STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365859	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Merriman	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and facility policy review, the facility failed to ensure the call light was within reach for Resident #20. This affected one resident (#20) of three residents reviewed for call light accessibility. The facility identified five residents (#20, #24, #27, #45 and #57) who were unable to self-ambulate. The facility census was 45.Findings include:Review of the medical record for Resident #20 revealed an admission date of 04/19/23. Diagnoses included end stage renal disease, asthma, left leg below the knee amputation, diabetes, respiratory failure, and right leg above the knee amputation.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 was cognitively intact. He required partial to moderate assistance for hygiene, set up help for eating, supervision for toileting was independent with oral care. Resident #20 used a manual wheelchair for ambulation.Observation and interview with Resident #20 on 11/06/25 at 2:11 P.M. revealed he was in a manual wheelchair in his room towards the foot of his bed. Resident #20 revealed he would like to lie down but could not reach his call light. Resident #20 further revealed he was unable to self-propel his wheelchair. Observation at the time of the interview revealed the wheels on Resident #20's wheelchair were located at the bottom of the wheelchair, and Resident #20 could not reach them to propel his wheelchair with his hands. Resident #20 began yelling for staff assistance. Certified Nursing Assistant (CNA) #547 entered the room at approximately 2:13 P.M. to assist Resident #20.Interview on 11/06/25 at 2:15 P.M. revealed CNA #547 confirmed Resident #20 could not propel his wheelchair independently and required staff assistance to move about his room or common areas. She also confirmed his call light was not within reach at the time he wished to lie down, and the resident's call light should be within reach at all times.Review of the facility policy titled Call Lights, dated April 2025, revealed call lights would remain within reach of residents at all times, and if traditional call lights could not be used, an alternative call light would be provided.This deficiency was an incidental finding identified during the complaint investigation.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, hospital record review, facility policy review and interview, the facility failed to develop and implement a comprehensive and individualized skin management program to prevent incidents of neglect for Resident #20 and Resident #46. This resulted in Immediate Jeopardy and Actual Harm beginning on 10/21/25 after the facility failed to ensure Resident #46, a severely cognitively impaired resident who was dependent on staff for care, received timely and proper treat to prevent a significant deterioration to a wound to the resident's left lateral foot, resulting in the resident being transferred to the emergency department (ED) where he was admitted and treated with intravenous (IV) medications for severe sepsis. The Immediate Jeopardy and Actual Harm continued on 10/23/25 when the facility failed to ensure Resident #20, who required staff assistance for bathing and lower extremity dressing, was free of neglect when staff failed to timely identify and treat a right leg diabetic ulceration to the resident's right heel requiring hospitalization and a right above the knee amputation.On 11/10/25 at 11:22 A.M., the Administrator was notified Immediate Jeopardy began on 10/21/25 when Nurse Practitioner (NP) #500 first identified a worsening wound to Resident #46's left lateral foot resulting in hospitalization with severe sepsis and on 10/23/25 when the facility failed to identify and treat a right leg diabetic ulceration to his right heel for Resident #20 resulting in hospitalization and right above the knee amputation. The lack of systematic, comprehensive and effective skin management program resulted in situations of neglect for Resident #46 and Resident #20.In addition, concerns that did not rise to Immediate Jeopardy were identified when the facility failed to protect Resident #15 and Resident #47's right to be free from verbal abuse by staff. This affected four residents (#20, #46, #15, and #47) of 29 residents reviewed for abuse and neglect. The facility census was 45. The Immediately Jeopardy was removed on 11/18/25 when the facility implemented the following corrective actions: On 10/21/25 Resident #46 was transferred to the hospital and did not return to the facility. On 10/23/25 Resident #20 was transferred to the hospital for emergent treatment. The resident returned to the facility on [DATE]. Upon return, Resident #20 was re-assessed for pressure injury risk with a Braden scale, a skin assessment was completed, pressure reducing device were ordered and implemented and weekly skin assessments and wound care chart audits were implemented. On 10/23/25 the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #504 completed assessments on all residents. On 10/24/25, Regional Nurse #566 educated the DON and ADON #504 on wound identification, staging and dressing changes. Beginning on 11/06/25 the facility initiated a plan for the DON/designee to audit 100% of skin assessments, weekly wound reports, and dialysis communication logs for eight weeks. Inaccurate findings would be reported to the facility Quality Assessment and Performance Improvement (QAPI) committee. Audits would be reviewed in monthly QAPI meetings to assess processes and performance of staff through proper identification and compliance. On 11/07/25 Regional Nurse #566, the DON and ADON #504 initiated education for all nurses on accurate wound documentation, wound documentation process and wound rounding expectations. On 11/10/25, ADON #504 contacted the dialysis center to verify processes for return communication for residents with wounds or new orders. On 11/11/25, the facility implemented a Monthly Dialysis Foot Check form. This form would be sent to the Dialysis Center monthly by the DON/designee for communication when they do monthly skin checks. On 11/11/25 Regional Nurse #566, the DON and ADON #504 completed additional education and competencies for all licensed nurses related to wound identification and staging was completed. On 11/11/25 the DON and ADON #504 completed in-service education for Certified Nursing Assistant (CNA) staff on early reporting of skin changes. On 11/10/25 and 11/11/25, all full time and part time licensed nurses were evaluated for competencies and completed return demonstrations for wound assessment and documentation (for a simulated wound). Competencies were completed by the DON and ADON #504. Licensed staff off or who worked as needed (PRN) would have competencies evaluated before their next shift on the floor. On 11/11/25 the DON revised the facility Resident Return admission Checklist to include wound verification and order reconciliation for all returning residents. Education on the new form was provided to licensed nurses by the DON and ADON #504 on 11/11/25. The checklist would also be reviewed by the DON or ADON #504 upon admission. These would be monitored during any new admission or readmissions to facility. New staff would also be educated by the nurse training them on this form. On 11/12/25 the DON and ADON #504 provided education for all nursing and CNA staff on proper wound care and to alert nurse if a resident dressing had come off or needed replaced. On 11/14/25 the facility

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a self-reported incident (SRI), interview and review of facility policy, the facility failed to ensure Resident #1 was free of misappropriation. This affected one (Resident #1) of five residents reviewed for misappropriation. The facility census was 45.Findings include:Review of the medical record for Resident #1 revealed an admission date of 11/15/24 with diagnoses including heart failure, hypertension, diabetes and depression.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 had intact cognition.Review of SRI tracking number 258489 dated 03/21/25 revealed the facility Business Office Manager (BOM) #505 discovered multiple charges on Resident #1's bank statement related to DoorDash and Lyft. It was noted Resident #1 did not make these charges. The Administrator was updated, and the bank statement showed a total amount of $3,941.66 that was charged to Resident #1's bank account. The police were notified. The facility unsubstantiated the SRI stating evidence was inconclusive that misappropriation occurred.Review of the facility investigation for SRI tracking number 258489 revealed resident #1 was interviewed, his debit card was cancelled and the bank fraud department was assisting in the unapproved charges. There were no interviews with staff or like residents related to the SRI.Interview on 11/13/25 at 9:56 A.M. with BOM #505 revealed when Resident #1 went to the store to take money out of his account, it would not release his funds. When Resident #1 returned to the facility, BOM #505 offered to assist in reviewing his account. BOM #505 received bank statements and noted charges the facility knew Resident #1 did not make. BOM #505 stated they called the police and filed a police report, cancelled Resident #1's debit card, called the bank who did an investigation. BOM #505 stated the bank reversed three months of charges but were unable to go back further as this had been going on for approximately six months. Interview on 11/13/25 at 10:46 A.M. with the Administrator verified she had not interviewed staff or residents related to the misappropriation of Resident #1's debit card and ultimately $3, 941.66. She stated the case is at the Attorney General's office, and they had requested copies of Resident #1's bank statements. The Administrator stated she unsubstantiated the SRI for misappropriation because the facility did not know who took Resident #1's money. Interview on 11/18/25 at 1:40 P.M. with Resident #1 revealed he thought a staff member or another resident had taken his debit card and charged on his account. He stated his debit card was always in his room unless he went out to the store. He stated he was not aware of the status of the investigation.Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/24/22, and last reviewed October 2023, revealed misappropriation of a resident's property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. During an investigation, the person investigating the incident should interview the resident, the accused and all witnesses. Witnesses generally include anyone who witnessed, came in close contact with the resident the day of the incident and employees who worked closely with the accused employee or alleged victim.This deficiency was an incidental finding identified during the complaint investigation.

