

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365847	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER Bath Manor Special Care Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2330 Smith Road Akron, 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was provided with a dignified dining experience. This affected one (#220) resident of one resident reviewed for dignity. The facility census was 112.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #220 revealed an admitted [DATE] with diagnoses that included congestive heart failure, mild protein-calorie malnutrition, and dysphagia.</p> <p>Review of the care plan dated 04/10/25 revealed Resident #220 had a self-care deficit with interventions that included, but not limited to, assistance from staff.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #220 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated she was alert and oriented to person pace, and time.</p> <p>Observation and interview on 05/06/25 at 8:30 A.M. revealed Resident #220 was lying in bed with her over-the-bed table positioned above her with her breakfast meal. Resident #220's breakfast meal consisted of pancakes and crumbled sausage. MDS Registered Nurse (RN) #709 was observed standing over Resident #220, scooping up crumbled sausage on a spoon and feeding her. Interview with MDS RN #709, at the time of the observation, revealed she walked by Resident #220's room and saw she needed to eat. MDS RN #709 revealed Resident #220 was just sitting there and usually had someone sitting, cueing, and encouraging her during meals. MDS RN #709 confirmed she was standing up and over Resident #220 feeding her and the policy was to sit down while assisting with meals.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165140, OH00165044, and OH00162078.</p>

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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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195</p> <p>Based on record review, interviews, and facility policy review, the facility failed to ensure quarterly statements for resident funds accounts were mailed to the individuals who were identified as the guardian or primary financial contact for residents. This affected three residents (#33, #71, #93) out of six residents reviewed for resident funds. The facility identified 50 residents (#1 to #3, #5, #6, #9, #11, #15 to #19, #21, #24, #26 to #28, #30 to #33, #35, #37, #39, #40, #42, #46, #47, #49 to #55, #61, #62, #64, #68, #69, #71, #72, #81, #82, #86, #89, #93, #94, and #121) as having a personal funds account. The facility census was 112.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #33 revealed an admitted [DATE] and the mother of Resident #33 was listed as the primary power attorney for healthcare and the primary financial contact.</p> <p>Review of the Resident Fund Management Service Authorization Agreement to Handle Resident Funds, revealed on 10/25/19, the mother had signed to set up a resident fund account for Resident #33. The document indicated with a signature, the person was authorizing the facility to establish an insured interest-bearing account and the person signing the document would receive a statement at least quarterly.</p> <p>Review of the facility document Trial Balance, dated 05/07/25, revealed Resident #33 had a resident fund account with a balance of \$73.27. Review of Resident #33's quarterly statements for the period of 10/01/24 through 12/31/24 and for the period of 01/01/25 through 03/31/25 revealed the resident had a balance of \$73.27 for both periods. The resident fund statement was addressed to Resident #33 at the facility's address of 2330 [NAME] Road, Akron, Ohio, 44333.</p> <p>Interview on 05/05/25 at 3:24 P.M. with the mother of Resident #33 revealed she had not received quarterly statements and she had no clue what was in his personal fund account.</p> <p>Interview on 05/12/25 at 9:03 A.M. with Business Office Manager (BOM) #715 revealed the facility used a third party to mail out the residents' quarterly statements, and the statements were mailed to the address at the top of the quarterly statements. BOM #715 confirmed Resident #33's quarterly statements were not mailed to the primary financial contact for Resident #33.</p> <p>2. Review of medical record for Resident #71 revealed an admitted [DATE] and the daughter of Resident #71 was listed as the primary financial contact.</p> <p>Review of the Resident Fund Management Service Authorization Agreement to Handle Resident Funds, revealed on 09/24/21, the daughter had signed to set up a resident Qualified Income Trust (QIT), a special form of trust designed to help people receive long-term benefits under Medicaid, fund account for Resident #71, and on 06/09/22 the daughter had signed to set up a resident personal fund account for Resident #71. The document indicated with a signature, the person was authorizing the facility to establish an insured interest-bearing account and the person signing the document would receive a statement at least quarterly.</p> <p>(continued on next page)</p>		

