

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365874	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/16/2025
NAME OF PROVIDER OR SUPPLIER  Hudson Elms Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  563 W Streetsboro Road Hudson, OH 44236	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review, review of self-reported incident (SRI) and interviews with staff the facility failed to report an allegation of abuse in a timely manner. This affected one resident (#55) of four residents reviewed for abuse. The census was 41. Finding include: Review of the closed medical record for Resident #55 revealed an admission date of 12/26/24. Diagnoses included major depressive disorder, paranoid personality disorder, mild cognitive impairment, insomnia, and schizoid personality disorder. A diagnosis of delusion disorder was added on 05/15/25 and diagnoses of suicidal ideations (SI) and post-traumatic stress disorder (PTSD) were added on 06/13/25. Review of the progress noted dated 06/07/25 and timed 1:57 P.M. revealed Resident #55 accused the nurse of being a murderer and an abuser. Review of the hospital records for Resident #55 revealed an admitting history and physical dated 06/13/25 at 4:40 A.M., listed the chief complaint as intentional ingestion of acid and attempt to self-harm. Past medical history included paranoid psychosis, schizoaffective disorder and bipolar (disorder). The record indicated Resident #55 had a history of self-harm including medication ingestion as well as an attempt with a firearm. The hospital record indicated Resident #55 reported she felt like she was being abused at the nursing facility and became overwhelmed and reportedly intentionally ingested half a bottle of drain cleaner. The records noted Resident #55 had a hoarse, gurgling voice with significant secretions, but was able to nod yes to pain. The records noted Resident #55 was yellow slipped (used for mentally ill patients subject to involuntary hospitalization who are not medically cleared for psychiatric care) in the emergency department and not allowed to leave against medical advice (AMA). Review of a facility SRI tracking number 261593 revealed it was initiated on 06/13/25 but listed a discovery date of 06/07/25. The SRI indicated Resident #55 had accused Registered Nurse (RN) #217 as being a murderer and an abuser. The SRI listed Resident #55 was unable to be interviewed as she was at the hospital at the time the allegation was identified. Interview on 07/07/25 at 4:10 P.M. with Administrator revealed the facility discovered a note on 06/13/25 in Resident #55's medical record dated 06/07/25 with an allegation of abuse. An SRI was started on 06/13/25 at the time of discovery. A follow-up interview on 07/14/25 at 8:40 A.M. with Administrator revealed Registered Nurse (RN) #217 was disciplined on 06/13/25 for not reporting an allegation of abuse. Interview on 07/14/25 at 9:42 A.M. with RN #217 revealed she did not report the comment Resident #55 made and stated the resident made those types of comments all of the time. RN #217 confirmed she was disciplined for not reporting an allegation of abuse. Review of the facility policy titled, Resident Rights to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure, dated 2025, revealed the facility should ensure all alleged violations are reported in the proper timeframe pursuant to this policy.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365874
		If continuation sheet Page 1 of 3

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of open and closed medical records, review of hospital records, review of the facility investigation, review of the hazardous chemical policy, review of in-service education, review of Material Safety Data Sheets (MSDS), review of facility self-reported incidents, observations of the housekeeping cart, interviews with staff, interviews with residents, and review of an emergency medical services report, the facility failed to properly store hazardous chemicals when a reasonable risk to resident safety was present. This resulted in Immediate Jeopardy and Actual Harm with subsequent death on 06/12/25 when Resident #55, who was known to have a history of depression and prior suicide attempts, consumed liquid from a bottle of mild acid disinfectant (Drano) bowl cleaner that had been left in the resident's bathroom unsecured by