| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365836 | A. Building<br>B. Wing | 03/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Village at St Edward Nrsg Care | 3131 Smith Rd<br>Fairlawn, OH 44333 |

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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and resident record reviews, the facility failed to ensure call lights were in reach. This affected two residents (#8 and #67) of three residents reviewed for call lights. The facility census was 79.Findings include: 1. Review of the medical record for Resident #8 revealed she was admitted to the facility on [DATE] with diagnoses that included respiratory syncytial virus, fall, dementia, and anxiety.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had severe cognitive impairment. Resident #8 had a history of inattention, disorganized thinking, was dependent on staff for activities of daily living (ADLs) that included, but not limited to, maximal assistance for upper body dressing and rolling left and right.Review of the care plan dated 01/14/26 revealed Resident #8 was at risk for falls and had an ADL self-care performance deficit related to dementia, impaired balance, impaired cognition and mobility with interventions that included assistance from staff for ADLs, assistance of one staff for bed mobility for turning and repositioning and ensure the call light was within reach.Review of the physician orders dated 01/14/26 revealed Resident #8 was a two person assist for transfers via mechanical lift.Observation and interview on 02/25/26 at 9:55 A.M. revealed Resident #8 was lying in the bed with her body facing towards the left wall. Resident #8's bed was positioned against the wall on the left-hand side of the room. Resident #8 call light was not visible and out of reach. Resident #8 stated she did not know where her call light was and could not reach it.Interview on 02/25/26 at 9:59 A.M. with Licensed Practical Nurse (LPN) #722 revealed Resident #8 required assistance with ADLs including bed mobility. LPN #722 stated Resident #8's call light was to always be in reach. Observation at the time of the interview upon entering Resident #8's room revealed LPN #722 was unable to locate Resident #8's call light. LPN #722 was then observed reaching under Resident #8's bed and using her hands to follow the cord which was wrapped around Resident #8's right handrail and hanging between the handrail and mattress. LPN #722 stated Resident #8 always faced the left side and that was her typical position. Continued observation revealed Resident #8 was still unable to reach the call light. LPN #722 confirmed and verified the above findings at the time of the observation.Observation and interview on 02/26/26 at 11:05 A.M. revealed Resident #8 lying in bed on her left side and facing the left side wall. Resident #8's call light was observed to be wrapped around the right-side handrail and hanging between the right handrail and mattress. Resident #8 stated she could not reach her call light, and she did not know where it was. Resident #8 was observed attempting to fold her arms backwards to try to reach and find the call light.Observation and interview on 02/26/26 at 11:07 A.M. with Registered Nurse (RN) #611 revealed RN #611 entered Resident #8's room. RN #611 was observed trying to locate Resident #8's call light by reaching under Resident #8's bed and using her hands to follow the cord which was wrapped around Resident #8's right handrail and hanging between the handrail and mattress. RN #611 stated, Oh, you can't reach that as she spoke to Resident #8. RN #611 was observed placing the call light at the top of the right handrail and asking Resident #8 if she could reach it. Resident #8 was observed attempting to reach the call light but could not. RN #611 continued to try to position the call light in a position on the right handrail that was within reach for Resident #8 but was unsuccessful. RN #611 stated Resident #8 always was on her left side and faced the left side<br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Village at St Edward Nrsg Care | 3131 Smith Rd<br>Fairlawn, OH 44333 |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | wall. RN #611 confirmed and verified the above findings at the time of the observation.2. Review of the medical record for Resident #67 revealed she was admitted [DATE] and had diagnoses including unspecified dementia, diabetes, amnesia, edema, and degenerative disease of nervous system. Review of her MDS assessment dated [DATE] revealed she had moderate cognitive impairment and required at least setup assistance for ADLs.Observation of Resident #67 on 02/26/26 at 10:13 A.M. revealed she was in bed. Her call light was sitting on a set of drawers roughly three feet from the bed and out of her reach. She was not interviewable.Interview with Registered Nurse #611 on 02/26/26 at 10:16 A.M. confirmed the above observation. This deficiency represents noncompliance investigated under Complaint Number 2629951. |