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility document Trial Balance, dated 05/07/25, revealed Resident #71 had a QIT account with a balance of \$21,574.62 and a resident fund account balance of \$151.28. Review of Resident #71's quarterly statements for the period of 01/01/25 through 03/31/25 revealed the resident's QIT account had a balance of \$21,574.24 and the resident's personal fund account had a balance of \$151.28. Both of the resident's fund statements were addressed to Resident #71 at the facility's address at 2330 [NAME] Road, Akron, Ohio, 44333.</p> <p>Interview on 05/08/25 at 11:53 A.M. with the daughter of Resident #71 revealed she was not receiving any quarterly statements.</p> <p>Interview on 05/12/25 at 9:03 A.M. with Business Office Manager (BOM) #715 revealed the facility used a third party to mail out the residents' quarterly statements, and the statements were mailed to the address at the top of the quarterly statements. BOM #715 confirmed Resident #33's quarterly statements were not mailed to primary financial contact for Resident #71.</p> <p>3. Review of medical record for Resident #93 revealed an admitted [DATE] and the resident had a guardian.</p> <p>Review of the Resident Fund Management Service Authorization Agreement to Handle Resident Funds, revealed on 11/25/24, the guardian had signed to set up a resident fund account for Resident #93. The document indicated with a signature, the person was authorizing the facility to establish an insured interest-bearing account and the person signing the document would receive a statement at least quarterly.</p> <p>Review of facility document Trial Balance, dated 05/07/25, indicated Resident #93 had a resident fund account with a balance of \$3642.01. Review of Resident #93's quarterly statements for the period of 11/07/24 through 12/31/24 revealed the resident had a balance of \$50.00 and for the period of 01/01/25 through 03/31/25 had a balance of \$200.00. The resident fund statement was addressed to Resident #93 at the facility's address at 2330 [NAME] Road, Akron, Ohio, 44333.</p> <p>Interview on 05/12/25 at 9:03 A.M. with Business Office Manager (BOM) #715 revealed the facility used a third party to mail out the residents' quarterly statements, and the statements were mailed to the address at the top of the quarterly statements. BOM #715 confirmed Resident #33's quarterly statements were not mailed to the guardian of Resident #93.</p> <p>Review of the facility policy Resident Fund Management (RFMS) Policy, revised 10/13/21, revealed quarterly trust statements would be mailed by a third party and statement addresses were to be correct.</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195</p> <p>Based on record review, interviews, and facility policy review, the facility failed to provide notice to Resident #94 when his resident funds account reached \$200 less than the Supplemental Security Income (SSI) resource limit for one person and failed to ensure Resident #226's account funds were dispersed timely after expiration. This affected two residents (#94 and #226) of six residents reviewed for resident funds. The facility census was 112 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #94 revealed an admitted [DATE] and Medicaid was a payor source. The resident was the primary financial contact and was cognitively intact.</p> <p>Review of Resident #94's resident fund account's quarterly statement for the period of [DATE] through [DATE] revealed a balance of \$8,266.94 and for the period of [DATE] through [DATE] revealed a balance of \$8,087.63.</p> <p>Review of the facility's document Trial Balance, dated [DATE], revealed Resident #94 had a current balance of \$3,797.16. There was no documented proof Resident #94 had received a spend down notification.</p> <p>Interview on [DATE] at 12:31 P.M. with Resident #94 revealed he did not know he had an account, and did not know how much he had in the account.</p> <p>Interview on [DATE] at 9:03 A.M. with Business Office Manager (BOM) #715 confirmed there was no documented proof spenddown letters had been sent to Resident #94, and when asked why there was no documented proof spenddown letters had been sent, BOM #715 stated during that time she had been busy covering the admissions position along with her own position as the BOM.</p> <p>Review of the facility policy Resident Fund Management (RFMS) Policy, revised [DATE], revealed the business office was to notify all Medicaid residents when the asset limit was approaching.</p> <p>2. Review of the medical record for Resident #226 revealed an admitted [DATE] and an expiration date of [DATE].</p> <p>Review of the facility document Resident Statement revealed Resident #226's account was closed on [DATE] and had a balance of \$1,192.86 dollars in the account when the account was closed.</p> <p>Review of a check, numbered 10055474 and dated [DATE], written to the funeral home in the amount of \$1,1192.86 for Resident #226's funeral expenses revealed the check was written over three months after the resident had expired.</p> <p>Interview on [DATE] at 11:52 A.M. with BOM #715 and Regional Director #950 confirmed the date on the check and the check had not been sent out timely.</p> <p>(continued on next page)</p>

