STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365862	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines Healthcare Center	3015 17th Street NW Canton, OH 44708

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, policy review, and interview, the facility failed to ensure non-pressure related skin impairment was comprehensively assessed. This affected one (Resident #28) of two residents reviewed for non-pressure related skin impairment. The facility census was 77.Findings include:Review of Resident #28's medical record revealed diagnoses including left side weakness and paralysis following a stroke, hypertensive heart and chronic kidney disease, chronic obstructive pulmonary disease, anemia, hidradenitis suppurativa (also known as acne inversa, is a condition that causes small, painful lumps to form under the skin. The lumps usually develop in areas where your skin rubs together, such as the armpits, groin, buttocks and breasts. The lumps heal slowly, recur, and can lead to tunnels under the skin and scarring.), type two diabetes mellitus, and generalized muscle weakness. An admission/Medicare five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #28 was able to make herself understood and was able to understand others. Resident #28 was assessed as cognitively intact.A nursing note dated 04/18/26 at 3:00 P.M. indicated Resident #28 returned from the hospital. Skin areas noted included a purple area to bilateral buttocks and an open area to the left armpit. There was no evidence staff assessed the etiology of the purple areas at that time. A weekly skin check dated 05/08/26 indicated there were skin areas noted which were not new. However, there was no documentation located indicating what the skin areas were.On 05/12/26 at 5:25 P.M., the Director of Nursing (DON) was informed no comprehensive assessments of the skin impairment noted in the 04/18/26 nursing note were located. The DON stated skin was assessed on a weekly basis and Resident #28 had no skin impairment.On 05/13/26 at 10:45 A.M., Licensed Practical Nurse (LPN) #595 stated she assessed Resident #28's skin the evening of 05/12/26 with no skin impairment identified. On 05/14/26 at 10:06 A.M., the DON was asked to provide any information regarding the skin areas referred to during the 05/08/26 weekly skin check.On 05/14/26 at 10:44 A.M., LPN #595 stated she was not informed that impaired skin was documented on the 05/08/26 weekly skin check. Therefore, a more comprehensive assessment of the area had not been completed. LPN #595 stated Resident #28 had chronic areas on her buttocks and her arms not related to pressure, but instead related to the hidradenitis suppurativa. Observations of Resident #28 with LPN #595 revealed a dime sized purple area to the right buttock (not on a bony prominence), a scabbed area to the inferior left buttock and pink/purple area to the left buttock in the area where the buttocks touch (not on a bony prominence). Resident #28 complained of pain when LPN #595 pressed on the superior area of the left buttock which was presenting as pink/purple. While assessing the areas, Resident #28 reported she had dealt with the condition (hidradenitis suppurativa) for years and had a history of one of the areas on the abdomen which had opened previously. LPN #595 verified the areas present on LPN #595's buttocks and it would be important to monitor the skin routinely, especially since Resident #28 complained of one of the areas being painful upon pressure being applied. LPN #595 stated the wound Nurse Practitioner (NP) would have assessed Resident #28's skin after her return from the hospital and provided a note from the NP dated 04/21/26 indicating Resident #28 had purple scarring present to the buttocks due to history of hidradenitis suppurativa. The note indicated no open areas were noted and she would sign off wound care (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services with a request for further consultation as needed for open wounds. Review of a wound NP note dated 05/15/26 indicated Resident #28 was assessed with abscesses to bilateral buttocks with the primary etiology being hidradenitis suppurativa. The overall measurement was 5 centimeters (cm) x 5 cm x 0.1 cm with 100% epithelial tissue and a light amount of serous (clear or pale yellow) drainage. Review of the facility's Skin Care and Wound Management Overview policy (implementation date not recorded) revealed skin impairment documentation was required for all skin impairment issues that required measurement to indicate if healing was occurring. This deficient practice represents non-compliance investigated under Master Complaint Number 2996672.