Housekeeper #800. Resident #55 was identified to have intentionally ingested an unknown quantity of the chemical, resulting in the resident's hospitalization and subsequent death due to complications from the ingestion of the chemical/liquid. Additionally, a concern that did not rise to Immediate Jeopardy occurred on 07/10/25 at 9:02 A.M. when observation of the housekeeping cart revealed only one-half of the housekeeping cart was locked where cleaning supplies were stored. The cleaning supplies were accessible from the opposite side of the cart, which had a keyhole but no key to secure it. Contained in the cart were two marked bottles of mild acid disinfectant bowl cleaner and a marked bottle of window cleaner. This affected one resident (#55) reviewed for potential self-harm and had the potential to affect all 41 residents residing in the facility. The facility census was 41. On 07/09/25 at 1:18 P.M., Corporate Nurse #560, Regional Nurse #570, the Administrator, and the Director of Nursing (DON) were notified Immediate Jeopardy began on 06/12/25 at approximately 11:30 P.M. when Resident #55 was found by Certified Nursing Assistant (CNA) #251 to have had an emesis. CNA #251 reported the resident's emesis to Licensed Practical Nurse (LPN) #265 who immediately assessed Resident #55. LPN #265 noted the emesis appeared blue in color and a smell of mint. LPN #265 asked the resident if she consumed mouthwash. Resident #55 stated she had ingested Drano. LPN #265 asked her where she got it from, and the resident pointed to a bottle of cleaning solution in a white drawstring bag on her bedside table. LPN #265 contacted the physician, called nine-one-one (911), and stayed with Resident #55 until Emergency Medical Services (EMS) arrived at 11:40 P.M. Resident #55 was hospitalized and passed away at the hospital on [DATE] due to complications as a result of the ingestion of the chemical liquid. The Immediate Jeopardy was removed on 07/11/25 when the facility implemented the following corrective actions: On 06/12/25 at 11:30 P.M., CNA #251 informed LPN #265 Resident #55 had an emesis. LPN #265 went to Resident #55's room and observed blue-colored emesis on the bed and around Resident #55's mouth. Resident #55 told LPN #265 she drank Drano and showed the bottle to her. LPN #265 asked the resident where she got the bottle of cleaning solution from, and the resident pointed to her bedside table where the bottle was in a white drawstring bag. On 06/12/25 at 11:40 P.M., EMS arrived at the facility to transport Resident #55 to a local hospital. On 06/13/25 at 8:30 A.M., Social Service Director (SSD) #209, Housekeeping Director #207, Activity Director #246, Minimum Data Set (MDS) Nurse #206, Staffing Coordinator (SC) #237 and admission Director (AD) #227 began performing room searches looking for any chemicals or other poisonous substances in residents' rooms using the facility's floor plan as guide. On 06/13/25 at approximately 9:00 A.M., the Administrator interviewed the resident's roommate, Resident #59, regarding the incident. Resident #59 stated I heard her talking about wanting to die. The resident denied reporting this to anyone and did not observe the resident drink the toilet bowl cleaner. On 06/13/25 at approximately 9:00 A.M., a statement was taken from Housekeeper #800, who had been assigned to clean Resident #55's room. Housekeeper #800 admitted to leaving the chemical in an unsecured area in the resident's room and was terminated effective 06/13/25. On 06/13/25 beginning at 9:00 A.M., MDS Nurse #206 and Assistant Director of Nursing (ADON) #203 began reviewing progress notes for all residents, specifically looking for anything out of the ordinary or related to suicidal ideations or behaviors, between the dates of 05/13/25 and ending on 06/13/25. On 06/13/25 at approximately 9:30 A.M., SSD #209 identified three like residents (#10, #17, and #39) based on their diagnoses and history of suicidal ideations. SSD #209 completed face-to-face interviews with Residents #10, #17, and #39 on their psycho-social well-being and history of trauma, with no concerns identified. Beginning on 06/13/25 at 9:30 A.M., SSD #209 completed psycho-social and trauma assessments on all residents. On 06/13/25 at 9:57 A.M., upon facility room searches, the following were found in the resident's rooms: Resident #2 had Snuggly Fabric Softener</p>		