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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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. (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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on review of personnel files and interview, the facility failed to conduct background checks on all employees prior to hire, failed to conduct a review of the Nurse Aide Registry (NAR) for all employees prior to hire, failed to conduct a review of the abuse registry for all employees prior to hire, failed to conduct professional or personal reference checks for all employees prior to hire, and failed to maintain the background check log in a complete and accurate manner. This had the potential to affect all 45 residents residing in the facility.Findings include:1. Review of the personnel file for Certified Nursing Assistant (CNA) #549 revealed a hire date of 03/04/25. There was no evidence in the personnel file that the following were completed for CNA #549 prior to hire: background check, abuse registry check, nurse aide registry (NAR) check, and reference checks. In addition, CNA #549 had received disciplinary action write-ups for unsatisfactory work performance on 03/21/25, impeding other staff from performing their work duties on 04/16/25, use of profane or inappropriate or abusive language and inappropriate or unprofessional conduct behavior toward residents or visitors or employees on 06/18/25, and a deliberate non-performance of work duties on 07/16/25.Review of the facility's background check log revealed CNA #549 was not listed on the log for March 2025, which indicated no background check was completed.On 11/13/25 at 8:20 A.M., an interview with Human Resources (HR) Director #509 confirmed reference checks were not completed prior to hire. She stated reference checks were not completed because they could proceed with hiring individuals as long as two attempts had been made to complete the reference checks. HR Director #509 confirmed there was no evidence that NAR checks and abuse registry checks were completed.On 11/13/25 at 8:28 A.M., an interview with HR Director #509 confirmed CNA #549 was not on the background check log for March 2025 and there was no evidence in the personnel file that a background check had been completed. HR Director #509 stated CNA #549 was a re-hire and that a new background check should have been completed at the time of re-hire. HR Director #509 also stated CNA #549 had been involved in multiple self-reported incidents (SRIs) for abuse allegations and had multiple disciplinary action write ups in his file.On 11/13/25 at 1:14 P.M. , an interview with Regional Director of Operations (RDO) #567 said in the past for reference checks, they attempted to call twice and the attempts were documented if there was no answer.On 11/13/25 at 1:21 P.M., an interview with the Administrator stated she did not know what the abuse registry was and said she thought it was the same thing as the NAR.2. Review of the personnel file for CNA #541 revealed a hire date of 06/18/24. There was no evidence in the personnel file that a background check and reference checks were completed for CNA #541 prior to hire.Review of the facility's background check log revealed CNA #541 was not listed on the log for June 2024, which indicated no background check was completed.On 11/13/25 at 8:20 A.M., an interview with HR Director #509 confirmed reference checks were not completed prior to hire. She stated reference checks were not completed because they could proceed with hiring individuals as long as two attempts had been made to complete the reference checks. On 11/13/25 at 9:26 A.M., an interview with the Administrator, with Regional Nurse #566 and RDO #567 present in the room, verified CNA #541 was not on the background check log for June 2024.On 11/13/25 at 1:14 P.M., an interview with RDO #567 said in the past for reference checks, they attempted to call twice and the attempts were documented if there was no answer.3. Review of the personnel file for Activities Assistant #821 revealed a hire date of 10/22/24. There was no evidence in the personnel file that the following were completed for Activities Assistant #821 prior to hire: abuse registry check, NAR check, and reference checks. Activities Assistant #821's employment was terminated on 04/18/25 after a verbal altercation with Resident #15.On 11/13/25 at 8:20 A.M., an interview with HR Director #509 confirmed reference checks were not completed prior to hire. She stated reference checks were not completed because they could proceed with hiring individuals as long as two attempts had been made to complete the reference checks. HR Director #509 confirmed there was no evidence that NAR checks and abuse registry checks were completed.On 11/13/25 at 1:14 P.M., an interview with RDO #567 said in the past for reference checks, they attempted to call twice and the attempts were documented if there was no answer.On 11/13/25 at 1:21 P.M., an interview with the Administrator stated she did not know what the abuse registry was and said she thought it was the same thing as the NAR. 4. Review of the personnel file for Licensed Practical Nurse (LPN) #501 revealed a hire date of 09/06/05. There was no evidence in the personnel file that the following were completed for LPN #501 prior to hire: background check, abuse registry check, NAR check, and reference checks. LPN #501's orientation and onboarding training documents were signed and dated 11/11/25 Review of the facility's background check

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, facility self-reported incident (SRI) reviews and facility policy review, the facility failed to timely investigate and report the results of the investigations to the State agency within five business days as required related to an allegation of physical abuse for Resident #41 and an allegation of misappropriation for Resident #50. This affected two residents (#41 and #50) of four residents reviewed for facility SRIs. The facility census was 45.Findings include:1. Review of the medical record for Resident #41 revealed an admission date of 04/12/24. Diagnoses included depression, alcohol abuse, arthritis, anxiety and kidney failure.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 was cognitively intact. He was independent in all activities of daily living (ADL) to include eating, toileting, showering, oral hygiene, personal hygiene and dressing.Review of SRI tracking #261288 dated 06/05/25 and timed 8:46 P.M. revealed Resident #41 was outside smoking when he began arguing with Resident #55, an assisted living (AL) resident. During the exchange, Resident #41 fell to the ground and reportedly poked Resident #55 in the eye. The facility investigated the incident by interviewing other residents, placing Resident #55 on 15-minute checks, conducting skin assessments on all residents and educating staff on abuse. The facility unsubstantiated physical abuse occurred. The facility investigation was completed on 06/13/25 at 4:09 P.M., six business days.2. Review of the medical record for Resident #50 revealed and admission date of 08/22/24 and a discharge date of 04/25/25. Diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, high cholesterol, respiratory failure, arthritis and malnutrition.Review of the quarterly MDS assessment dated [DATE] revealed Resident #50 was cognitively intact. He required set-up help for eating, dressing, and oral care and required supervision for toileting, personal hygiene and showering.Review of SRI tracking #257892 dated 03/05/25 and timed 2:06 P.M. revealed Resident #50 reported his wallet, identification (ID), debit card and $500 was missing from his room. The facility investigated the allegation by interviewing other residents, encouraging the resident to keep important items in a lock box which the resident refused, and interviewing staff who had worked with the resident within the days prior to the allegation. Resident #50 could not recall when the items had gone missing. The facility unsubstantiated misappropriation occurred. The facility investigation was completed on 03/17/25 at 6:54 PM., eight business days.Interview 11/17/25 at 12:59 P.M. with the Administrator confirmed the SRI investigations for Residents #41 and #50 were not completed and reported to the State agency within five business days. She confirmed investigations should be concluded within five business days, unless extenuating circumstances were identified and included in the report. She confirmed she had no evidence to support the need for a longer investigation for SRI's #261288 or #257891, and the investigations were not completed and submitted to the State agency timely.Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated October 2023, revealed investigations would be completed within five days unless there were special circumstances causing the investigation to continue beyond those five days.This deficiency was an incidental finding identified during the complaint investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, review of self-reported incidents (SRIs) and review of the facility policy, the facility failed to thoroughly investigate allegations of abuse, neglect and misappropriation. This affected three residents (#37, #41 and #50) out of 29 residents reviewed for abuse, neglect and misappropriation. The facility census was 45.Findings include:1. Review of the medical record for Resident #37 revealed an admission date of 05/10/24 with diagnoses including depression, anxiety, cognitive communication deficit, and dementia. Review of SRI tracking number (#) 264751 dated 09/02/25, labeled as neglect, revealed Resident #37 had $353 missing. Review of the facility investigation revealed similar residents at the facility were interviewed as well as two residents from the assisted living which is in an attached building. No staff were interviewed to try to determine what happened to Resident #37's missing money. Interview on 11/13/25 at 9:08 A.M. with the Administrator stated she had not interviewed staff related to Resident #37's missing money. She verified she had not performed a thorough investigation related to Resident #37's missing money. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/24/22 and last reviewed October 2023, revealed misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. During an investigation, the person investigating the incident should interview the resident, the accused and all witnesses. Witnesses generally include anyone who witnessed, came in close contact with the resident the day of the incident and employees who worked closely with the accused employee or alleged victim. 2. Review of the medical record for Resident #41 revealed an admission date of 04/12/24. Diagnoses included depression, alcohol abuse, arthritis, anxiety and kidney failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 was cognitively intact. He was independent in all activities of daily living (ADL) to include eating, toileting, showering, oral hygiene, personal hygiene and dressing. Review of SRI tracking #261288 dated 06/05/25 revealed Resident #41 was outside smoking when he began arguing with Resident #55, an assisted living (AL) resident. During the exchange, Resident #41 fell to the ground and reportedly poked Resident #55 in the eye. The facility unsubstantiated physical abuse occurred. The investigation revealed no evidence of the incident in Resident #41's medical record, no evidence of an assessment of Resident #41 and no evidence that vital signs were obtained. The witness statements included in the investigation were conflicting; some saying Resident #41 did poke Resident #55 in the eye and one clearly indicating Resident #41 did not poke Resident #50 in the eye. The incident was first reported by Therapist #820, and no witness statement was obtained from him. Interview on 11/17/25 at 12:59 P.M. with the Administrator confirmed there was no witness statement from Therapist #820, who originally witnessed the incident, and witness statements included in the investigation contained conflicting reports of what happened. She also confirmed that an assessment of Resident #41 was not included in the investigation, and the investigation was not thorough. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #50 revealed and admission date of 08/22/24 and a discharge date of 04/25/25. Diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, high cholesterol, respiratory failure, arthritis and malnutrition. Review of the quarterly MDS assessment dated [DATE] revealed Resident #50 was cognitively intact. He required set-up help for eating, dressing and oral care and supervision for toileting, personal hygiene, and showering. Review of SRI tracking #257892 dated 03/05/25 revealed Resident #50 reported his wallet, identification (ID), debit card and $500 were missing from his room. The facility investigated the allegation by interviewing other residents, encouraging Resident #50 to keep important items in a lock box which the resident refused, and interviewing staff who had worked with the resident within the days prior to the allegation. Resident #50 could not recall when the items had gone missing. The facility unsubstantiated the complaint regarding misappropriation.The investigation revealed Resident #50 could not recall the exact date the items went missing, giving as many as three different dates within the week prior. Other residents were interviewed about whether they had seen Resident #50 with a wallet or large sums of money; however, no residents were asked if they were missing any personal items, other than clothing, or large sums of money. Interview on 11/13/25 at 2:38 PM with the Administrator revealed she could not confirm if all staff had been interviewed regarding the misappropriation, since Resident #50 could not recall exactly when the items went missing. She also confirmed the facility did not complete personal inventories; therefore, it could not be determined if Resident #50 did in fact own a wallet. She confirmed the investigation was not thorough. Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated October 2023, revealed as part of an investigation regarding abuse, mistreatment, neglect, exploitation or misappropriation of resident property, the facility would interview the affected resident, the accused resident, and all witnesses where applicable. If there were no witnesses, the interview pool would be expanded. This deficiency was an incidental finding identified during the complaint investigation.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365859	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Merriman	209 Merriman Rd Akron, OH 44303