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|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record review, resident interview, and staff interviews, the facility failed to accurately assess and document a resident's hearing status on the minimum data set (MDS) assessment. This affected one resident (#1) of four residents reviewed for assessments. The facility census was 79.Findings include:Review of the medical record for Resident #1 revealed she was admitted to the facility on [DATE] with diagnoses that included pulmonary fibrosis, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and type two diabetes.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had no cognitive impairment. Resident #1 required supervision or touching assistance with eating, and some assistance with activities of daily living (ADLs). Resident #1's ability to hear was adequate and she did not utilize hearing devices.Review of the care plan dated 01/12/26 revealed Resident #1 had an ADL self-care performance deficit with interventions that included, but not limited to, assistance with care. Review of the care plan revealed nothing related to hearing devices.Review of the physician orders revealed an order dated 01/22/26 to provide audiology services.Review of the current physician orders revealed no orders related to Resident #1 hearing devices.Review of the audiology consultation dated 05/16/23 revealed Resident #1 utilized hearing aids and/or amplifiers in both ears. A whisper test (a simple and accurate test for detecting hearing impairment) was conducted on both ears and was positive. Resident #1 could not hear the whisper test.Review of the audiology consultation dated 08/16/23 revealed Resident #1 utilized hearing aids and/or amplifiers in both ears. A whisper test was conducted on both ears and was positive. Resident #1 could not hear the whisper test and was working with audiologist regarding hearing aids echoing.Review of the hearing, speech, and vision assessment dated [DATE] revealed Resident #1 hearing was adequate and utilized no hearing devices.Review of the quarterly MDS assessments dated 04/21/25, 07/22/25, and 10/22/25, Section B for hearing, speech and vision revealed Resident #1's hearing was adequate and utilized no hearing devices.Review of the annual MDS assessments dated 03/04/25 and 01/27/26, Section B for hearing, speech and vision revealed Resident #1's hearing was adequate and utilized no hearing devices.Observation on 02/25/26 at 8:34 A.M. revealed Resident #1 seated in a recliner adjacent to the left side of her bed. Resident #1 was visibly upset and struggling to place both left and right hearing aids into her ears. Interview at the time of the observation with Resident #1 revealed no one had helped with putting in her hearing aids. Resident #1 stated it's so hard to put in my hearing aids.Interview on 02/25/26 at 8:40 A.M. with Registered Nurse (RN) #313 revealed Resident #1 preferred to get up prior to breakfast and required help from staff with hearing aids. RN #313 revealed Certified Nurse Assistant (CNA) #721 had already dressed and prepared Resident #1 for the day. The CNA's or the nurse assisted with Resident #1's hearing aid devices and she let staff know if they were placed correctly through a monitoring device on her phone.Observation and interview on 02/25/26 at 8:42 A.M. revealed RN #313 enter Resident #1 room with Resident #1 stating I been trying for ten minutes to put hearing aids in. I can't do it. RN #313 was observed assisting Resident #1 with the hearing aids. RN #313 confirmed and verified the above findings at the time of the interviews and observations.Interview on 02/26/26 at 10:31 A.M. with RN #611 confirmed Resident #1 utilized hearing aids that linked to her phone, and she required assistance with ADLs. Resident #1's phone provided instructions on how to assist with the hearing aids, which were color coordinated to determine what ear each one was placed in and if the batteries were dead. Staff were responsible for assisting with hearing aids and keeping them charged. Resident #1 required more assistance with her ADLs due to a decline in her health and care needs. RN #611 verified the hearing aid devices were not coded on the above MDS assessments. Interview on 02/26/26 at 1:57 P.M with Licensed Social Worker (LSW) #519 verified Resident #1 was admitted to the facility approximately three years prior with hearing aids for both her left and right ears. |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record review, resident interview, and staff interviews, the facility failed to develop and implement a comprehensive care plan to reflect a resident's hearing impairment. This affected one resident (#1) of one resident reviewed for care planning. The facility census was 79.Findings include:Review of the medical record for Resident #1 revealed she was admitted to the facility on [DATE] with diagnoses that included pulmonary fibrosis, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and type two diabetes.