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure timely incontinence care. This affected one resident (#37) of four residents reviewed for bowel and bladder incontinence and had the potential to affect 42 residents (#8, #10, #11, #12, #13, #16, #17, #19, #20, #23, #24, #27, #28, #29, #32, #36, #37, #38, #39, #40, #41, #42, #43, #46, #47, #48, #54, #56, #59, #60, #61, #65, #66, #67, #68, #69, #72, #77, #78, #79, #86, and #89) identified by the facility as incontinent. The facility census was 77.Findings include: A review of medical records for Resident #37 revealed a date of admission [DATE]. Significant diagnosis included chronic respiratory failure with hypoxia (low oxygen level), type II diabetes mellitus, depression, morbid obesity, and need for assistance with personal care. There were no significant orders for the finding.A care plan dated 03/15/26 revealed Resident #37 to be occasionally incontinent of bowel and bladder related to limited mobility, weakness, and obesity. Interventions included checking resident for incontinence, washing, rinsing, and drying perineum, changing clothing as needed after incontinence episodes. A quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) with a score of 15 indicating Resident #37 was cognitively intact. The assessment further revealed Resident #37 was dependent on staff for toileting and hygiene. Resident #37 was always continent of bladder and bowel.On 05/11/26 at 3:30 P.M. an observation of incontinence care for Resident #37 revealed a strong smell of urine in the room. The top sheet was noted to have a light brown liquid on it appearing to be dried urine. A bath blanket that was used as a draw sheet was dotted with a light brown liquid on it that was saturated and seeping under the right leg. This surveyor was able to visualize the saturation on the bath blanket under pad while the top sheet was in place on Resident #37. Upon turning the resident, she was noted to be saturated from the middle of her back to the middle of the thigh. The bath blanket under pad was saturated with a foul smell of urine noted. Upon removal of the bath blanket the bed sheet was noted to be wet from the resident's mid-thigh to the middle back. Resident #37 stated the last time she was placed on the bedpan was yesterday morning. Certified Nurse Aide (CNA) #574 who was rendering the incontinence care verified the strong smell of urine in the room and the other above findings indicating lack of incontinence care for Resident #37 at the time of the observation. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) #519 also verified the findings at the time of the observation. A review of the undated facility policy titled perineal care for male and female revealed perineal care is performed on residents who are unable or unwilling to maintain body cleanliness and are who are incontinent of bowel and bladder. Perineal care will be care planned for each individual resident to meet his or her specific needs, choice, and frequency.This deficiency represents non-compliance investigated under Complaint Number 2668793.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to maintain accurate and comprehensive medical records for two (Residents #10 and #28) of 34 residents whose records were reviewed. The facility census was 77.Findings include:1. Review of Resident #28's medical record revealed diagnoses including left side weakness and paralysis following a stroke, hypertensive heart and chronic kidney disease, chronic obstructive pulmonary disease, anemia, hidradenitis suppurativa (also known as acne inversa, is a condition that causes small, painful lumps to form under the skin. The lumps usually develop in areas where your skin rubs together, such as the armpits, groin, buttocks and breasts. The lumps heal slowly, recur, and can lead to tunnels under the skin and scarring.), type two diabetes mellitus, and generalized muscle weakness. A skin assessment dated [DATE] indicated Resident #28 had a history of hidradenitis suppurative but had no open areas at the time. On 03/18/26, an order was started for miconazole nitrate powder 2% to be applied to abdominal folds/breast folds topically twice a day for fungal areas for two weeks. A weekly skin check dated 03/20/26 indicated no skin areas were noted. A weekly skin check dated 03/27/26 indicated skin area(s) were noted. However, no documentation was located regarding the skin area(s). A weekly skin check dated 05/08/26 indicated skin area(s) were noted. However, no documentation was located regarding the skin area(s). On 05/14/26 at 10:06 A.M., the Director of Nursing (DON) was informed weekly skin check assessments dated 03/27/26 and 05/08/26 indicated Resident #28 had skin areas but no assessments of the skin areas were able to be located. On 05/14/26 at 10:44 A.M., Licensed Practical Nurse (LPN) #545 stated she was not informed nurses had documented skin areas on 03/27/26 or 05/08/26, so no further assessments were documented. On 05/14/26 at 11:32 A.M., the DON stated she understood the concern regarding staff not documenting skin areas that were observed but upon review of the medical record she believed the nurse who documented the skin issue on 03/27/26 did so because Resident #28 had a treatment to the abdominal and breast folds. The same nurse (LPN #581) had done both assessments in question. On 05/18/26, two written statements by LPN #581 dated 05/15/26 indicated she documented the presence of skin areas on 03/27/26 due to the treatment to the abdominal and breast folds. The statement indicated she had not observed any new or impaired areas at the time of the assessment. The second statement indicated she documented Resident #28 had a skin area noted because staff were applying triad (wound treatment) to bilateral buttocks. LPN #581 indicated she did not observe any new or impaired areas. 