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a discharge notice, interview, and review of the facility policy, the facility failed to provide evidence of an appropriate discharge, including completing a discharge summary or recapitulation of stay and documenting the details of the discharge in the medical record for Resident #56. This affected one resident (#56) of one resident reviewed for discharge. The facility census was 45.Findings include:Review of the medical record for Resident #56 revealed an admission date of 07/05/25 with diagnoses including osteomyelitis of vertebrae, asthma, psychoactive substance abuse, anxiety disorder, bipolar disorder, other stimulant abuse, hypertension, depression, and muscle weakness. Resident #56 was discharged from the facility on 11/04/25.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was cognitively intact. Review of the list of completed MDS assessments revealed a discharge return not anticipated assessment dated [DATE].Review of the physician's orders, standard assessments, progress notes, paper chart, and documents uploaded to the electronic medical record revealed there was no documentation regarding Resident #56's need for an immediate discharge and there was no discharge summary or recapitulation of stay.Review of the discharge notice, dated 11/04/25, indicated Resident #56 was discharged on 11/04/25 with less than 30 days' notice due to an emergency exists in which the safety of individuals in the home is endangered. The discharge location was a local hotel. The discharge notice was not signed by the resident or facility staff.Review of the facility's investigation that led to Resident #56's discharge revealed there were no written statements from any residents, there were no written statements from any facility staff (other than the Administrator) or contracted staff, and there was no substantial evidence necessitating the immediate discharge of Resident #56. The only statement provided by the facility regarding this investigation was written by the Administrator with claims that interviews with other residents and staff indicated Resident #56 was dealing illicit drugs in the facility, which represented hearsay, Resident #56 was interviewed and denied the allegations, and that Resident #56 was discharged immediately to a hotel room that was paid for one week.On 11/19/25 at 10:46 A.M., an interview with the Administrator verified Resident #56 was discharged from the facility on 11/04/25. On 11/19/25 at 2:53 P.M., an interview with the Administrator confirmed Resident #56 was issued with an immediate discharge notice for suspected drug distribution and verified there was no documentation in Resident #56's medical record indicating the reason for the discharge or a discharge summary. The Administrator also confirmed the only evidence obtained during their investigation was hearsay from other residents saying Resident #56 was distributing illicit drugs; however, the Administrator claimed those residents refused to provide written statements.On 11/20/25 at 9:09 A.M., an interview with the Administrator verified there was no physician's order for Resident #56's discharge.On 11/20/25 at 9:28 A.M., Assistant Director of Nursing (ADON) #504 provided a telephone physician's order sheet on which she had handwritten an order for Resident #56's discharge date d 11/04/25. ADON #504 claimed she received the verbal order from Medical Director #569 on 11/04/25, confirmed the order was never signed by Medical Director #569, and said it was not signed because it was not put into his mailbox. Review of the facility's policy regarding discharge, dated 08/2024, revealed nursing would obtain a discharge order when residents were ready to discharge, and the facility would provide the resident or responsible party with an appropriate summary of information to ensure optimal continuity of care. In addition, the facility would initiate the discharge for the following circumstances: the transfer or discharge is necessary for the resident's welfare and/or the resident's needs cannot be met in the facility, the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility or the services provided by a specialized unit, the safety or health of individuals in the facility is endangered, or the resident has failed after reasonable and appropriate notice to pay for the care and services provided by the facility.This deficiency was an incidental finding identified during the complaint investigation.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, observation, interview and facility policy review, the facility failed to ensure pressure ulcer treatments were completed as ordered for resident #5. This affected one resident (#5) of three residents reviewed for pressure ulcers. The facility census was 45.Findings include:Review of the medical record for Resident #5 revealed an admission date of 04/08/24 with diagnoses including multiple sclerosis and pressure ulcer stage IV (a severe, open wound with full-thickness tissue loss that extends down to the muscle, bone, or other supporting structures like tendons or joints) of the penis.Review of the physician's orders for Resident #5 revealed he had an order dated 07/30/25 to cleanse the penis with soap and water, apply Skin Prep (forms a protective barrier on the skin) to the left penis peri wound area, apply collagen filler to the wound and cover with an abdominal (ABD) pad at bedtime. Review of the Medication Administration Record (MAR) for November 2025 revealed nursing had performed Resident #5's treatment to his penis on 11/11/25.Observation on 11/12/25 at 8:30 A.M. of wound care and Foley catheter care to Resident #5 revealed the wound treatment to the pressure ulcer to his penis was not in place. Resident #5 stated the treatment had come off during incontinence care the previous night, and staff had not replaced the wound dressing. Licensed Practical Nurse (LPN) #522 verified there was no dressing in place.Interview and update on 11/12/25 at 8:55 A.M. with the Administrator related to Resident #5's wound treatment not being in place as ordered by Nurse Practitioner (NP) #500. The Administrator asked if the resident had updated staff that the dressing had come off. The wound dressing was to his penis in his incontinence brief where staff would have seen the dressing was not intact. The Administrator agreed staff should have noted the dressing had come off during incontinence care and updated the nursing staff that a new treatment would be needed. Review of the undated facility policy titled Pressure Injury Treatment revealed pressure injuries would be treated with consistent treatment protocols to aid in the healing process. This deficiency was an incidental finding identified during the complaint investigation.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review, observation, interview and review of the facility policy, the facility failed to maintain a safe smoking environment for Resident #13. This affected one resident (#13) of two residents reviewed for smoking. The facility census was 45.Findings include:Review of the medical record for Resident #13 revealed an admission date of 03/24/23 with diagnoses including schizophrenia, muscle weakness, and hypertension.Review of the physician's orders for Resident #13 identified an order for supervised smoking with a smoking apron beginning 01/23/25.Review of the care plan dated 07/28/25 revealed Resident #13 was at increased risk for injury related to smoking cigarettes. Interventions included, but were not limited to, supervision at all times while smoking (07/28/25) and a smoking apron to be worn while smoking (07/28/25). Review of the smoking and safety assessment dated [DATE] revealed Resident #13 required supervision for smoking due to dropping ashes on self, unable to light tobacco or marijuana safely, an unable to extinguish tobacco or marijuana safely. The assessment did not have utilize smoking apron marked as an intervention or apply smoking apron marked as a clinical suggestion.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of six, which was indicative of severe cognitive impairment.On 11/17/25 at 1:42 P.M., an observation of the facility's designated smoking area in the courtyard revealed there were three residents present, including Resident #13, and no facility staff. Resident #13 was smoking a cigar at this time and was not wearing a smoking apron. There were no staff in the vicinity to verify this observation.On 11/17/25 at 2:30 P.M., an interview with the Administrator and Assistant Director of Nursing (ADON) #504 verified Resident #13 was one of two supervised smokers in the facility. On 11/18/25 at 8:33 A.M., an observation of the facility's designated smoking area in the courtyard revealed there were three residents present, including Resident #13, and no facility staff. Resident #13 extinguished a cigarette and disposed of it at this time. During the observation, Resident #16 entered the courtyard, lit a cigarette and started smoking, then dropped the cigarette on the ground without extinguishing the cigarette. Resident #13 picked up Resident #16's cigarette off the ground and Resident #13 began smoking it. Resident #13 was not wearing a smoking apron. There were no staff in the vicinity to verify this observation.On 11/18/25 at 8:52 A.M., an interview with the Director of Nursing (DON) and ADON #504 confirmed again that Resident #13 was a supervised smoker. The DON stated she educated Resident #13 the previous day on the facility's designated supervised smoking times. The DON also stated if Resident #13 was smoking, someone else must have provided him with cigarettes without their knowledge.On 11/18/25 at 9:27 A.M., an interview with Regional Nurse #566 verified Resident #13 had a physician's order for supervised smoking with a smoking apron.On 11/18/25 at 9:48 A.M., an interview with the Administrator stated the smoking apron was ineffective for Resident #13 because he continued dropping ashes on himself in the areas the smoking apron did not cover. She further stated the intervention had previously been changed to a smoking jacket instead and that jacket was stored in the DON's office.Review of the facility's policy for smoking, dated 04/28/25, indicated smoking would be supervised by staff or volunteers during supervised smoking times for supervised smokers and all smoking material, cigarettes, cigars, lighters, electronic smoking devices and chargers would be kept at the nurse's station or designated area for supervised smokers.This deficiency was an incidental finding identified during the complaint investigation.

