STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365937	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohman Family Living at Briar	15950 Pierce St Middlefield, OH 44062

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, interviews, review of manufacture's guidelines and facility policy review, the facility failed to clean a glucometer machine (a machine used to check blood sugars utilizing a drop of a person's blood). This affected one resident (#83) of five residents observed for medication administration and had the potential to affect one additional resident (#114) identified by the facility as utilizing the same glucometer. The facility also failed to follow contact precautions for Resident #5. This affected one resident (#5) of eight residents reviewed for infection control and had the potential to affect one additional resident (#60) identified by the facility as being on contact precautions. In addition, the facility failed to follow enhanced barrier precautions (EBP) for Resident #21. This affected one resident (#21) of eight residents reviewed for infection control and had the potential to affect 44 additional residents (#3, #4, #8, #9, #10, #14, #15, #16, #18, #20, #22, #23, #26, #28, #31, #32, #36, #37, #38, #40, #41, #44, #45, #46, #52, #54, #58 #62, #65, #69, #70, #73, #75, #76, #80, #81 #87, #88, #92, #96, #103 , #106, #107, and #110) identified by the facility as being on EBP. The facility census was 92.Findings include:1. Review of the medical record revealed Resident #83 was admitted on [DATE] with diagnosis of diabetes mellitus type II. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for mental Status (BIMS) of 06, indicating Resident #83 had severe cognitive impairment. Resident #83 received insulin injections for seven days during the seven-day assessment period. Review of the Medication Administration Record (MAR) for February 2026 and March 2026 revealed orders for the following: Humalog injection solution 100 units/ml (Insulin Lispro). Inject as per sliding scale: if 0-150 = 0; 151-200 = 2; 201-250 = 4; 251-300 = 6; 301-350 = 8; 351-400 = 10 if blood sugar is greater than 400, please call medical doctor (MD), subcutaneously before meals for blood sugar. Accu-check (blood glucose reading) at HS (bedtime) one time a day for diabetes. Further review of the February 2026 MAR revealed blood sugar checks were performed every evening and before each meal (three times a day scheduled at 7:30 A.M., 11:00 A.M., and 4:00 P.M.) Review of the MAR for March 2026 revealed blood sugars were performed the evening of 03/01/26 and 03/02/26 and before each meal (three times a day scheduled at 7:30 A.M., 11:00 A.M., and 4:00 P.M.) on 03/01/26, 03/02/26, and before breakfast on 03/03/26 when the observation of the blood glucose testing was observed. Review of the care plan revealed a diabetes mellitus care plan with an intervention to administer Accu-checks as ordered and PRN (when necessary) and to document results. Observation on 03/03/26 at 8:00 A.M. during medication administration for Resident #83 by Registered Nurse (RN) #364 revealed one Assure Prism glucometer in the 400 Long Hall medication cart. The Assure Prism glucometer was not labeled with a resident name. Interview of RN #364 at the time of observation revealed it was the only glucometer on the unit for one resident (Resident #83) (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use. RN #364 verified there was no resident name on the glucometer. RN #364 proceeded to clean the glucometer (after donning disposable gloves) with a fresh alcohol pad over the entire surface prior to entering Resident #83's room to administer the ordered blood sugar test. RN #364 then entered Resident #83's room and completed the ordered glucometer test using appropriate infection control practices during medication administration. After completing the glucometer blood sugar test, the nurse cleaned off the glucometer with a fresh alcohol wipe and returned it to the medication cart drawer. There were no visible blood or debris on the glucometer prior or after blood sugar testing. RN #364 verified that Resident #83 was the only resident on the hall that used the glucometer. Interview on 03/03/26 at 11:27 A.M. with the Assistant Director of Nursing (ADON) #394 verified that the glucometers are shared for blood testing and that Cavi1 (disinfecting towelettes) are used to clean and disinfect the equipment between residents. Review of the facility policy titled, Glucometer Cleaning and Disinfection Policy and Procedure (03/25) revealed to open Cavi1 wipe package, remove one wipe, wipe down the device three times vertically, three times horizontally, and then wrap around entire device and allow to sit for one minute. After one minute is up, may wipe device with a clean dry cloth. Review of the manufacturer Assure Prism reference manual (02/16), revealed the system may be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. Cleaning procedure included wear appropriate protective gear (such as disposable gloves) to wipe the entire surface with an appropriate towelette three times horizontally and three times vertically to clean. To disinfect after cleaning, use another towelette to wipe the entire surface three times horizontally and three times vertically, allowing the exteriors to remain wet for the appropriate contact time. Disinfectant brand name CaviWipes1 had a contact time of two minutes. 2. A review of medical records for Resident #5 revealed the date of admission as 12/01/25. Significant diagnoses included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and acquired absence of part of the lung. Significant orders included collect stool sample for clostridium difficile (C-diff) (a highly contagious infection of the large intestine usually after antibiotic use causing mild diarrhea to life threatening inflammation of the colon) 02/18/26 and transmission-based precautions: contact precautions for C-diff 02/18/26. A quarterly MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15 indicating Resident #5 was cognitively intact. Resident #5 was always incontinent of bowel. A stool sample dated 02/17/26 revealed Resident #5 was positive for c-diff. An observation on 03/04/26 at 8:11 A.M. revealed Agency Licensed Practical Nurse (LPN) #475 in the room of Resident #5. LPN #475 did not have any personal protective equipment (PPE) on. LPN #475 opened a soda for Resident #5 per his request. LPN #475 came out of the room and did not wash her hands. LPN #475 verified she did not have on PPE and did not wash her hands. LPN #475 stated Resident #5 was in contact isolation for C-diff but this is his last day. A review of the facility policy titled; Isolation-Guidelines for Categories of Transmission Based Precautions revised 10/24/24 revealed contact precautions are to be used for patients with known or suspected infections that represent an increased risk for contact transmission examples include diarrhea associated with C. difficile. The policy also revealed staff were to use PPE including gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and gown for all interactions that may involve contact with the patient or with the patient's environment. The policy further stated to don (put on) PPE upon room entry and properly discarding before exiting the patient room to contain pathogens. 