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had no cognitive impairment. Resident #1 required supervision or touching assistance with eating, and some assistance with activities of daily living (ADLs). Resident #1's ability to hear was adequate and she did not utilize hearing devices.Review of the care plan dated 01/12/26 revealed Resident #1 had an ADL self-care performance deficit with interventions that included, but not limited to, assistance with care. Review of the care plan revealed nothing related to hearing devices.Review of the physician orders revealed an order dated 01/22/26 to provide audiology services.Review of the current physician orders revealed no orders related to Resident #1 hearing devices.Review of the audiology consultation dated 05/16/23 revealed Resident #1 utilized hearing aids and/or amplifiers in both ears. A whisper test (a simple and accurate test for detecting hearing impairment) was conducted on both ears and was positive. Resident #1 could not hear the whisper test.Review of the audiology consultation dated 08/16/23 revealed Resident #1 utilized hearing aids and/or amplifiers in both ears. A whisper test was conducted on both ears and was positive. Resident #1 could not hear the whisper test and was working with audiologist regarding hearing aids echoing.Review of the hearing, speech, and vision assessment dated [DATE] revealed Resident #1 hearing was adequate and utilized no hearing devices.Review of the quarterly MDS assessments dated 04/21/25, 07/22/25, and 10/22/25, Section B for hearing, speech and vision revealed Resident #1's hearing was adequate and utilized no hearing devices.Review of the annual MDS assessments dated 03/04/25 and 01/27/26, Section B for hearing, speech and vision revealed Resident #1's hearing was adequate and utilized no hearing devices.Observation on 02/25/26 at 8:34 A.M. revealed Resident #1 seated in a recliner adjacent to the left side of her bed. Resident #1 was visibly upset and struggling to place both left and right hearing aids into her ears. Interview at the time of the observation with Resident #1 revealed no one had helped with putting in her hearing aids. Resident #1 stated it's so hard to put in my hearing aids.Interview on 02/25/26 at 8:40 A.M. with Registered Nurse (RN) #313 revealed Resident #1 preferred to get up prior to breakfast and required help from staff with hearing aids. RN #313 revealed Certified Nurse Assistant (CNA) #721 had already dressed and prepared Resident #1 for the day. The CNA's or the nurse assisted with Resident #1's hearing aid devices and she let staff know if they were placed correctly through a monitoring device on her phone.Observation and interview on 02/25/26 at 8:42 A.M. revealed RN #313 enter Resident #1 room with Resident #1 stating I been trying for ten minutes to put hearing aids in. I can't do it. RN #313 was observed assisting Resident #1 with the hearing aids. RN #313 confirmed and verified the above findings at the time of the interviews and observations.Interview on 02/26/26 at 10:31 A.M. with RN #611 confirmed Resident #1 utilized hearing aids that linked to her phone, and she required assistance with ADLs. Resident #1's phone provided instructions on how to assist with the hearing aids, which were color coordinated to determine what ear each one was placed in and if the batteries were dead. Staff were responsible for assisting with hearing aids and keeping them charged. Resident #1 required more assistance with her ADLs due to a decline in her health and care needs. RN #611 verified the hearing aid devices and Resident #1's hearing impairment were not included in the care plan.Interview on 02/26/26 at 1:57 P.M with Licensed Social Worker (LSW) #519 verified Resident #1 was admitted to the facility<br>(continued on next page) |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | approximately three years prior with hearing aids for both her left and right ears.Review of Resident #1's care plan initiated on 03/28/23 with multiple subsequent revisions had no focus of or interventions for hearing aid use including monitoring, maintenance, or staff assistance with the application and removal of the hearing aids. