

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365859	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER The Merriman		STREET ADDRESS, CITY, STATE, ZIP CODE 209 Merriman Rd Akron, OH 44303	

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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record reviews and interview, the facility failed to ensure resident medical records contained all required discharging information and appropriate information was communicated to the receiving facility. This affected two residents (Resident #55, and Resident #65) of three residents reviewed for discharge planning. The census was 49.</p> <p>Findings include:</p> <p>1. Review of the closed medical record for Resident #65 revealed an admission date of 03/13/25 and a discharge of 03/28/25. Diagnoses included aftercare following major joint replacement, dementia and osteoarthritis.</p> <p>Review of the Discharge Return Not Anticipated Minimum Data Set (MDS) 3.0 dated 03/28/25 revealed Resident #65 was cognitively impaired. He required maximum assistance for showering and moderate assistance with toileting.</p> <p>Review of the progress notes revealed there was no indication Resident #65 was being discharged or to where.</p> <p>Review of the March 2025 orders revealed Resident #65 had a follow-up appointment ordered on 03/17/25 scheduled for 03/28/25 at 10:45 A.M.</p> <p>Review of the Discharge summary dated [DATE] revealed Resident #65 was going to an unnamed nursing home. It stated the other facility was transporting him. It also stated Resident #65's doctor's appointment would be followed up in house by the new facility. Review of the printed copy of the summary revealed Resident #65 signed it.</p> <p>Interview on 06/25/25 at 12:10 P.M. with Administrator and Director of Nursing (DON) revealed the prior social worker's last day was 04/04/25. There was coverage by a sister facility's social worker 05/01/25 through 05/05/25. The current social service designee started 06/10/25. Administrator and DON stated they were all helping cover social service's responsibilities including discharge planning. They verified there was a lack of documentation which did not paint a clear picture of Resident #65's discharge plans. They verified Resident #65's appointment was missed because it was not relayed to the receiving facility.</p> <p>(continued on next page)</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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/25/25 at 1:00 P.M. with Resident #65's doctor's office revealed he was a no-show for his scheduled appointment on 03/28/25. His appointment had to be rescheduled for 04/23/25.</p> <p>Review of the facility policy titled Discharge Policy, last revised 08/2024, revealed at the time of discharge, the facility will provide the resident/responsible party with an appropriate summary of information to ensure optimal continuity of care.</p> <p>2. Review of the closed medical record for Resident #55 revealed an initial admission date of 07/03/20 and a re-admission date of 10/07/22. He was discharged on 04/04/25. Diagnoses included chronic obstructive pulmonary disorder, sleep apnea and diabetes.</p> <p>Review of the Discharge Return Not Anticipated MDS 3.0 dated 04/04/25 revealed cognition was not assessed. He was dependent for his activities of daily living.</p> <p>Review of the progress notes revealed there was no indication Resident #55 was being discharged or to where.</p> <p>Review of the the Discharge summary dated [DATE] revealed Resident #55 was going to an unnamed nursing home.</p> <p>Interview on 06/25/25 at 12:10 P.M. with Administrator and Director of Nursing (DON) revealed the prior social worker's last day was 04/04/25. There was coverage by a sister facility's social worker 05/01/25 through 05/05/25. The current social service designee started 06/10/25. Administrator and DON stated they were all helping cover social service's responsibilities including discharge planning. They verified there was a lack of documentation which did not paint a clear picture of Resident #55's discharge plans. They verified Resident #65's appointment was missed because it was not relayed to the receiving facility.</p> <p>Review of the facility policy titled Discharge Policy, last revised 08/2024, revealed at the time of discharge, the facility will provide the resident/responsible party with an appropriate summary of information to ensure optimal continuity of care.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162554.</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>Based on observations and interviews with staff the facility failed to label and date food and failed to ensure dietary staff wore hair restraints. This had the potential to affect all 49 residents who received food from the kitchen. The census was 49.</p> <p>Findings include:</p> <p>Observation and interview on 06/24/25 at 10:45 A.M. of the kitchen revealed [NAME] #305 and Dietary Aide #227 were not wearing hair restraints in the food preparation area. They verified they did not have hair restraints on at that time.</p> <p>Observation and interview on 06/24/25 at 10:55 A.M. of the cooler revealed a small pan of two hamburgers in broth, a large plastic bucket of meatballs and a large pan of hamloaf were all undated and unmarked. Dietary Supervisor #412 verified the observation at this time.</p> <p>Review of the facility policy titled Labeling and Dating, undated, revealed proper date labeling was essential for food safety, legal compliance and quality control in the kitchen.</p> <p>Review of the facility policy titled Food Safety and Sanitation, copyrighted 2023, revealed hair restraints were required and should cover all hair on the head. [NAME] nets were required when facial hair was visible.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162554.</p>		