STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365878	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Skilled Nursing and Rehab	463 East Pike Street Morrow, OH 45152

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to ensure residents were treated with dignity during meals. This affected two (Resident #37 and #49) of 18 residents observed for dining. The facility census was 49.Findings include:1.Review of the medical record revealed Resident #37 was admitted to the facility on [DATE]. Diagnoses included anxiety disorder, contracture of the left hand, chronic pain, and degeneration of nervous system. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #37 had severely impaired cognition and required partial to moderate assistance when eating.2.Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. Diagnoses included anxiety disorder, dementia, and Parkinson's Disease. Review of the MDS comprehensive assessment dated [DATE] revealed Resident #49 had severely impaired cognition and required partial assistance for eating.Observation on 06/28/26 at 11:30 A.M. in the facility's main dining room revealed nine residents sitting at tables awaiting meals, one certified nursing assistant (CNA) #202 and one Licensed Practical Nurse (LPN) #110 assisting residents with positioning at the tables and awaiting meal trays. CNA #202 distributed meals to residents, removing the plates, cups, utensils, and placing the trays back on the counter and retrieved the next tray. Resident #49 was served her tray by placing the tray in front of her and LPN #110 sat down next to her, opened her drink, inserted a straw and began to feed Resident #49. CNA# 202 continued to serve meals to residents then placed a tray in front of Resident #37, and while standing next to him, began feeding him. CNA #202 served meals to two additional residents, removing the plates, cups, utensils, etc., and returned to Resident #37, sat down and continued to feed him.Interview on 06/28/26 at 12:02 P.M. with LPN #110 revealed she was there to assist and since the tray was in front of Resident #49 she started feeding her, LPN #110 was unsure if all residents who required assistance with feeding were served meals on trays.Interview on 06/28/26 at 12:05 P.M. with CNA #202 she was only standing to watch for trays and normally sits when assisting a resident with eating, confirmed its normal for her to leave plates, cups, napkins and flatware on the trays for residents' who required feeding assistance.Interview on 06/30/26 at 12:10 P.M. with the Executive Director (ED) confirmed the staff was to serve all the residents in the same fashion by removing all items from the tray and placing the empty tray on the cart in the corner of the dining room.Review of the facility policy titled Dignity Policy, dated December 2020, revealed the facility staff will promote residents' independence and dignity in dining.This deficiency represents non-compliance investigated under Complaint Number 3053748.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, and policy review, the facility failed to ensure the kitchen sanitation was maintained and provide meals in a sanitary manner. This had the potential to affect 47 of 47 residents who received food from the kitchen. The facility identified two (Resident #2 and #3) who did not receive food from the kitchen. The facility census was 49.Findings Include:Observation during initial kitchen tour on 06/28/26 at 8:35 A.M. the following was observed:1. In the reach in refrigerator there was an opened undated package of donuts. There was a plate of food unwrapped with no date or label. There were two large pans of gelatin dessert, undated and unlabeled. The reach in refrigerator had no thermometer inside.The deep freezer had no thermometer inside. There were six wrapped sandwiches dated 06/22/25.There was a plate of sliced tomatoes undated.The upright freezer had a heavy build up of approximately a quarter inch of white frost on top, bottom and on the shelves.2.The refrigerator temperature logs, for three different refrigerators and freezers, had no temperature entries for the dates of 06/05/26, 06/06/26, 06/07/26, 06/08/26, 06/09/26, 06/10/26, 06/11/26, 06/12/26, 06/13/26, 06/14/26, 06/15/26, 06/16/26, 06/17/26, 06/18/26, 06/19/26, 06/21/26,06/23/26, 06/24/26, 06/25/26, 06/26/26 and 6/27/26.The three compartment sink sanitation logs had no sanitation documentation for the dates of 06/05/26 through 06/29/26.Testing of the three compartment sink on 06/30/26 at 10:45 A.M. with the Administrator and [NAME] #318 revealed the testing strip registered no sanitizing indication. The Administrator verified the three compartment sink was not registering any sanitizer solution and that the three compartment sink had no documentation it had been tested since 06/04/26.Review of the dishwasher temperature and sanitation log for June 2026 revealed from 06/01/26 through 06/04/26 had temperature and sanitizer documenting initials, identified by the facility of the Former Dietary Manger (FDM)#700. Dates of 06/05/26 through 06/17/26 had temperatures and sanitizer documentation that matched exactly 120 degrees and 50 parts per million (PPM) and initialed by [NAME] #318. There was no documentation of the dishwasher temperatures and sanitizer levels from dates of 06/18/26 through 06/30/26.Observation on 06/30/26 at 10:30 A.M. of the dishwater directions posting near the dishwasher, revealed the dishwasher was a low temperature dishwasher and should have a rinse cycle temperature of 120 degrees Fahrenheit and reach a sanitizer solution of chlorine level of 50 to 100 PPM.Interview on 06/30/26 at 12:45 P.M. [NAME] #318 stated she did not know where the dishwasher sanitation testing strips were located and had never used the testing strips. The [NAME] #318 verified she had documented dishwasher temperatures and sanitizer levels on the dishwasher log form from 06/05/26 through 06/17/26 and did not complete the log from 06/18/26 through 06/30/26 because she ran out of time to fill out the form. The [NAME] #318 stated she was asked by the Administrator on 06/28/26 to complete the log form 06/28/26 of date 06/05/26 through 06/28/26. The [NAME] #318 verified the dishwasher log was not accurate and the dishwasher had not been monitored for temperature and sanitizer level from o6/05/26 through 06/29/26.3.Observation on 06/29/26 at 12:15 P.M. revealed [NAME] #358 preparing pure foods for the lunch meal. [NAME] #358 placed