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record reviews, interviews, review of a Self-Reported Incident (SRI) and facility policy review, the facility failed to provide adequate assistance with activities of daily living (ADL) for dependent residents. This affected two residents (#1 and #86) of four residents reviewed for ADL care. The facility census was 79.Findings include:1. Review of the medical record for Resident #1 revealed she was admitted to the facility on [DATE] with diagnoses that included pulmonary fibrosis, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and type two diabetes.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had no cognitive impairment. Resident #1 required supervision or touching assistance with eating, and some assistance with activities of daily living (ADLs). Resident #1's ability to hear was adequate and she did not utilize hearing devices.Review of the care plan dated 01/12/26 revealed Resident #1 had an ADL self-care performance deficit with interventions that included, but not limited to, assistance with care. Review of the care plan revealed nothing related to hearing devices.Review of the physician orders revealed an order dated 01/22/26 to provide audiology services.Review of the current physician orders revealed no orders related to Resident #1 hearing devices.Review of the audiology consultation dated 05/16/23 revealed Resident #1 utilized hearing aids and/or amplifiers in both ears. A whisper test (a simple and accurate test for detecting hearing impairment) was conducted on both ears and was positive. Resident #1 could not hear the whisper test.Review of the audiology consultation dated 08/16/23 revealed Resident #1 utilized hearing aids and/or amplifiers in both ears. A whisper test was conducted on both ears and was positive. Resident #1 could not hear the whisper test and was working with audiologist regarding hearing aids echoing.Review of the hearing, speech, and vision assessment dated [DATE] revealed Resident #1 hearing was adequate and utilized no hearing devices.Observation on 02/25/26 at 8:34 A.M. revealed Resident #1 seated in a recliner adjacent to the left side of her bed and a bedside table with a breakfast tray, which was untouched with three sealed white containers with lids. The bed was left unmade with the covers tossed aside at the foot of the bed. Resident #1 appeared to be visibly upset and struggling to place both left and right hearing aids into her ears. Interview at the time of the observation with Resident #1 revealed the facility staff did not get her up when she requested at 7:00 A.M. She preferred to be showered, dressed and prepared for breakfast prior to her breakfast tray being placed in her room. Resident #1 stated the staff did not get her up until 7:50 A.M. Her care and shower were rushed, staff did not make her bed, and no one helped her with opening her breakfast containers or putting in her hearing aids. Resident #1 stated, It's so hard to put in my hearing aids.Interview on 02/25/26 at 8:40 A.M. with Registered Nurse (RN) #313 verified Resident #1 preferred to get up prior to breakfast and required help from staff with meal set-up and hearing aids. RN #313 stated Certified Nurse Assistant (CNA) #721 had already dressed and prepared Resident #1 for the day. The CNA's or the nurse assisted with Resident #1's hearing aid devices and she let staff know if they were placed correctly through a monitoring device on her phone.Observation and interview on 02/25/26 at 8:42 A.M. revealed RN #313 entered Resident #1's room with Resident #1 stating, I been trying for ten minutes to put hearing aids in. I can't do it. I need help with breakfast to open all this stuff. RN #313 was observed assisting Resident #1 with hearing aids and the breakfast tray. RN #313 confirmed and verified the above findings at the time of the interviews and observations.Interview on 02/25/26 at 8:45 A.M. with CNA #721 revealed she had already assisted Resident #1 with her morning care and was now assisting other residents. CNA #721 confirmed she did not assist with Resident #1 hearing aids, did not make her bed and did not assist with her breakfast tray. CNA #721 stated, I don't usually work with her. CNA #721 revealed if her assignment was changed, information on the resident care needs was available. CNA #721 confirmed and verified the above findings at the time of the interview.Interview on 02/26/26 at 10:31 A.M. with RN #611<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | revealed Resident #1 utilized hearing aids that linked