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	365859	A. Building B. Wing	11/26/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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	365859	A. Building B. Wing	11/26/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide evidence of timely Foley catheter care for Resident #5. This affected one resident (#5) out of three reviewed for activities of daily living (ADL). The facility census was 45.Findings include:Review of the medical record for Resident #5 revealed an admission date of 04/08/24 with diagnoses including Multiple Sclerosis, anxiety disorder, and muscle weakness.Review of the health status note dated 02/19/25 at 6:37 A.M. revealed Resident #5 had moderate hematuria (bloody urine) in his brief, and new orders were given to obtain a urine sample for a urinalysis. Review of the health status note dated 02/19/25 at 2:18 P.M. revealed Resident #5 had blood in his brief, new orders were given to obtain a urine sample which was unable to be collected, and Resident #5 requested to go to the hospital due to having pelvic pain.Review of the health status note dated 02/20/25 at 2:43 A.M. revealed Resident #5 was admitted to the hospital due to renal calculi (kidney stones).Review of the health status note dated 02/24/25 at 2:14 P.M. revealed Resident #5 returned to the facility on a cot by emergency medical services (EMS) and had a Foley catheter in place.Review of the skilled evaluation note dated 02/24/25 at 6:44 P.M. revealed Resident #5 had a Foley catheter in place due to urinary obstruction and urinary retention, urine was yellow in color, and the Foley catheter was intact. There was no indication that catheter care was provided.Review of the skilled evaluation note dated 02/25/25 at 3:11 P.M. revealed Resident #5's Foley catheter was intact. There was no indication that Foley catheter care was provided.Review of the skilled evaluation note dated 02/26/25 at 7:44 A.M. revealed Resident #5's Foley catheter was intact. There was no indication that catheter care was provided.Review of the skilled evaluation note dated 02/27/25 at 10:44 P.M. revealed Resident #5's Foley catheter was intact. There was no indication that catheter care was provided.Review of the skilled evaluation note dated 02/28/25 at 6:30 P.M. revealed Resident #5's Foley catheter was intact and urine was clear yellow in color. There was no indication that catheter care was provided.Review of the skilled evaluation note dated 03/01/25 at 6:34 P.M. revealed Resident #5's Foley catheter was intact. There was no indication that catheter care was provided.Review of the skilled evaluation note dated 03/02/25 at 2:33 A.M. revealed Resident #5's Foley catheter was intact. There was no indication that catheter care was provided. Review of the skilled evaluation note dated 03/03/25 at 10:48 P.M. revealed Resident #5's Foley catheter was patent and intact. There was no indication that catheter care was provided.Review of the skilled evaluation note dated 03/04/25 at 11:38 P.M. revealed Resident #5's Foley catheter was intact. There was no indication that catheter care was provided.Review of the skilled evaluation note dated 03/05/25 at 7:00 P.M. revealed Resident #5's Foley catheter was intact. There was no indication that catheter care was provided.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact, had an indwelling Foley catheter, and required substantial or maximum assist for toileting hygiene.Review of the treatment administration records (TAR) for February 2025 and March 2025 for Resident #5 revealed there were no physician's orders for Foley catheter care and no documentation of catheter care prior to 03/06/25.Review of the physician's orders for February 2025 and March 2025 for Resident #5 revealed an order for Foley catheter care beginning 03/06/25. There were no physician's orders identified for Foley catheter care prior to 03/06/25.Review of the care plan dated 06/11/25 revealed Resident #5 had an indwelling Foley catheter and was at-risk for complications such as infection, sepsis, and skin decline. Interventions included a French Size 16 Foley catheter with 10 milliliter balloon and standard drainage, monitor and document for pain or discomfort due to the catheter, monitor and record signs and symptoms of urinary tract infections and notify the medical provider, and position catheter bag and tubing below the level of the bladder and away from the entrance room door. There were no interventions identified in the care plan related to the provision of Foley catheter care.On 11/10/25 at 3:00 P.M., an interview with the Director of Nursing (DON) verified Resident #5 returned from the hospital on [DATE] with a Foley catheter in place and there were no orders for catheter care until 03/06/25 (10 days later). The DON also verified the TAR and progress notes at this time.On 11/12/25 at 8:30 A.M., an interview with Resident #5 stated residents did not get the care they needed, and incontinence care was not provided timely.This deficiency represents non-compliance investigated under Complaint Number 2615467.

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	365859	A. Building B. Wing	11/26/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, resident interview, staff interviews, facility investigation, and facility policy review, the facility failed to ensure pain medication was available as needed. This affected one resident (#7) of one resident reviewed for pain management. The facility census was 45.Findings include:Review of the medical record for Resident #7 revealed she was admitted to the facility on [DATE] with diagnoses including spondylolisthesis, lumbar region, acute upper respiratory infection, unspecified, colostomy status.Review of the baseline care plan dated 02/20/25 revealed Resident #7 was at risk for pain related to fractures with interventions that included assessing pain levels and administer pain medications per order.Review of the physician orders dated 02/20/25 revealed an order to monitor pain every shift and an order for 10 milligram (mg) oxycodone (opioid pain medication) oral tablet to be given by mouth every four hours as needed for pain. Review of the physician orders dated 02/21/25 revealed an order for 10 mg oxycodone oral tablet to be given by mouth every four hours as needed for pain for three days.Review of the electronic medication administration record (eMAR) dated 02/22/25 at 12:27 P.M. revealed a now crossed out note that Resident #7 had a rating of pain of six out of 10 on a pain scale of zero to 10, 10 being the worst.Review of the eMAR dated 02/22/25 at 7:44 P.M. revealed Resident #7 received her first dose of 10 mg of oxycodone for pain, two and a half days after arrival to the facility.Review of the medication administration record (MAR) for February 2025 revealed Resident #7 was not assessed for pain and had not received oxycodone on 02/20/25 and 02/21/25. Further review of the MAR revealed Resident #7 did not receive a pain assessment and oxycodone until 02/22/25 at 7:44 P.M., approximately two and a half days after admission.Review of the controlled drug administration record (CDAR) for Resident #7 revealed the facility received 12 tablets of 10 mg oxycodone on 02/22/25 (two and a half days after admission) to be given one tablet by mouth every four hours as needed. Further review of the CDAR revealed Resident #7 first dose of oxycodone was signed off on 02/22/25 at 7:45 P.M.Review of the drop ship from the pharmacy, dated 02/22/25 at 7:43 P.M. revealed the facility received Resident #7's oxycodone 10 mg tablets in a 12 count. Review of the drop ship revealed the medication was delivered at 7:28 P.M. on 02/22/25, approximately two and a half days after Resident #7 admission.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #7 was independent for activities of daily living (ADL).Interview on 11/12/25 at 1:40 P.M. with the Director of Nursing (DON) revealed facility staff informed her that Resident #7's oxycodone was still not available the day after she arrived at the facility. The DON revealed the nurse on duty did not complete Resident #7's assessment because Resident #7 went outside to smoke and the following day, the oxycodone was still not available. The DON revealed she did not know why the night shift nursing staff did not follow-up on Resident #7's oxycodone medication. The DON confirmed and verified the above information at the time of the interview.Interview on 11/12/25 at 1:50 P.M. with Resident #7 revealed she had surgery in February 2025 and went days without pain medication. Resident #7 revealed facility staff blamed each other for not ordering it upon her arrival. Resident #7 revealed she had 200 internal stitches and she was in so much pain that she could not get out of bed. Interview on 11/12/25 at 2:15 P.M. with Assistant Director of Nursing (ADON) #504 revealed Resident #7 admitted to the facility with compression fractures on 02/20/25. ADON #405 revealed Resident #7 did not receive her first dose of oxycodone until 02/22/25 at 7:45 P.M. as she confirmed and verified the information with the CDAR.Review of the facility document titled Pain Management, dated 04/28/25, revealed the facility had a policy in place to ensure pain management was provided to residents who required such services, including assessment of pain and working in collaboration the physician and/or prescriber to prevent and manage a resident's pain. Review of the document revealed the facility did not implement the policy.This deficiency represents non-compliance investigated under Master Complaint Number 2658947.

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	365859	A. Building B. Wing	11/26/2025

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. (continued on next page)

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	365859	A. Building B. Wing	11/26/2025

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure wound care was overseen by a physician. This affected two residents (#20 and #46) of seven reviewed for wound management. The facility identified 11 current residents (#5, #10, #12, #17, #20, #25, #32, #37, #38, #39 and #45) with wounds. The facility census was 45.Findings include:1. Review of the closed medical record for Resident #46 revealed an admission date of 07/29/25. Resident #46 was transferred to the hospital on [DATE] and did not return to the facility. Resident #46 had diagnoses including congestive heart failure, dementia, diabetes, muscle weakness and epilepsy.Review of the care plan dated 07/30/25 revealed Resident #46 was at risk of skin breakdown due to diabetes, cognitive decline and immobility. Interventions included administering treatments as ordered, assisting in turning and repositioning as needed, educating family and caregivers about causes of skin breakdown and following the facility protocol for the prevention and treatment of skin breakdown. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 was severely cognitively impaired. The assessment revealed the resident required staff set-up help for eating, substantial staff assistance for oral hygiene and was totally dependent on staff for toileting, showering, dressing and hygiene. The assessment revealed the resident was at risk for the development of pressure ulcers and had two unstageable deep tissue injuries (DTI), (a DTI is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue) and one diabetic foot ulcer (DFU).Review of the weekly wound report dated 10/07/25 authored by Licensed Practical Nurse (LPN) #501, the facility's wound nurse, revealed a wound to Resident #46's left foot measuring 6.0 centimeters (cm) long by 6.0 cm wide by 0.1 cm depth which was declining. There was no evidence that the physician was notified of the condition of the wound and no evidence that wound treatments were in place.Review of the weekly wound report dated 10/14/25 authored by LPN #501 revealed the wound to Resident #46's left foot measured 7.0 cm long by 7.0 cm wide with 0.1 cm depth and was declining. There was no evidence the physician was notified of the condition of the wound, and no evidence that wound treatments were in place.Review of NP #500's note dated 10/21/25 revealed Resident #46 was seen for weekly wound follow-up care. The note revealed Resident #46 had a worsening wound to the left lateral foot with tunneling and exposed muscle. The wound was described as an arterial wound with full thickness, measuring 4.2 cm wide by 8.0 cm long and 0.2 cm deep with 10% granulation, 50% epithelial (outer layer of tissue), 10% slough (dead tissue which blocks healing) and 30% eschar (dead, dry tissue). A large amount of bloody, purulent (thick fluid or pus) drainage was noted to be present. NP #500 recommended Resident #46 be transferred to the hospital for treatment.Review of the treatment administration record (TAR) for October 2025 revealed no evidence of any type of wound treatment in place to address Resident #46's left lateral foot wound.Review of Resident #46's hospital history and physical dated 10/21/25 revealed the resident was admitted and required treatment for severe sepsis as a result of worsening wounds. Review of an email communication between the Administrator and Resident #46's guardian dated 10/29/25 revealed the hospital expressed concerns for Resident #46's extensive wounds with the guardian and advised it was against medical advice for the resident to return to the facility (post-hospitalization). As a result, the guardian chose to move Resident #46 to a different skilled nursing facility.Interview on 11/05/25 at 2:40 P.M. with LPN #501 revealed she documented Resident #46's left lateral foot wound on her weekly wound reports on 09/23/25, 09/30/25, 10/07/25 and 10/14/25 and knew what orders to include; however, she did not notify the physician of the wound or orders and did not add the treatment orders to the TAR. She revealed she did not assess the wound, only obtained measurements, and then stated she notified facility administration.Interview on 11/05/25 at 11:27 A.M. with Medical Director (MD) #569 revealed he spoken with NP #500 (date of conversation not provided) and learned she was not wound certified but stated she reported she had been following the residents with wounds, and consulting with her supervisor, who he believed was wound certified. The NP denied providing any direct care such as debridement. During the interview, MD #569 revealed he was never made aware of the wound to Resident #46's foot. (Additional information obtained during the survey revealed NP #500's supervisor was also an advanced practice NP, was located and licensed in Kansas not Ohio, and was not wound care certified).2. Review of the medical record for Resident #20 revealed an admission date of 04/19/23 with diagnoses

