STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365927	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regina Health Center	5232 Broadview Rd Richfield, OH 44286

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, observation, record review, and family and staff interviews, the facility failed to ensure a resident who was dependent on staff for transfers received timely assistance with being transferred back to bed. This affected one (#8) of one resident reviewed for activities of daily living. The facility census was 95.Findings include:Review of the medical record for Resident #8 revealed an admission date of 05/05/26. Diagnoses included fracture of superior rim of left pubis, anorexia, and dementia. Interview on 05/07/26 at 9:00 A.M. with the daughter of Resident #8 revealed she had a concern with Resident #8 receiving timely assistance to be put back into bed. The daughter stated today (05/07/26) at 8:40 A.M., Resident #8 put her call light on as she wanted to go to bed because she was in pain. She stated Certified Nursing Assistant (CNA) #400 told her that after she picked up the breakfast trays, she would be back to put Resident #8 to bed. Daughter reactivated the call light at 9:01 A.M.Observation and interview on 05/07/26 at 9:07 A.M. with Activities Assistant #404 answered the call light and stated he would find a CNA.Observation and interview on 05/07/26 at 9:08 A.M. with CNA #401 came into Resident #8's room, turned off the call light and stated she would be right back because Resident #8 was a two-person assist.Observation on 05/07/26 at 9:21 A.M. revealed CNA #401 and CNA #264 put Resident #8 to bed with a sit-to-stand lift.Interview on 05/07/26 at 10:20 A.M. with CNA #400 verified she did turn off Resident #8's light and stated she would be back after breakfast trays were picked up. CNA #400 could not remember the time but stated that she got sidetracked, and Resident #8 was not on her assignment.Review of the alarm history dated 05/07/26 revealed Resident #8's call light was activated at 8:25 A.M. and turned off at 8:27 A.M. Resident #8's call light was reactivated at 9:00 A.M. and turned off at 9:08 A.M. This was verified by the Director of Nursing (DON) on 05/07/26 at 1:07 P.M. Review of the facility policy titled Resident Call System dated September 2023 revealed all staff are responsible to answer call lights promptly.This deficiency represents non-compliance investigated under Master Complaint Number 3007442 and Complaint Number 2580657.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365927	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regina Health Center	5232 Broadview Rd Richfield, OH 44286

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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 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. Based on observation, staff interviews and record review, the facility failed to ensure medications were not left at a resident bedside unattended. This affected one (#36) of one resident observed for environmental safety. The facility census was 95.Findings include:Review of the medical record for Resident #36 revealed a re-admission date of 12/28/22. Diagnoses included frontotemporal neurocognitive disorder, convulsions, and heart disease.Review of the physician's order for May 2026 revealed the following morning medications were ordered: one tablet of Eliquis five milligrams (mg) by mouth for anticoagulation therapy, two capsules of Zonisamide 100 mg for seizures/migraine, one tablet of pantoprazole sodium oral delayed release 20 mg for acid reflux, one capsule of celecoxib (anti-inflammatory) 100 mg by mouth, one tablet of potassium chloride (vitamin) extended release 20 milliequivalent (mEq), one tablet thiamine (vitamin) 100 mg by mouth, one tablet calcium-vitamin D3 tablet 600-400 mg by mouth every day shift for dietary supplement, one tablet metoprolol succinate extended release 25 mg by mouth for hypertension, one tablet multivitamin (MVI) tablet by mouth for dietary supplement, four tablets of vitamin D3 Tablet 1,000 units (cholecalciferol) by mouth for dietary supplement, one tablet of one mg of folic acid by mouth for dietary supplement, one tablet of escitalopram oxalate 10 mg by mouth one time a day for depression, one tablet of memantine 10 mg by mouth for dementia, and 1.5 tablets of furosemide tablet 40 mg by mouth one time a day for fluid retention.Resident #36 did not have a physician order or care plan in place for self-administration of medications in their medical record. The Medication Administration Record (MAR) for May 2026 revealed Eliquis, two capsules of Zonisamide, pantoprazole sodium oral delayed release, celecoxib, potassium chloride extended release , thiamine, calcium-vitamin D3, metoprolol succinate extended release, MVI, four tablets of vitamin D3, folic acid, escitalopram oxalate, memantine, 1.5 tablets of furosemide were administered to Resident #36 on 05/11/26 in the morning.Observation on 05/11/26 at 12:10 P.M. revealed Certified Nursing Assistant (CNA) #405 brought a breakfast tray into the dining room. CNA #293 removed the lid to the plate and verified there were pills in a medicine cup on the plate.Observation and interview on 05/11/26 at 12:14 P.M. with Nurse #227 verified Resident #36's medications was underneath the lid. Nurse #227 verified there were 14.5 pills on the tray and identified the medications included Eliquis, two capsules of Zonisamide, pantoprazole sodium oral delayed release, celecoxib, potassium chloride extended release , thiamine, calcium-vitamin D3, metoprolol succinate extended release, MVI, four tablets of vitamin D3, folic acid, escitalopram oxalate, memantine, 1.5 tablets of furosemide. Nurse #227 verified Resident #36 did not have physician orders or was care-planned to self-administer medications. Nurse #227 verified Resident #36's MAR was marked off that the medications were administered to Resident #36.Interview on 05/11/26 at 12:18 P.M. with Registered Nurse (RN) #240 revealed Resident #36 was sleeping and wanted her medications when she wanted them, so she just left the medications on her breakfast tray. Review of the facility policy titled Medication Storage in the Facility dated 05/2020 revealed medications are stored safely and properly.This was an incidental finding discovered during the complaint investigation.