to her phone and required assistance with ADLs. Resident #1's phone provided instructions on how to assist with the hearing aids, which were color coordinated to determine what ear each one was placed in and if the batteries were dead. Staff were responsible for assisting with hearing aids and keeping them charged. RN #611 verified Resident #1 required more assistance with her ADLs due to a decline in her health and care needs. RN #611 confirmed and verified the above findings at the time of the interview.2. Review of the medical record for Resident #86 revealed he was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, intervertebral disc displacement lumbar region and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Resident #86 was discharged from the facility on 01/20/26.Review of the MDS assessment dated [DATE] revealed Resident #86 had no cognitive impairment. Resident #86 required assistance from staff for ADLs including, but not limited to, toileting, lower body dressing, sit-to-stand position, and toilet transfers. Resident #86 was occasionally incontinent with bladder and frequently incontinent with bowel.Review of the care plan dated 12/23/25 revealed Resident #86 had an ADL self-care performance deficit related to left hemiplegia, was at risk for falls, and had mixed bladder incontinence with interventions that included assistance from staff including toileting. Review of the physician orders dated 12/22/25 revealed Resident #86 required staff assistance of one for transfers.Review of the physician orders dated 12/23/25 revealed Resident #86 required staff assistance with ADLs due to left hemiparesis.Review of the skilled charting assessment dated [DATE] revealed Resident #86 required assistance with toilet use.Review of the occupational therapy treatment encounter notes dated 12/23/25 through 01/19/26 revealed Resident #86 was dependent on toileting, hygiene and moderate assistance with toilet transfers.Review of the progress note dated 01/03/26 at 3:21 P.M. revealed Resident #86 was found on the floor in his room holding onto the bedrail. Resident #86's visitor reported observing Resident #86's left leg give out, and he landed on the buttocks. Resident #86 was educated to ask for assistance from staff.Review of the progress note dated 01/05/26 at 2:00 A.M. revealed Resident #86 was compliant with allowing staff to assist with ADLs and transfers.Review of the progress note dated 01/05/26 at 9:37 A.M. revealed Resident #86 continued to have weakness related to post cerebrovascular accident (CVA) and/or stroke. Resident #86 was encouraged to have assistance.Review of SRI #269883 dated 01/16/26 revealed Resident #86 alleged that CNA #220 was neglectful after requesting assistance with incontinence care. Resident #86 reported after requesting assistance via the call light, CNA #220 replied why can't you wait until first shift. Resident #86 stated he requested briefs and when he was provided briefs, CNA #220 did not provide assistance. The facility unsubstantiated the SRI. Review of the progress note dated 01/18/26 at 6:45 A.M. revealed Resident #86 was found on the floor at the foot of his bed lying on his left side. Resident #86 was assisted to his wheelchair from the floor with assistance of two staff and a gait belt. Resident #86 was assessed due to concern related to landing on his affected and/or weak side and could barely move his lower left extremity. Resident #86 stated he fell attempting to clean himself up after a bowel movement and fell due to his bad leg. Resident #86 was assisted with donning a clean brief and sweatpants and was encouraged to use call light for staff assistance. Interview on 02/25/26 at 3:11 P.M. with Resident #86's friend revealed Resident #86 was treated rudely and alleged CNA #920 threw a pack of briefs at him, did not offer any help and asked him, why he couldn't wait until the next shift?Interview on 02/26/26 at 10:54 A.M. with CNA #920 revealed she provided care for Resident #86 when he was a resident in the facility. Resident #86 required assistance from staff for incontinence care but stated Resident #86 thought he was more independent than he was. She recalled the event related to SRI #269883 and gave identical details on what occurred and stated management spoke to her about the incident because she was named as an alleged perpetrator. CNA #920 revealed on the day in question, Resident #86 requested a pack of briefs for incontinence care and said he needed to go to the bathroom. She verified she provided Resident #86 with a pack of briefs and left the room without assisting him. CNA #920 stated she returned an hour later to find Resident #86 visibly