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	365859	A. Building B. Wing	11/26/2025

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews, resident interview, staff interviews, review of facility self-reported incidents (SRIs), review of police reports, review of facility investigations, review of Substance Abuse and Mental Health Services Administration (SAMHSA) publication titled Treatment of Stimulant Use Disorders, review of Centers for Disease Control and Prevention (CDC) publication titled Stimulant Guide, review of the Smoking/Alcohol/Non-Prescribed Drugs Agreement, review of the behavior contract and facility policy review, the facility failed to provide an environment that was safe and free from drugs and alcohol as well as have an effective substance abuse program. This affected four residents (#6, #7, #12 and #41) of four residents reviewed for drug use. The facility census was 45.Findings include:1. Review of the medical record for Resident #12 revealed an admission date of 09/09/25 with diagnoses including hypertension, congestive heart failure, major depressive disorder, opioid dependence, and type two diabetes mellitus. Review of the clinical admission note dated 09/09/25 at 7:59 P.M. revealed Resident #12 arrived to the facility by ambulance, was alerted and oriented to person, place, and time, and was currently using substances or had a diagnosis of substance use disorder with substances of choice including alcohol, opioids, street drugs, prescription drugs, and marijuana with frequency of use listed as daily. Review of the physician's orders for Resident #12 identified orders for Methadone Hydrochloride (HCl) (10 milligram (mg)) (a long-acting opioid used in the treatment of narcotic addiction) tablet to give 10 mg by mouth four times daily for long-term methadone use for three days which was ordered on 09/10/25 and discontinued on 09/10/25, Percocet 5-325 mg (opioid pain medication) tablet to give one tablet by mouth every four hours as needed (PRN) for pain which was ordered on 09/10/25 and discontinued on 10/23/25, and Percocet 5-325 mg tablet to give one tablet by mouth every six hours PRN for pain which was ordered on 10/23/25 and discontinued on 11/05/25. Review of the medication administration record (MAR) for September 2025 revealed Resident #12 received one dose of Methadone HCl 10 mg on 09/10/25 at 12:00 P.M. There was no other documentation of Methadone HCl administration on the MAR. Resident #12 received PRN doses of Percocet on 09/11/25, 09/12/25, 09/14/25, 09/17/25, 09/18/25, 09/20/25, 09/21/25, 09/22/25, 09/24/25, 09/25/25, 09/26/25, 09/27/25, 09/28/25, 09/29/25, and 09/30/25. Review of the psychiatry progress note dated 09/12/25 at 1:00 A.M. revealed Resident #12 had substance abuse history including past alcohol use with 16 months sobriety, current tobacco use of one and a half packs of cigarettes daily, and current marijuana use. Review of the nurse practitioner's note dated 09/12/25 at 11:48 P.M. revealed Resident #12 had been in the intensive care unit (ICU) in the hospital due to opioid intoxication, mentation, bradycardia, and hypotension (low blood pressure), which all improved with Narcan (medication to reverse the effects of opioids) infusion and peripheral Levophed (medication to raise blood pressure). Resident #12 reported smoking one and half packs of cigarettes daily and claimed he had not consumed alcohol in a long time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365859	A. Building B. Wing	11/26/2025

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The Merriman	209 Merriman Rd Akron, OH 44303

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MAR for October 2025 revealed Resident #12 received PRN doses of Percocet on 10/01/25, 10/02/25, 10/03/25, 10/04/25, 10/06/25, 10/07/25, 10/08/25, 10/09/25, 10/10/25, 10/11/25, 10/12/25, 10/12/25, 10/13/25, 10/14/25, 10/15/25, 10/16/25, 10/17/25, 10/18/25, 10/19/25, 10/20/25, 10/21/25, 10/22/25, 10/23/25, 10/24/25, 10/25/25, 10/26/25, 10/27/25, 10/28/25, 10/29/25, 10/30/25, and 10/31/25. Review of the non-compliance care plan initiated 10/08/25 revealed Resident #12 was non-compliant with the facility's drug and alcohol policy. Interventions included, but were not limited to, administer medications as ordered and monitor for side effects and effectiveness, give resident items or tasks to be used as diversional activities, involve in activities of choice, keep schedules routine and predictable, praise the resident for demonstrating consistent desired or acceptable behavior, and provide emotional support and reassurance as needed to help decrease or resolve anxiety. There were no interventions specific to preventing or reducing illicit drug use. Review of the urinary drug screening report, collected on 10/10/25, revealed Resident #12 tested positive for the following: a) Marijuana Metabolite (cTHC) with a result of 108 nanograms per milliliter (ng/ml) and a negative result would be a value of less than 15 ng/ml. The report indicated the detection window was two to three days for single use, five to seven days for moderate use, 10 to 15 days for heavy use, 19 to 40 days for chronic use, and one to five days for oral ingestion. b) Methadone with a result of 240 ng/ml and a negative result would be a value of less than 100 ng/ml. The report indicated the detection window was three to 11 days. The report also indicated Resident #12 had no matching prescription to account for the positive result. c) Methadone Metabolite (EDDP) with a result of 258 ng/ml and a negative result would be a value of less than 100 ng/ml. The report indicated the detection window was three to 11 days. The report also indicated Resident #12 had no matching prescription to account for the positive result. d) Methamphetamine with a result of 246 ng/ml and a negative result would be a value of less than 100 ng/ml. The report indicated the detection window was two to four days. e) Cocaine Metabolite with a result of greater than 6,400 ng/ml and a negative result would be a value of less than 50 ng/ml. The report indicated the detection window was up to three days for single use and up to nine days for chronic use. Review of the nurse practitioner's note dated 10/22/25 at 8:35 A.M. revealed Resident #12 smelled like marijuana, and Resident #12 reported he had been outside smoking. Review of the urinary drug screening report, collected on 10/22/25, revealed Resident #12 tested positive for Marijuana Metabolite (cTHC) with a result of 45 ng/ml and a negative result would be a value of less than 15 ng/ml. The report indicated the detection window was two to three days for single use, five to seven days for moderate use, 10 to 15 days for heavy use, 19 to 40 days for chronic use, and one to five days for oral ingestion. Resident #12 tested negative for Methadone, Methadone Metabolite (EDDP), Methamphetamine, and Cocaine Metabolite. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the urinary drug screening report, collected on 10/28/25, revealed Resident #12 tested positive for the following: a) Amphetamine with a result of 735 ng/ml and a negative result would be a value less than 100 ng/ml. The report indicated the detection window was two to seven days. The report also indicated Resident #12 had no matching prescription to account for the positive result. b) Marijuana Metabolite (cTHC) with a result of 42 ng/ml and a negative result would be a value of less than 15 ng/ml. The report indicated the detection window was two to three days for single use, five to seven days for moderate use, 10 to 15 days for heavy use, 19 to 40 days for chronic use, and one to five days for oral ingestion. c) Methamphetamine with a result of 2,215 ng/ml and a negative result would be a value of less than 100 ng/ml. The report indicated the detection window was two to four days. Review of the psychiatry progress note dated 10/29/25 at 1:00 A.M. revealed Resident #12 had displayed agitated behaviors toward other residents and aggressive behaviors toward staff. Resident #12 admitted to current daily marijuana use. Facility staff reported finding drug paraphernalia in Resident #12's room that was believed to be a cocaine pipe. Resident #12 recently tested positive for cocaine and methamphetamine. Interventions included continuing to encourage abstinence while at the facility, continuing with participation in drug rehab program, and staff to monitor and document any new or worsening behaviors. Review of the urinary drug screening report, collected 11/03/25, revealed Resident #12 tested positive for the following: a) Cocaine with a result of 300 ng/ml. b) Cannabinoid (THC) with a result of 50 ng/ml. c) Oxycodone with a result of 100 ng/ml. d) Methamphetamine with a result of 1,000 ng/ml. This drug screen was conducted by a different laboratory and did not indicate the detection window for the substances or the negative result threshold. Review of the nurse practitioner's note dated 11/04/25 at 3:40 P.M. revealed Resident #12 was upset that his pain medication had been reduced. Review of the nursing note dated 11/05/25 at 9:34 P.M. revealed Resident #12 expressed concern for withdrawals due to his pain medication being discontinued. Review of the nurse practitioner's note dated 11/11/25 at 1:26 P.M. revealed Resident #12 admitted to using crystal methamphetamine and facility staff reported that Resident #12 had tested positive for cocaine. Resident #12's Percocet was discontinued due to drug use. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive care plan for Resident #12, last reviewed on 11/11/25, revealed there was no care plan or interventions in place regarding the use of methamphetamine or cocaine. Review of the nurse practitioner's note dated 11/13/25 at 3:07 P.M. revealed Resident #12 was alert but drowsy. Concerns were raised for drug use, and a rapid urine screen was ordered. Review of the urinary drug screening report, collected on 11/13/25, revealed Resident #12 tested positive for the following: a) Amphetamine with a result of 132 ng/ml and a negative result would be a value less than 100 ng/ml. The report indicated the detection window was two to seven days. The report also indicated Resident #12 had no matching prescription to account for the positive result. b) Methamphetamine with a result of 208 ng/ml and a negative result would be a value of less than 100 ng/ml. The report indicated the detection window was two to four days. c) Buprenorphine with a result of 11 ng/ml and a negative result would be a value less than 5 ng/ml. The report indicated the detection window was four to eight days. The report also indicated Resident #12 had no matching prescription to account for the positive result. d) Norbuprenorphine with a result of 34 ng/ml and a negative result would be a value less than 20 ng/ml. The report indicated the detection window was four to eight days. The report also indicated Resident #12 had no matching prescription to account for the positive result. e) Marijuana Metabolite (cTHC) with a result of 68 ng/ml and a negative result would be a value of less than 15 ng/ml. The report indicated the detection window was two to three days for single use, five to seven days for moderate use, 10 to 15 days for heavy use, 19 to 40 days for chronic use, and one to five days for oral ingestion. An addendum to the nurse practitioner's note from 11/13/25 at 3:07 P.M., added on 11/15/25 at 7:16 A.M., indicated Resident #12 had tested positive for Suboxone, for which Resident #12 did not have a prescription. On 11/18/25 at 1:32 P.M., an interview with Nurse Practitioner (NP) #500 confirmed Resident #12's pain medication was stopped recently due to the resident testing positive for cocaine and his admission to using crystal methamphetamine. NP #500 said drug access in the facility was a common problem among residents, and the facility was not doing anything about it. On 11/18/25 at 3:12 P.M., an interview with the Administrator verified the facility did not have a policy regarding residents testing positive for illicit substances and their drug policy only indicated the physician would be notified of suspected use. The Administrator confirmed the facility had a contracted drug rehabilitation program in place and she was unable to explain why there was no facility policy addressing confirmed use of illicit substances among residents. On 11/18/25 at 10:04 A.M., an interview with Social Services Designee (SSD) #531 stated Resident #12 had the right of self-determination to make poor life choices regarding drug use. (continued on next page)