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Resident Fund Management (RFMS) Policy, revised [DATE], revealed trust accounts for expired residents were to be closed and funds dispersed timely.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on observations, record review, interviews, and facility policy review, the facility failed to develop a person- centered care plan related to the consumption of alcohol. This affected one (#44) of one resident reviewed for alcohol consumption. The facility census was 112.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #44 revealed he was admitted to the facility on [DATE] with diagnoses that included chronic diastolic congestive heart failure, cellulitis of left lower limb, and acute kidney failure.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 14 that indicated he was alert and oriented to person, place, and time. Review of the MDS assessment also revealed Resident #44 required some assistance from staff for Activities of Daily Living (ADLs).</p> <p>Review of Resident #44's current physician orders revealed no orders for alcohol consumption.</p> <p>Review of Resident #44's current care plan revealed no plan/interventions related to alcohol consumption.</p> <p>Observation on 05/06/25 at 8:35 A.M. revealed the Administrator looking inside Resident #44's compact refrigerator located inside his room. The Administrator was observed removing two 6.8 ounce bottles of [NAME] Bootlegger Ice Lemonade canned cocktails which contained 12 percent (%) alcohol. The Administrator was then observed informing Resident #44 he had no care plan or orders in place to consume or have alcohol stored in his room. The Administrator was then observed placing the alcohol bottles back into the refrigerator and exiting Resident #44's room.</p> <p>Interview and observation on 05/06/25 at 8:46 A.M. revealed Resident #44 had two 6.8 ounce bottles of [NAME] Bootlegger Ice Lemonade canned cocktails which contained 12 percent (%) alcohol located in his compact refrigerator. Resident #44 revealed his friend purchased the alcohol for his consumption. The Administrator entered Resident #44's room during this observation and interview and confirmed the above findings. The Administrator stated Resident #44 did not have a order or care plan in place to consume or store alcohol beverages in his room.</p> <p>Interview on 05/06/25 at 4:25 P.M. with Regional Registered Nurse (RRN) #900 revealed Resident #44 had two bottles of hard liquor removed from his room compact refrigerator.</p> <p>Review of the facility document titled Alcoholic Beverage Use revised 08/11/20, revealed residents could have alcoholic beverages if prescribed by their provider, could be obtained by family, and must be administered by a licensed nurse only. Further review of the policy revealed residents were not allowed to keep alcoholic beverages in their room.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on observation, resident record review, resident interview, staff interview, and facility policy review, the facility failed to ensure oxygen tubing was changed and an order was in place for administering oxygen. This affected one (#221) of one resident for respiratory care. The facility census was 112.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #221 revealed an admitted d of 04/28/25 with diagnoses that included peripheral vascular disease, type 2 diabetes, and congestive heart failure.</p> <p>Review of the progress note dated 04/29/25 timed 2:03 P.M. revealed Resident #221 had oxygen established in the home.</p> <p>Review of Resident #221's current physician orders revealed no orders for oxygen.</p> <p>Review of Resident #221's care plan dated 04/30/25 revealed no current interventions related to oxygen administration.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #221 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated he was alert and oriented to person, place, and time. Further review of the MDS assessment revealed Resident #221 required some assistance for activities of daily living (ADLs).</p> <p>Observation and interview on 05/05/25 at 12:11 P.M. revealed Resident #221 seated in his wheelchair with oxygen in place and being administered via nasal cannula. The oxygen tubing and nasal cannula was undated. Resident #221 revealed his oxygen and nasal cannula tubing had not been changed.</p> <p>Observation and interview on 05/05/25 at 12:15 P.M. with Licensed Practical Nurse (LPN) #638 revealed Resident #221 was on oxygen via nasal cannula as needed. LPN #638 revealed she did not know when the last time the tubing and nasal cannula was changed. LPN #638 confirmed there were no current orders in place for Resident #221's oxygen administration.</p> <p>Review of Resident #221's Medication Administration Record from 04/28/25 to 05/13/25 revealed the first documentation the oxygen concentrator and filter were cleaned and oxygen tubing changed was 05/09/25.</p> <p>Review of the facility policy Oxygen Administration (All Routes) revised 07/30/24, revealed the facility would verify the provider order and then assemble equipment. Further review of the policy revealed the facility would change tubing, mask and cannula weekly and document.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on observation, resident record review, resident interview, staff interview, and facility policy review, the facility failed to ensure all drugs and biologicals were properly secured and permit only authorized personnel to have access. This affected one (#221) of one resident reviewed for self-administration of medications. The facility census was 112.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #221 revealed an admitted d of 04/28/25 with diagnoses that included peripheral vascular disease, type 2 diabetes, and congestive heart failure. Further review of Resident #221's medical record revealed there was no assessment indicating Resident #221 was safe to self-administer medication.</p> <p>Review of the progress note dated 04/29/25 timed 11:08 A.M. revealed Resident #221 had multiple scattered tinea areas on bilateral arms with discoloration.