2. During an interview on 05/11/26 at 4:15 P.M., Resident #10's listed Power of Attorney (POA) stated she did not feel she was consistently notified of changes in orders/treatment plans. The POA indicated Resident #10 was hard of hearing and did not always understand what was being said to her. Review of Resident #10's medical record revealed diagnoses including dementia, angina pectoris, chronic obstructive pulmonary disease, constipation, major depressive disorder and cognitive communication deficit. A baseline care plan dated 08/21/25 indicated Resident #10 had a communication problem related to hearing problems and dementia. One of the interventions was to include family support. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 had moderate difficulty with hearing and was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 7 (out of a possible 15 points). Review of contact information revealed Resident #10 was listed as her own resident representative with her son listed as emergency contact #2 with the niece listed as POA/alternate contact. The designation did not indicate if POA was financial or medical. Review of progress notes revealed there were occasions when staff documented Resident #10's son was notified of changes in orders or results of tests. However, the instances listed below did not reveal any family notification or involvement in decision making and were discussed with the DON on 05/19/26 at 12:31 P.M. - A nurse practitioner note on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/02/26 indicated the reason for the visit was due to diarrhea and nausea and vomiting that morning. An order was received for a STAT (immediate) KUB (kidney, ureter and bladder) x-ray. There was no documentation of interested parties being notified of the order or of the results. The DON verified no notification of the resident's son or POA being documented. The DON stated when she spoke with the nurse she recalled notifying Resident #10's son of the results, so she did a late entry note on 05/18/26 indicating the results were reported to Resident #10's son. -A telehealth note dated 01/30/26 indicated the nurse reported Resident #10 was more confused than her baseline. Orders were given for a urinalysis/urine culture, hydroxyzine (antihistamine) 25 milligrams (mg) every 12 hours as needed for two days and to call back if Resident #10's condition worsened. The DON stated she spoke with the nurse who recalled calling and leaving a message. On 05/18/26 at 2:35 P.M. the nurse documented Resident #10's POA was updated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to follow enhanced barrier precautions (EBP) (an infection control measure used to prevent the spread of multi drug resistant organisms) during wound care. This affected one (Resident #11) of six residents reviewed for infection control and had the potential to affect 17 additional residents (#9, #19, #20, #29, #35, #39, #44, #48, #54, #56, #58, #66, #67, #72, #75, #86, and #87) identified as being on EBP. The facility census was 77.Findings include:A review of medical records for Resident #11 revealed the date of admission as 04/03/19. Significant diagnoses included diabetes mellitus type II. Significant orders included cleanse the right heel with normal saline solution, pat dry, apply collagen to the wound bed, and cover with border foam dressing; cleanse the coccyx area with normal saline solution, pat dry, apply Medi-Honey to alginate and place on wound bed cover with thin layer of Triad paste to the peri area, cover with silicon super absorbent gauze; and EBP related to wounds. A quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #11 was cognitively intact. The assessment further revealed application of non-surgical dressings, application of ointments, and application of dressings to the feet.A review of the current care plan for Resident #11 revealed the resident required EBP. Interventions included appropriate personal protective equipment (PPE) will be utilized during high contact activities.Observation of wound care on 05/13/26 at 10:05 A.M. with Licensed Practical Nurse (LPN) #595 who was identified as the facility wound care nurse revealed a wound to Resident #11's coccyx. LPN #595 did not utilize a gown during the wound care observation. LPN #595 verified she did not utilize the gown during care and stated, she forgot.A review of the undated facility policy titled; Enhanced Barrier Precautions Revealed enhanced barrier precautions refers to an infection control intervention designed to reduce transmission of multi drug resistant organism that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of central lines, urinary catheter care, feeding tube care, tracheostomy ventilator care, wound care and any opening requiring a dressing. The policy further revealed EBP are indicated for residents with any of the following including wounds. and or indwelling medical devices.This deficiency represents noncompliance identified under Master Complaint Number 2996672.