upset<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | due to having experienced a bowel incontinence episode. CNA #920 stated Resident #86 had asked her to leave his room because she did not care about his condition and did not assist him. CNA #920 confirmed she was aware Resident #86 required assistance but since he did not ask for help, she did not provide it. CNA #920 could not explain why she did not assist a resident who was dependent on staff with incontinence care.Interview on 03/02/26 at 9:19 A.M. with the Administrator and Director of Nursing (DON) revealed Resident #86's concerns related to SRI #269883 were brought forward regarding CNA #220. Resident #86 requested assistance, CNA #220 came and gave him briefs and left his room. CNA #220 said Resident #86 was able to provide his own care despite his medical record indicating assistance was needed. CNA #920 was named as an alleged perpetrator but was not listed in the SRI. They revealed that due to multiple staff members being named in the SRI, CNA #920 was not added, and no disciplinary actions were taken due to Resident #86's story changing. The Administrator and DON confirmed and verified Resident #86 required assistance and was not provided with incontinence care.Review of the facility document titled, ADL Care Policy, undated, revealed the facility had a policy in place to provide individualized and person-centered assistance with ADLs to all residents including, but not limited to, essential self-care tasks, assessments and care planning. This deficiency represents noncompliance investigated under Complaint Number 2720699. |

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|---|---|
| Village at St Edward Nrsg Care | 3131 Smith Rd<br>Fairlawn, OH 44333 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care planned interventions to prevent resident falls. This affected one (Resident #67) of two residents reviewed for accident hazards. The total census was 79.Findings include:Review of the medical record for Resident #67 revealed she was admitted [DATE] and had diagnoses including unspecified dementia, diabetes, amnesia, edema, and degenerative disease of nervous system. Her last fall assessment dated [DATE] revealed she was at high risk for falls. Her care plan noted she was at risk for falls related to impaired cognition, poor safety awareness, and impaired mobility. One care planned intervention dated 07/19/22 revealed Resident #67 was to have Dycem (a rubber-like material designed to have high friction and prevent slipping) above and below the pressure cushion in her wheelchair.Observation on 02/25/26 at 2:03 P.M. revealed Resident #67 lying down on the floor in front of her wheelchair in the second-floor hallway by the dining room. She said she was not sure how she fell and felt she just slipped out of the chair. Observation of her wheelchair revealed a Dycem sheet beneath her seat pad, but none elsewhere on the wheelchair or on or near her person. Staff post-fall response was ongoing at the time of the observation.Interview with Registered Nurse #611 on 02/25/26 at 2:16 P.M. confirmed Resident #67 was care planned to have a Dycem sheet both above and below her wheelchair pad, and only had one located below it. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365836 | A. Building<br>B. Wing | 03/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Village at St Edward Nrsg Care | 3131 Smith Rd<br>Fairlawn, OH 44333 |

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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to appropriately track and account for dispensed narcotics. This affected one (Resident #18) of three residents reviewed for narcotic tracking. The facility census was 79.Findings include:Review of the medical record for Resident #18 revealed she was admitted [DATE] and had diagnoses including major depressive disorder, pain in lower leg, and deep vein thrombosis. Her only past or current order of oxycodone tablets began 08/24/25 and was discontinued 08/27/25. Review of her October medication administration record revealed no active orders or documented administrations of oxycodone in that timeframe.Observation of the 200-hall medication cart on 03/02/26 at 9:40 A.M. revealed Resident #18 had one card of 54 oxycodone tablets which matched the medication count sheet. The most recent non-wasted removals of oxycodone tablets were dated 10/01/25, 10/12/25 and 10/31/25.Interview with the Administrator on 03/02/26 at 9:53 A.M. confirmed the above findings, including that multiple doses were removed from Resident #18's oxycodone card with no documentation of their final disposition.This deficiency represents noncompliance investigated under Complaint Number 2791137. |