</p> <p>Review of the care plan dated 04/30/25 revealed Resident #221 had tinea corporis located on the left and right posterior forearm.</p> <p>Review of the physician orders dated 04/30/25 revealed Resident #221 had an order for clotrimazole one percent cream to be applied twice a day to bilateral forearms.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #221 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated he was alert and oriented to person, place, and time. Further review of the MDS assessment revealed Resident #221 required some assistance for activities of daily living (ADLs).</p> <p>Observation and interview on 05/05/25 at 12:11 P.M. revealed two tubes of clotrimazole one percent cream located on Resident #221's bedside table. Resident #221 revealed he had ringworm on both arms and he applied the cream himself.</p> <p>Interview on 05/05/25 at 12:15 P.M. with Licensed Practical Nurse (LPN) #638 revealed Resident #221 had ringworm and the facility applied cream daily. LPN #638 confirmed Resident #221 did not have a self-administration assessment or order to apply the antifungal cream himself. At the time of the interview, LPN #638 entered Resident #221's room as he was rubbing the cream into his forearm. LPN #638 revealed the cream located on the bedside table was the prescribed medication for his ringworm. LPN #638 was observed putting on gloves and removing two tubes of clotrimazole one percent cream from Resident #221's room.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Self-Administration of Medications revised 06/01/24, revealed the facility, in conjunction with the interdisciplinary care team was to assess and determine, with respect to each resident, whether self-administration of medication was safe and clinically appropriate, based on the resident's functionality and health condition. The facility was to ensure that orders for self-administration listed the specific medication(s) the resident could self administer.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44457</p> <p>Based on kitchen observation, staff interview, and facility policy review, the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect all residents receiving meals from the kitchen. The facility identified six Residents (#30, #57, #60, #75, #119, and #269) as receiving nothing by mouth (NPO). The facility census was 112.</p> <p>Findings include:</p> <p>Observations on 05/05/25 (Monday) at 9:03 A.M. of the facility kitchen with Food and Nutrition Services Director (FNSD) #633 revealed in the reach-in refrigerator near the steam table there was two undated or labeled salads and approximately 10 bagged sandwiches without labels or dates. FNSD #633 indicated they usually disposed of salads and sandwiches after the weekend. There was dried food splatter on the preparation table for the food processor and a container of applesauce and a spoon on floor under the table. Observation of the kitchen hood revealed the metal grates and fire suppression system had a coating of built-up dust. FNSD #633 indicated there was an outside company who cleaned the kitchen hood every three months. The microwave had dried food splatter on the top panel. There was a whisk on the floor under the steamer. Observation inside the walk-in refrigerator revealed a container of milk with expiration date of 05/01/25. The floors of the walk-in refrigerator under storage racks were dirty with debris and dried milk on the left side of the walk-in refrigerator. There were boxes stacked to the ceiling on the storage racks. There was an undated salad covered with plastic wrap. FNSD #633 indicated staff had last cleaned the floor of the walk-in refrigerator about a month prior. Observation inside the walk-in freezer revealed ice buildup on boxes of fish, mashed potatoes, and egg rolls. There was additional ice buildup on the ceiling of the freezer. There were boxes stacked to the ceiling in the freezer. Observation inside the dry storage room revealed a box of powdered thickener was open to air and a one cup measuring cup in the box resting on the product.</p> <p>Interview on 05/05/25 with FNSD #633 confirmed findings at time of observation during kitchen tour.</p> <p>Review of the facility policy Kitchen Sanitation and Cleaning Schedules Policy dated 05/24/18 revealed food and nutrition services staff would maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.</p> <p>Review of the facility policy Storage of Refrigerated Foods Policy dated 03/09/25 revealed all refrigerated items must be stored at least six inches above the floor and 18 inches from the ceiling and sprinkler heads.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51518</p> <p>Based on record review, observation, and interview, the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented as required. This had the potential to affect all residents residing in the facility. Facility census was 112.</p> <p>Findings include:</p> <p>Review of Resident #269 medical record revealed the resident was admitted on [DATE] with diagnoses of Parkinsonism, primary pulmonary hypertension, protein-calorie malnutrition, acute respiratory failure, other rheumatic mitral valve diseases, pressure ulcer stage 4, history of malignant neoplasm of prostate, dysphagia and muscle weakness. Further review of the medical record revealed an order dated 04/18/25 for enhanced barrier precautions (EBP).</p> <p>Observation on 05/07/25 at 11:34 A.M. revealed a sign outside Resident #269's room for Enhanced Barrier Precautions with instructions stating Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use, and Wound Care.