the soiled blender bowl and blade in the dishwasher and reassembled the blade into blender bowl with bare hands. The [NAME] #358 then pureed the next food item in the reassembled blender bowl. The [NAME] #358 repeated the same process reassembling the blade in the bowl with bare hands and then blended more food in the bowl.Interview on 06/29/26 with the [NAME] #358 verified he reassembled the blade with his bare hands and continued to puree the next food item, and stated he should not touch the clean blade with his bare hands to reassemble the bowl.Observation on 06/30/26 at 10:30 A.M. the Dishwasher Aide (DA) #312 loaded the dirty pans into the dishwasher and removed clean pans from the dishwasher without sanitizing or using different gloves to unload the dishwasher.Interview on 06/30/26 at 10:30 A.M. the DA #312 stated he washed off the gloves used during loading the dishwasher before he unloads the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	clean dishes. The DA #312 stated he did not change gloves or sanitize hands between loading and unloading the dishwasher.4. Observation on 06/30/26 at 12:15 P.M. revealed the eight ceiling vents in the kitchen had heavy buildup of gray debris in the louvers of the vents. The vents were located over food preparation areas.Interview 06/30/26 at 12:15 P.M. with Maintenance Director (MD) #375 verified the eight kitchen ceiling vents had a heavy buildup of debris and needed cleaned.5. Observation on 06/28/26 at 1:10 P.M. of a resident refrigerator on the 100 unit revealed one container of thickened juice dated 06/15/26. There was a two-inch-wide brown substance extending 12 inches on the back side of refrigerator cavity and pooling into the bottom drawers of the refrigerator. Interview on 06/28/26 at 1:10 P.M. with the Assistant Director of Nursing (ADON) #354 verified the refrigerator should be cleaned of the brown substance.Interview on 06/28/26 at 2:15 P.M the Clinical Region Nurse (CRN) #800 said the thickened juice should have been discarded after seven days on 06/22/26. Observation on 06/28/26 at 1:20 P.M. of a resident refrigerator on the 200 unit revealed in the refrigerator section, there were three unlabeled insulated bags, identified by the ADON #354 as staff lunch bags. There were two containers of uncovered food with no label and no date. There were 10 clear bags containing protein sandwiches dated 06/24/26. The temperature log was missing temperatures for dates of 06/24/26, 6/25/26, 6/26/26 and 6/27/26.Interview on 06/28/2026 at 1:20 P.M. the ADON #354 verified the unlabeled staff lunch bag should not be stored in the refrigerator and the foods should be labeled, dated and foods discarded in three days.Review of a facility policy titled Dish machine Temperatures, undated revealed cold (low) temperature machines prior to use run a test strip through the dishwasher. Document all action on the dish machine temperature record form. Review of a facility policy titled Pot Sink, undated revealed test the chemical sanitizer using the appropriate strip and maintain a temperature of 170 degrees Fahrenheit in the rinse compartment.Review of a facility policy titled Food Brought in By Family Members, undated revealed foods are to kept in containers with lids and perishable foods destroyed daily.Review of a facility policy titled Storage Temperatures, undated revealed refrigeration temperatures are to be recorded daily of each storage unit.This deficiency represents non-compliance investigated under Complaint Number 3053748.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and policy review, the facility failed to ensure the kitchen garbage was sealed.This had the potential to affect 47 of 47 residents who received food from the kitchen. The facility identified two (Resident #2 and #3) who did not receive food from the kitchen. The facility census was 49.Findings Include:Observation during initial kitchen tour on 06/28/26 at 8:35 A.M. revealed three garbage cans, not actively in use, were not covered.Interview on 06/28/26 at 8:35 A.M. the Administrator verified the three kitchen garbage cans were not actively in use and should have been covered.Observation on 06/29/26 at 12:15 P.M. with [NAME] #358 verified three garbage cans, which were not actively in use, were not covered.Observation on 06/30/26 at 8:45 A.M. [NAME] #318 verified three garbage cans, which were not actively in use, were not covered.Review of facility policy titled Garbage and Rubbish Disposal, undated revealed all garbage containers shall be provided with tight fitting lids and must be kept covered when stored or not in continuous use. This deficiency represents non-compliance investigated under Complaint Number 3053748.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview and policy review, the facility failed to ensure essential kitchen equipment was operating and maintained in good condition. This had the potential to affect 47 of 47 residents who received food from the kitchen. The facility identified two (Resident #2 and #3) who did not receive food from the kitchen. The facility census was 49.Findings Include:1. Observation during the initial kitchen tour on 06/28/26 at 8:35 A.M. and on 06/30/26 at 12:15 P.M., of the large three-door refrigerator, revealed there was one quarter to one half inch of standing water on the bottom of the refrigerator shelf and dripping from the top of the refrigerator. Bags of food were wet from the dripping water. Observation on 06/28/26 at 1:20 P.M. of a resident refrigerator on the 200 unit revealed the freezer section had a heavy one half inch build-up of white ice on the top and side surfaces. The gasket around the freezer was splintered and did not attach well to the freezer compartment. Interview on 06/28/26 at 1:20 P.M., the Assistant Director of Nursing (ADON) #354 verified the freezer gasket was in disrepair and did not attach well to the freezer compartment.Interview on 06/30/26 at 12:15 P.M. with Maintenance Director (MD) #375 verified the three-door refrigerator in the kitchen had standing water in the bottom and water was dripping from inside the top onto covered food. The MD #375 verified the refrigerator was not working properly and needed repaired.Review of facility policy titled Maintenance Repairs and Requests, undated revealed maintenance will attempt to make repairs, and if unable will use outside contractors. This deficiency represents non-compliance investigated under Complaint Number 3053748.