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	365859	A. Building B. Wing	11/26/2025

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/25 at 10:13 A.M., an interview with Qualified Behavioral Health Specialist #809 and Qualified Behavioral Health Specialist #810 stated continued illicit drug use was evaluated on an individual basis. If interventions were unsuccessful and the residents were not willing to try to improve, then they were discharged from the program because they had reached their maximum potential. Resident #12 was open and honest with them about his desire to stop using illicit drugs, and he reported that he started using again because his pain medications had been stopped abruptly. Qualified Behavioral Health Specialist #809 stated they had made multiple recommendations to the facility about possible interventions to improve the drug problem in the facility and the only response they ever received from the Administrator was let me talk to corporate. Both Qualified Behavioral Health Specialists #809 and #810 confirmed residents in the facility were having major substance abuse issues recently and the facility had been clear of drugs for one year prior to current concerns. They stated the Administrator was notified of drug use and drug instruments found in resident areas, and the Administrator told them she had to build a case before she could do anything about it. Qualified Behavioral Health Specialist #809 stated she felt the drug rehab program and the facility were two separate entities and care was not cohesive. On 11/19/25 at 10:46 A.M., an interview with the Administrator, with Regional Nurse #566 and Regional Director of Operations (RDO) #567 present in the room, verified illicit drug use in the facility had increased over the past several months. The Administrator also confirmed Resident #12 tested positive for methamphetamine on 11/13/25. RDO #567 stated the facility had to be allowed to conduct an investigation before discharges occurred related to illicit drug use or alleged drug distribution. RDO #567 said the facility does accept residents with a history of illicit drug use, they offer the drug rehab program, and they do not want to kick out someone who has a relapse. In regard to the suggested interventions by Qualified Behavioral Health Specialists #809 and #810 for participants of the drug rehab program, RDO #567 said their suggestions to provide supervised visitation and conduct inspections for residents upon returning from unsupervised leaves of absences infringed on resident rights and that was why they were not implemented. On 11/19/25 at 2:05 P.M., an interview with Resident #12 said the facility did not do a good job at keeping drugs out of the facility. On 11/19/25 at 2:53 P.M., an interview with the Administrator stated she had called the local police department on 11/04/25 to notify them of an allegation that a resident had $2,000 worth of methamphetamine. The Administrator claimed the dispatcher, whom she was unable to name, stated they would not send any officers to investigate. The Administrator did not provide any evidence of this call. On 11/19/25 at 3:06 P.M., a review of the Akron Police Department Crime Report Search found at https://online.akronohio.gov/APDWebPortal/crime-search indicated no crimes had been reported for the facility's address on 11/04/25. There were no crime reports listed for the facility between 09/28/25 and 11/05/25. Review of the facility's policy for drug and alcohol use, dated 04/24/18, indicated the use and/or consumption of illegal drugs, illegal substances, or alcohol were strictly prohibited in the facility. The policy indicated the physician would be notified of suspected drug use among residents, the facility reserved the right to issue an intent to discharge notice for any resident who violated the drug and alcohol policy, and the facility reserved the right to notify local law enforcement of violations. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Substance Abuse and Mental Health Services Administration (SAMHSA) publication titled Treatment of Stimulant Use Disorders, dated 2020, indicated stimulant use was on the rise and becoming a public health crisis. Illicit stimulants like cocaine and amphetamines are more accessible, harmful to the cardiovascular system, and can cause lung diseases, brain diseases, stroke or even death. Chronic stimulant use could permanently alter brain structure, leading to impaired cognitive, neurological, and emotional systems. Long-term use of cocaine and methamphetamine can cause decreased attention, confusion, impaired memory, inhibited impulse, and reduced motor skills. Practices associated with treatment of stimulant use disorders include motivational interviewing, contingency management, community reinforcement approach, and cognitive behavioral therapy. Management strategies for polydrug use included considering the pharmacological, psychosocial, and behavioral reasons for combining certain substances, evaluate for the presence of other substance use disorders, and implement targeted treatment options addressing all substances for people who use multiple drugs. In addition, clinicians should be aware of the relationship between stimulant use and violence, being cognizant of the consequences of violence on individuals using stimulants, their families, program staff, and other program participants. Review of the Centers for Disease Control and Prevention (CDC) publication titled Stimulant Guide, dated 2022, revealed individuals who have used stimulants may present with the following behaviors or characteristics: physically unable to keep still, physically unable to hear or follow direct orders, confused or disoriented, may show signs of physical exertion, may not be able to recall certain facts or events, and may be agitated, irritable, or paranoid. The publication indicated reducing or eliminating stimulant use could prevent stimulant overdose and evidence-based interventions included motivational interviewing, contingency management, community reinforcement, and cognitive behavioral therapy. Contingency management consists of providing meaningful rewards to individuals who meet certain treatment goals, such as treatment adherence, attendance at meetings and appointments, or negative urine drug screens. Strategies that combine contingency management with cognitive behavioral therapy or a community reinforcement approach produced the best treatment outcomes in clinical studies. 2. Review of the medical record for Resident #6 revealed he was admitted to the facility on [DATE] with diagnoses including thoracic aortic aneurysm, without rupture, unspecified, heart failure, unspecified, chronic pain syndrome. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, that indicated he was alert and oriented to person, pace, and time. Review of the MDS assessment revealed Resident #6 was independent for activities of daily living (ADL). Review of the care plan dated 08/25/25 revealed Resident #6 was noncompliant with the drug and alcohol policy with interventions that included observing environment and/or situation for possible noncompliance. Review of Resident #6 medical record revealed he shared a room with Resident #7. 3. Review of the medical record for Resident #7 revealed she was admitted to the facility on [DATE] with diagnoses including spondylolisthesis, lumbar region, acute upper respiratory infection, unspecified, colostomy status. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment dated [DATE] revealed Resident #7 had a BIMS score of 15, that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #7 was independent for ADL. Review of the care plan dated 02/20/25 revealed Resident #7 was noncompliant with the drug and alcohol policy with interventions that included observing environment and/or situation for possible noncompliance. Review of Resident #7 medical record revealed he shared a room with Resident #6. Review of the physician order dated 03/30/25 revealed an order for one-on-one supervision. Review of the progress note dated 03/30/25 at 12:31 P.M. revealed Resident #7 had an unknown visitor in her room. Registered Nurse (RN) #800 attempted to go inside Resident #7's room, but the door was blocked. RN #800 looked through the crack in the door and observed the unknown visitor sitting down with his penis out with multiple bags of unknown substance and strings on the bedside table. Resident #7's boyfriend, Resident #6, was sitting in his chair on the opposite side of the bed. RN #800 contacted the Administrator and the local police department. Review of the progress note dated 03/30/25 at 12:31 P.M., now crossed out as an error, revealed Resident #7 was caught having sex with her narcotic dealer in her room with her roommate, Resident #6, present. Resident's #6 and #7 were caught doing drugs together in their room. RN #800 notified the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #504 via text message with no response. RN #800 notified Resident #7's physician and the Ohio Department of Health (ODH). Review of the progress note dated 03/30/25 at 1:03 P.M., now crossed out as an error, revealed Resident #7 refused education on drug use including risk and benefits. ADON #504 returned RN #800's call, and no further interventions were given. Review of the progress note dated 03/30/25 at 4:43 P.M. revealed ADON #504 was notified by text message approximately at 12:31 P.M. by RN #800 informing her that Resident #7 and #6 had blocked the doorway to their room with the chairs and upon entering the room, an unknown visitor had his pants down and was pulling them up as RN #800 entered the room. RN #800 revealed she observed illegal drugs on the tray table. RN #800 informed ADON #504 that she did not remove the illegal substance from the room and the unknown visitor left swiftly. ADON #504 informed RN #800 that Akron Police Department would be called to report the suspected incident and would be coming to the facility. Review of the progress note dated 04/15/25 at 1:00 A.M. revealed Resident #7 was admitted to the facility and shared a room with her boyfriend, Resident #6. Review of the note revealed Resident #7 had a history of cocaine abuse and opioid dependence. Review of the note revealed Resident #7 had drug seeking behaviors and the police was recently called due to Resident #7 being caught having sexual relations with a man, who was a visitor, in an exchange for substance use. Review of SRI tracking number (#) 258811 revealed an allegation of alleged sexual abuse was initiated by the facility on 03/30/25. Review of the SRI revealed an agency nurse (RN #800) reported residents in room [ROOM NUMBER] (Residents #6 and #7) were turning tricks with the dope man in the room. Review of the SRI revealed on 03/30/25 at 10:00 A.M. RN #800 witnessed Resident #7 performing oral sex with a visitor with drugs laid out on the bedside table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365859	A. Building B. Wing	11/26/2025