</p> <p>Observation on 05/07/25 at 11:34 A.M. revealed Rehab #910 and Rehab #909 in Resident #269's room assisting the resident with repositioning in his wheelchair. Rehab #910 and Rehab #909 were not wearing PPE.</p> <p>Interview on 05/07/25 at 11:35 A.M. with Rehab #910 and Rehab #909 revealed they heard Resident #269 yelling out and they both ran into resident's room to assist him without donning PPE. Rehab #910 and Rehab #909 confirmed they should have donned PPE prior to assisting Resident #269.</p> <p>Review of the facility Transmission-Based Precautions and Isolation Policy with a revision date of 03/20/25 revealed EBP were indicated for high contact care actives for residents with chronic wounds and indwelling devices such as central lines, urinary catheters, and trachs and for all those colonized or infected with a Multidrug-resistant bacteria (MDRO) currently targeted by the Centers for Disease Control. Review of the facility Transmission-Based Precautions and Isolation Policy with a revision date of 03/20/25 revealed EBP were indicated for high contact care actives for residents with chronic wounds and indwelling devices such as central lines, urinary catheters, and trachs and for all those colonized or infected with a Multidrug-resistant bacteria (MDRO) currently targeted by the Centers for Disease Control.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365847	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER Bath Manor Special Care Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2330 Smith Road Akron, 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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>19736</p> <p>Based on observation and interview, the facility failed to ensure clean linen rooms and common shower rooms were maintained in a clean and sanitary manner. This affected 25 (#43, #33, #220, #24, #15, #48, #400, #219, #45, #78, #51, #97, #220, #225, #107, #44, #79, #221, #112, #113, #80, #269, #270, #114, and #63) of 112 facility residents.</p> <p>Findings include:</p> <p>Environmental tour on 05/12/25 from 2:06 P.M. to 2:37 P.M. with Maintenance Assistant (MA) #806 and Housekeeping and Laundry Supervisor (HLS) #620 revealed the floor of the 300-unit clean linen room was covered with old, dried spills, scuffs marks, paper scraps, straw covers, large dust bunnies, and multiple Chetos. Observation of the 300 hall shower room revealed a toilet, sink, shower area, bathtub, storage cabinet, bedside commode, and a shower bed. A tee shirt was on the floor. A cigarette butt, pillow without pillow case, two plastic parts of a bedside commode, a fitted sheet that was wet with a large reddish brown stain and when lifted a strong urine odor was noted, a multicolored sweater, three wet wash cloths, a bottle of body wash, deodorant, and a bottle of peri wash were inside the bathtub and beneath the items was loose black debris and dried unidentifiable liquid spills. HLS #620 and MA #806 indicated the bath tub was not functional and never used.</p> <p>Interview with Certified Nurse Aide (CNA) #808 on 05/12/25 at approximately 2:15 P.M. revealed after showering a resident in the 300 unit shower room she had to return the resident to her room quickly. CNA #808 threw the fitted bed sheet, wash cloths, body wash, deodorant and peri wash in the bathtub and then went on break. CNA #808 said she had planned to come back to clean. She indicated the bathtub was not used. Further observation revealed the shower room floor was not wet to indicate a resident was recently showered, nor was the room filled with humidity.</p> <p>Interview on 05/13/25 at 8:40 A.M. with CNA #654 revealed housekeeping was responsible for cleaning the shower rooms. CNA #654 thought the shower rooms were cleaned twice daily but was not sure.</p> <p>Interview on 05/13/25 at 8:45 A.M. with Housekeeper #625 revealed she was assigned to clean the 300 unit. Housekeeper #625 normally started at the front of the unit and worked her way through to the shower room. The shower room was cleaned everyday, sometimes twice a day if needed. Housekeeper #625 said she rechecked the shower room throughout the day; however, yesterday (05/12/15) she had not made it back to check a second time. Housekeeper #625 was unsure whose responsibility it was to ensure the bath tub was cleaned and maintained in a sanitary manner so she completed the task.</p> <p>Interview on 05/13/25 at 8:58 A.M. with Regional Registered Nurse #900 revealed there was not a specific policy and procedure or job description related to keeping the shower rooms in a clean and sanitary manner. Because the bathtub in the shower room on the 300 hall had not been functional for several years the staff were using it as a storage area. The CNAs were responsible for cleaning and sanitizing the areas of the shower room which were used. All residents residents on the 300 unit used the shower room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365847	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER Bath Manor Special Care Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2330 Smith Road Akron, 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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility census dated 05/12/25 revealed Residents #43, #33, #220, #24, #15, #48, #400, #219, #45, #78, #51, #97, #220, #225, #107, #44, #79, #221, #112, #113, #80, #269, #270, #114, and #63 resided on the 300 halls.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162078.</p>		