommended that you work with your behavioral health providers, facility staff, and others to develop a plan that meets your needs in order to prepare for discharge to the community.Additional review of Resident #42's medical record revealed since October 2025, there was no evidence of discharge planning, referrals, care conferences, or other efforts to transition Resident #42 to a more appropriate setting, as recommended by the PASRR authority.Interview with PASRR Representative #999 on 05/21/26 at 8:30 A.M. confirmed Resident #42 had a Level II mental illness designation and was denied continued stay approval by OMHAS per the 10/28/25 determination. The representative further confirmed Resident #42 appealed the decision; however, following a hearing held on 01/12/26, the denial was upheld by a third-party hearing officer in a written decision dated 01/15/26.Interview with Social Worker #500 on 05/21/26 at 9:44 A.M. confirmed Resident #42 remained in the facility without continued stay approval from the State PASRR authority.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure nebulizer masks and tubing were dated and stored appropriately. This affected two residents (Residents #55 and #56) out of two residents reviewed for respiratory care. The facility census was 56.Findings include:1. Review of the medical record revealed Resident #55 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (an abnormal heart rhythm), type two diabetes mellitus, depression, and chronic blood clots in the lower extremities.Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 was moderately cognitively impaired, sometimes rejected care, was independent with toileting and personal hygiene, and required supervision with transferring.Review of Resident #55's physician orders revealed an order for ipratropium-albuterol (medications that relax airway muscles and increase air flow to the lungs) inhalation solution 0.5 milligrams (mg)/2.5 mg per 3 milliliters (ml) every eight hours for shortness of breath (SOB) dated 01/08/26. The physician orders were absent from an order to change and date respiratory equipment.Observation on 05/18/26 at 9:55 A.M. revealed Resident #55's nebulizer (a medical device that turns liquid medication into a mist for inhalation into the lungs) mask was not stored appropriately in a bag and was undated.Observation on 05/19/26 at 11:42 A.M. with Licensed Practical Nurse (LPN) #329 revealed Resident #55's nebulizer mask was not stored appropriately in a bag and was undated. Interview at the time of the observation with LPN #329 verified the findings and stated that nebulizer masks were to be stored in a bag when not in use and dated. 2. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease stage four (severe kidney disease), type two diabetes mellitus, congestive heart failure, atrial fibrillation and SOB.Review of the Significant Change MDS 3.0 assessment dated [DATE] revealed Resident #56 was cognitively intact, did not reject care, required supervision assistance with activities of daily living, and received dialysis.Review of Resident #56's physician order dated 04/24/26 revealed an order to change the nebulizer mask, cup, and tubing weekly and to date the mask.Observation on 05/18/26 at 11:15 A.M. revealed Resident #56's nebulizer mask was not stored appropriately in a bag while not in use.Observation on 05/19/26 at 11:45 A.M. with LPN #329 revealed Resident #56's nebulizer mask was not stored in a bag while not in use. Interview at the time of the observation with LPN #329 verified the findings.Review of the facility policy titled, ?Nebulizer Aerosol Therapy' dated 08/2024 revealed the facility was to adhere to best practices for infection control. The nebulizer mask and tubing were to be changed weekly; the nebulizer storage bag was to be changed weekly; the nebulizer was to be stored in a bag to prevent contamination when not being used; and the mask was to be dated.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure parameters for Resident #49's blood pressure medications were monitored before administration. This affected one of five residents reviewed for unnecessary medications. The total census was 56.Findings include:Record review of Resident #49 revealed she was admitted [DATE] and had diagnoses including dementia, hypertension, and edema. She had an order dated 05/06/25 for amlodipine (an anti-hypertensive medication) to be given daily. The medication was to be held if her systolic blood pressure was under 110 or her heart rate was under 60. Review of her medication administration record revealed the amlodipine was given regularly with no evidence of the blood pressure and heart rate being assessed before administration. Review of her vital signs assessments revealed the heart rate and blood pressure were not being checked daily.Interview with the Director of Nursing on 05/20/26 at 5:05 P.M. confirmed the above findings.This deficiency represents non-compliance investigated under Complaint Number 2995801.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure respiratory medications were stored securely. This affected one resident (Resident #55) out of six residents reviewed for medication administration. The facility census was 56.Findings include:Review of the medical record revealed Resident #55 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (an abnormal heart rhythm), type two diabetes mellitus, depression, and chronic blood clots in the lower extremities.Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 was moderately cognitively impaired, sometimes rejected care, was independent with toileting and personal hygiene, and required supervision with transferring. Review of Resident #55's physician orders revealed an order for ipratropium-albuterol (medications that relax airway muscles and increase air flow to the lungs) inhalation solution 0.5 milligrams (mg)/2.5 mg per 3 milliliters (ml) every eight hours for shortness of breath dated 01/08/26. Observation on 05/19/26 at 11:42 A.M. with Licensed Practical Nurse (LPN) #329 revealed five unopened ipratropium-albuterol unit dose vials were stored on Resident #55's kitchenette counter near her nebulizer (a medical device that turns liquid medication into a mist for inhalation into the lungs). Interview at the time of the observation with LPN #329 verified the findings and that the unit dose vials were from the facility. LPN #329 stated she did not think Resident #55 had an order to self-administer ipratropium-albuterol.Further review of the medical record for Resident #55 revealed a Medication Self-Administration Safety Screen dated 11/07/25 which indicated ipratropium-albuterol was not a medication Resident #55 was able to self-administer.Review of the facility policy titled, Self-Administration of Medications, dated 09/2018 revealed bedside storage was to be used if a resident self-administered the medication.Review of the facility policy titled, Storage of Medication, dated 09/2018 revealed medications were to be stored securely and only accessible to licensed personnel, pharmacy personnel or staff members lawfully authorized to administer medications.