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/13/25 at 10:49 A.M. with the Administrator revealed RN #800 posted on clipboard, a healthcare staffing agency, that Resident #7 was giving oral sex, and drugs were observed in the room on the table. The Administrator revealed no one contacted RN #800 back and after two and a half hours, the Administrator stated she came to the facility and interviewed RN #800. The Administrator revealed RN #800 said she observed the incident through a crack in the door but couldn't see what was inside the bags on the table, the Administrator revealed it was an unknown visitor that was observed coming and going, but she did not have statements from staff and no other resident interviews. Review of the facility investigation revealed an incident report dated 03/30/25 at 12:57 P.M. from the Akron Police Department (APD) that revealed the ADON #504 reported an unknown tall black male, medium in size, entered the facility through a door other than the main entrance. Review of the APD report revealed Residents #6 and #7, who were a couple, blocked the door to their shared room in order to keep RN #800 out. Review of the APD report revealed RN #800 witnessed Resident #7 performing oral sex on the unknown male visitor who subsequently brought a bunch of drugs and then left the facility after RN #800 observed the incident. Review of the APD report revealed the unknown visitor left drugs in the room upon his exit. Review of the facility document titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, reviewed October 2023, revealed the facility had a policy in place that residents would be free from sexual abuse and/or exploitation and alleged incidents would be reported within two hours to ODH. Review of the facility document revealed the facility did not implement the policy. 4. Review of the medical record for Resident #41 revealed an admission date of 11/24/23 with diagnoses including alcohol abuse with withdrawal, sleep disorders, cocaine abuse, anxiety and hypertension. Review of the Smoking/Alcohol/Non-Prescribed Drugs Agreement, dated 12/04/24, signed by both Resident #41 and the Administrator, revealed the facility did not recommend residents consume alcohol or non-prescribed illegal drugs during their stay. The agreement stated if a resident returned to the facility after a leave and had signs/symptoms of being under the influence of drugs or alcohol, the physician would be notified. If the resident was found to be smoking in the facility, the resident would be given a discharge notice that would state the resident would need to find housing elsewhere immediately. The agreement also stated it was against the policy for a resident to smoke indoors or bring or have alcohol or non-prescribed medications into the facility. If at any time the team felt the resident's behaviors exhibited the use of alcohol or other non-prescribed medications put the resident or other residents at risk and the resident refused to comply with the facility policy, the resident may be given a 30-day discharge. Review of the behavior contract dated 03/28/25 and signed by both Resident #41 and the Administrator revealed he understood that he would not become intoxicated or under the influence of drugs or alcohol while he was a resident at the facility. The contract stated if the conditions were not followed, he would be discharged to another facility or back to the community. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 07/22/25 for Resident #41 revealed he was non-compliant with drug and alcohol policy and had been asked to leave the drug and alcohol recovery program located inside the facility. Resident #41 also had a history of addiction related to alcohol and cocaine use with a history of felony drug charges and incarceration. Interventions included to inform resident of the facility policy related to use of drugs and alcohol and discuss risks of non-compliance. Facility staff were to notify the physician if staff suspected Resident #41 was under the influence of alcohol or illicit substances. Review of the care plan dated 07/22/25 for Resident #41 revealed he had a behavior problem secondary to mood and would become verbally aggressive at times or physically aggressive towards staff when drinking and would antagonize his peers. Resident #41 refused therapies, laboratory testing, medications and care at times and refused to allow staff to enter his room and throw items away. Review of the quarterly MDS assessment dated [DATE] revealed Resident #41 had intact cognition. He had physical and verbal behaviors towards others one to three days on this assessment. He was independent for all ADL. Review of the nursing progress note dated 05/29/25 at 1:06 P.M. revealed Resident #41 fell during an activity, and it was evident to the staff as he was intoxicated, and his balance was off. There was no follow-up in the nursing progress notes related to his alcohol use. Review of the nursing progress note dated 05/30/25 at 3:19 P.M. revealed Resident #41 had fallen in the hallway, witnessed by the assisted living nurse. Resident #41 smelled of alcohol and appeared to be intoxicated. There was no follow-up related to his alcohol use. Review of SRI tracking #261288 dated 06/05/25 revealed Resident #41 and another resident were outside smoking when Resident #41 became verbally aggressive towards the other resident and then a physical alteration ensued. Review of the nursing progress note dated 06/07/25 at 8:10 P.M. revealed Resident #41 was observed by the nurse smoking marijuana throughout the facility. The facility nurse redirected him to smoke outside, and he became verbally aggressive. There was no follow-up related to his drug use. Review of the primary routine care note dated 09/29/25 at 9:52 A.M. by Nurse Practitioner (NP) #500 revealed Resident #41 was a daily drinker, at least five standard drinks a day and had daily substance abuse up to seven times per week of marijuana, crack and cocaine. NP #500 stated during her visit with the resident, a distinct odor of cannabis was detected in Resident #41's room. An immediate discussion was held with NP #500 and the nursing staff to clarify addressing incidents and the availability of Narcan in the event of an opioid overdose. There were no nursing progress notes related to addressing his drug use by the facility staff. Review of the SRI #265919 dated 10/01/25 revealed Resident #41 and another resident were outside smoking when Resident #41 got into a verbal altercation that led to a physical altercation. An unknown resident statement revealed you could tell he (Resident #41) was drunk by how he was acting. There was no follow-up related to his alcohol use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365859	A. Building B. Wing	11/26/2025

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/17/25 at 11:15 A.M. with the Administrator revealed residents at the facility were not allowed to smoke marijuana. She stated Resident #41 was no longer part of the drug and alcohol recovery program because there was nothing else he could get out of it as he was non-compliant with alcohol and drug use. She stated Resident #41 usually stayed in his room unless he went on leave of absence from the building. She stated when Resident #41 returned to the facility he usually self-isolated in his room if he had been drinking. She stated he only would come out to smoke in the courtyard and that was when he fought with other residents. Review of the primary routine care note dated 11/18/25 at 12:03 P.M. by NP #573 revealed Resident #41 was a daily drinker, at least five standard drinks a day and had daily substance abuse up to seven times per week of marijuana, crack and cocaine. There was no nursing progress note related to addressing his drug or alcohol use by the facility staff. On 11/18/25 at 1:32 P.M. NP #500 said drug access in the facility was a common problem among residents, and the facility was not doing anything about it. On 11/18/25 at 3:12 P.M., an interview with the Administrator verified the facility did not have a policy regarding residents testing positive for illicit substances and their drug policy only indicated the physician would be notified of suspected use. The Administrator confirmed the facility had a contracted drug rehabilitation program in place and she was unable to explain why there was no facility policy addressing confirmed use of illicit substances among residents. On 11/18/25 at 10:04 A.M., an interview with SSD #531 stated Resident #41 had been kick

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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. Based on record review and interview, the facility failed to ensure Resident #13 received medications as ordered. This affected one resident (#13) of eight residents reviewed for medication administration. The facility census was 45.Findings include:Review of the medical record for Resident #13 revealed an admission date of 03/24/23 with diagnoses including schizophrenia, hypertension and history of falling. Review of the medication error investigation by the Director of Nursing (DON) dated 09/23/25 at 3:42 P.M. revealed Licensed Practical Nurse (LPN) #568 administered the wrong medication to Resident #13. LPN #568 stated he had two different residents' medications in the top of his medication cart in medication cups. Resident #13 was in the hallway and stopped so the nurse could provide his medication. When LPN #568 reached into the medication cart, he knocked over the two different residents' medication cups in the drawer. He then replaced the medications in the cups and administered Resident #13 his medications. After Resident #13 took the medications, LPN #568 noted that he had given him the other resident's narcotic medication Tramadol (opioid medication for pain).Review of the physician's orders for Resident #13 for September 2025 revealed he did not have a physician's order for Tramadol 50 milligrams (mg). Interview on 11/05/25 at 3:39 P.M. with the DON verified LPN #568 made a medication error when giving Resident #13 Tramadol 50 mg which was not ordered. She also stated LPN #568 was no longer at the facility, and nursing staff were not to pre-pour multiple residents' medications at one time.Review of the facility policy titled Administering Medications, dated 04/28/25, stated the individual administering medications must verify the resident's identity before giving the resident his/her medications. The medications must be administered in accordance with the orders.This deficiency represents non-compliance investigated under Master Complaint Number 2658947 and Complaint Number 2615467.

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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 record review, observation, interview and facility policy review, the facility failed to ensure medications were properly stored. This affected one resident (#38) of three reviewed for proper medication storage. The facility census was 45.Findings include:Review of the medical record for Resident #38 revealed and admission date of 10/20/25. Diagnoses included fracture of the left foot, difficulty walking, and muscle weakness.Review of the self-medication administration assessment dated [DATE] revealed Resident #38 required assistance to administer oral medication.Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was cognitively intact. He required substantial to maximum assistance with toileting and showering, partial assistance with personal hygiene and was independent and eating in oral care.Review of the physician's orders for October 2025 revealed the resident began taking Bactrim (used to treat bacterial infections) 800 milligrams (mg) one tablet by mouth two times per day for a urinary tract infection (UTI) on 11/03/25 and was to take the medication for a period of seven days.Review of the care plan dated 11/05/25 revealed Resident #38 had a UTI and was receiving antibiotic therapy. Interventions included administering medications per the providers' orders, encouraging periods of rest and maintaining universal precautions when providing resident care.Observation and interview on 11/05/25 at 9:34 A.M. with Resident #38 revealed a clear plastic cup at Resident #38's bedside with what appeared to be a white pill in the cup. Resident #38 confirmed there was an antibiotic in the cup which he was told he did not need any more, so he did not take it.Observation and interview on 11/05/25 at 9:38 A.M. with certified nurse aide (CNA) #542 confirmed the observation of the pill in the cup at Resident #38's bedside. She also confirmed she was aware nurses were supposed to observe residents taking medications and medications should not be left with residents.Review of the facility policy titled Administering Medications, dated 04/28/25, revealed medications would be administered within one hour of their prescribed time frame unless otherwise specified. If a medication was withheld, refused or given at a time other than the scheduled time, the individual administering the medication would document the medication as refused on the Medication Administration Record (MAR), and residents could only self-administer their own medications if the attending physician in conjunction with the interdisciplinary care planning team had determined the resident had the decision making capacity to do so safely.This deficiency was an incidental finding identified during the complaint investigation.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on record reviews, observations, interviews, review of personnel files, review of facility self-reported incident (SRIs), and facility policy review, the facility failed to be administrated in a manner that uses its resources effectively and efficiently to ensure resident safety, prevent neglect, as evidenced by the failure to provide proper wound care and ensure physician oversight for Residents #20 and #46, failure to conduct required pre-employment criminal background checks, Nurse Aise Registry (NAR) checks, abuse registry checks, and personal and professional background checks, failure to maintain an accurate background check log; failure to thoroughly investigate allegations of abuse, neglect, and misappropriation involving Residents #37, #41, and #50; and failure to maintain a safe environment free from illicit drugs, placing Residents #6, #7, and #12 at risk. This deficient practice demonstrated significant breakdowns in administrative oversight and had the potential to affect all 45 residents residing in the facility.Findings include: 1. During the complaint and partial extended survey, observations, record reviews and interviews resulted in concerns including but not limited to situations of neglect, resulting in Immediate Jeopardy and Substandard Quality of Care (SQC).The facility failed to provide proper wound care and ensure physician oversight for Residents #20 and #46 to prevent incidents of neglect.These concerns resulted in Immediate Jeopardy and actual harm on 10/21/25 when Nurse Practitioner (NP) #500 first identified a worsening wound to Resident #46's left lateral foot resulting in hospitalization with severe sepsis and on 10/23/25 when the facility failed to identify and treat a right leg diabetic ulceration to his right heel for Resident #20 resulting in hospitalization and right above the knee amputation. The lack of systematic, comprehensive and effective skin management program resulted in situations of neglect for Resident #46 and Resident #20.2. A situation of SQC (that did not rise to an Immediate Jeopardy level) was also identified on 11/13/25 when Human Resources (HR) Director #509 confirmed there was no evidence that NAR checks, background checks and abuse registry checks were completed for Certified Nursing Assistant (CNA) #549, who she confirmed had been involved in multiple SRIs for abuse allegations and had multiple disciplinary action write ups in his employee file, and confirmed background checks, abuse registry checks, NAR checks and/or reference checks were not completed for multiple staff, including CNAs #541, #554 and #558, Licensed Practical Nurses (LPNs) #501 and #824, Activity Assistant ##521 and [NAME] #825.3. Review of the facility SRIs revealed situations of alleged abuse, neglect and misappropriation were not thoroughly investigated including: a.) Review of the SRI tracking number (#) 264751 dated 09/02/25, labeled as neglect, revealed Resident #37 had $353 missing. Review of the facility investigation revealed similar residents at the facility were interviewed as well as two residents from the assisted living which is in an attached building. There were no staff interviewed to attempt to determine what happened to Resident #37's missing money. The Administrator stated she had not interviewed staff related to Resident #37's missing money and had not carried out a thorough investigation related to Resident #37's missing money. b.) Review of SRI tracking #261288 dated 06/05/25 revealed Resident #41 was outside smoking when he began arguing with Resident #55, an assisted living (AL) resident. During the exchange Resident #41 fell to the ground and reportedly poked Resident #55 in the eye. The facility unsubstantiated physical abuse occurred. The investigation revealed no evidence of the incident in Resident #41's medical record, no evidence of an assessment of Resident #41, and no evidence vital signs were obtained. Witness statements included in the investigation were conflicting; some saying Resident #41 did poke Resident #55 in the eye and one clearly indicating Resident #41 did not poke Resident #55 in the eye. The incident was first reported by Therapist #820, and no witness statement was obtained from him. The Administrator verified the investigation was not thorough.c.) Review of SRI tracking #257892 dated 03/05/25 revealed Resident #50 reported his wallet, identification (ID), debit card and $500 was missing from his room. The facility investigated the allegation by interviewing other residents, encouraging Resident #50 to keep important items in a lock box which the resident refused, and interviewing staff who had worked with the resident within the days prior to the allegation. Resident #50 could not recall when the items had gone missing. The facility unsubstantiated the complaint regarding misappropriation. The investigation revealed Resident #50 could not recall the exact date the items went missing, giving as many as three different dates within the week prior. Other residents were interviewed about whether they had seen Resident #50 with a wallet or large sums of money; however, no residents were asked if they had been missing any personal items, other than clothing, or large sums of money. The Administrator confirmed the investigation was not thorough.4. An unsafe environment was identified when a

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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. Based on record review, observation, interview and facility policy review, the facility failed to maintain proper infection control practices while providing wound care for Resident #12. This affected one resident (#12) of two residents observed for wound care. The facility census was 45.Findings include:Review of the medical record for Resident #12 revealed an admission date of 09/09/25 with diagnoses including congestive heart failure, diabetes mellitus and chronic venous ulcers of bilateral lower extremities.Review of the physician's orders for Resident #12 revealed an order dated 09/10/25 for enhanced barrier precautions (EBP) (infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes) due to wounds.Review of the care plan dated 09/10/25 for Resident #12 revealed he had EBP related to open wounds requiring a dressing. Interventions included using gowns and gloves when providing high-contact resident care activities including wound care.Observation was performed on 11/10/25 at 1:45 P.M. of wound care to Resident #12's right heel by Licensed Practical Nurse (LPN) #504. Outside of Resident #12's room by his door revealed signage stating he was on EBP, and everyone must clean their hands before entering and when leaving, wear gloves and gown for high contact activities including wound care that required a wound dressing due to skin openings. There was personal protective equipment (PPE) in a cart down the hall from Resident #12's room. LPN #504 cleansed her hands and donned gloves. She then proceeded and completed wound care without donning a gown. LPN #504 was questioned if Resident #12 had a physician's order for EBP, and she stated that he was on EBP and the cart with the PPE was in the hallway. She verified she had not donned a gown prior to wound care with Resident #12.Review of the facility policy titled, Enhanced Barrier Precautions, dated 04/01/24, revealed EBP was indicated for residents with wounds.This deficiency represents non-compliance investigated under Complaint Number 2615467.

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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. Based on observation, interview, work request review and facility policy review, the facility failed to ensure all areas of the facility were in good repair. This had the potential to affect all 45 residents residing in the facility. Findings include:Observation on 11/17/25 at 8:01 A.M. on the nursing unit revealed a glass door leading outside had broken, shattered glass overing the bottom half of the door. Interview at the time of the observation with the Director of Nursing (DON) confirmed the broken glass door and reported it had been that way for approximately two weeks.Interview on 11/17/25 at 8:09 A.M. with the Administrator revealed the broken glass door was used by families and ambulances and the facility was aware the door was in need of repair but did not know what had happened and had not yet been able to repair it, although quotes had been obtained. She was unsure how long the door had remained unrepaired.Review of the work request form dated 10/29/25 revealed a request to repair the broken glass on the ambulance door. The form revealed calls had been made for quotes to repair the glass. There was no follow-up information available for review. Review of the facility policy titled Home-Like Environment revealed the facility would provide residents with a safe, clean, comfortable and homelike environment including maintaining cleanliness and comfort in all resident areas, providing housekeeping and maintenance services to maintain an orderly and comfortable interior. Concerns were to be reported and addressed promptly.This deficiency represents noncompliance investigated under Complaint Number 2656875.