3. A review of medical records for Resident #21 revealed the date of admission as 07/05/25. Significant diagnoses included acute and chronic respiratory failure, chronic kidney disease stage three, dependence upon a respirator, attention for a tracheostomy tube, and personal history of cardiac arrest. Significant orders included transmission-based precautions-enhanced barrier precautions for tracheostomy, percutaneous endoscopic gastrostomy (PEG) tube (a tube for feeding inserted through the stomach) and Foley catheter. A quarterly MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15 indicating Resident #21 was cognitively intact. A care plan dated 01/21/26 revealed Resident #21 to be on EBP related to tracheostomy, PEG tube, and Foley catheter. Interventions included encourage hand hygiene per Centers for Disease Control and Prevention (CDC) guidelines, PPE donned for any anticipated close physical contact with the resident, and PPE donned for device care such as central line, Foley catheter, feeding tube, and drains. An observation on 03/04/26 at 8:10 A.M. revealed the call light of Resident #21 to be on. Agency Certified Nurse Aide (CNA) #475 entered the room and closed the door. This surveyor knocked on the door and CNA #475 stated resident care. This state surveyor announced herself and opened the door. CNA #475 was rendering care to Resident #21 with no gown or gloves on. LPN #394 who serves as the infection control nurse verified the aforementioned findings at the time of the observation. A review of the facility policy titled; Isolation-Guidelines for Categories of Transmission Based Precautions revised 10/24/24 revealed EBP are an infection control intervention designed to reduce transmission of multi drug resistant organisms (MDROs) in nursing homes. EBP involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk for acquisition. All residents with any of the following require EBP: an indwelling medical device such as a central line, urinary catheter, feeding tube, tracheostomy, ventilator etc. The policy further stated gown and gloves are to be used for resident care activities such as dressing, bathing, transferring, changing linens, providing hygiene, changing briefs, assisting with toileting, and/ or care for any wound or skin opening requiring a dressing.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on review of beneficiary notification and interview, the facility failed to ensure Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) was issued to residents discharged from a Medicare Part A stay. This affected three (Residents #118, #119, and #120) of the three discharged records reviewed for beneficiary notification. The facility census was 92.Findings include:Review of the Notice of Medicare Non-Coverage (NOMNC) for Resident #118 revealed the last covered day of a Medicare Part A covered service was 10/21/25. The facility was unable to provide documentation the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) was provided to the resident/representative. Review of the NOMNC for Resident #119 revealed the last covered day of a Medicare Part A covered service was 09/06/25. The facility was unable to provide documentation the SNF ABN was provided to the resident/representative. Review of the NOMNC for Resident #120 revealed the last covered day of a Medicare Part A covered service was 11/26/25. The facility was unable to provide documentation the SNF ABN was provided to the resident/representative. Interview on 03/05/26 at 1:02 P.M. Administrative Personnel #357 confirmed no SNF ABN's for residents discharged from a Medicare part A stay from 09/04/25 to 03/04/26 had been completed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accommodation was made for Resident #65 to participate in an activity of choice. This affected one resident (#65) of two residents reviewed for activities. The facility census was 92.Findings include:Record review revealed Resident #65 was admitted [DATE] with diagnoses of chronic obstructive pulmonary disease, morbid (severe) obesity, borderline personality disorder, and legal blindness.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 was cognitively intact and was dependent for toileting hygiene, showers, dressing, and personal hygiene.Interview on 03/02/26 at 12:15 P.M. with Resident #65 revealed she was banned from participating in activities which resulted in her no longer being able to play bingo telephonically due to Resident #65's impaired vision with the assistance of staff from her bedroom. Bingo was played by one staff member in the activity room having the phone on the speaker function and the other staff member was in Resident #65's room with another phone on the speaker function and would assist with marking the bingo card. Resident #65 reported it had been at least one month since she played bingo. Interview on 03/04/26 at 8:43 A.M. with Activity Director #396 confirmed Resident #65 participated regularly in bingo with the assistance of staff but no longer does due to Resident #65 contacting staff during their off time after obtaining their personal cell phone numbers. Activity Director #396 explained that staff were no longer permitted to use their personal cell phones for activities for that reason. Activity Director was unable to confirm when Resident #65 last played bingo and stated, I actually forgot about it and did not put any accommodations in place for Resident #65 to play bingo.Interview on 03/04/26 at 10:46 A.M. with Activity Staff #342 who confirmed she previously assisted Resident #65 with playing bingo using her personal phone but was informed she was no longer permitted to do so and was advised to block Resident #65 from contacting her.Review of the January 2026 activity calendar revealed bingo was scheduled 01/02/26, 01/06/26, 01/08/26, 01/13/26, 01/14/26, 01/20/26, 01/22/26, and 01/27/26. Review of Resident #65's January participation calendar revealed Resident #65 played bingo on 01/08/26 and 01/20/26. Further review of the activity participation calendars revealed Resident #65 did not participate in any activities in the month of February 2026 although bingo was scheduled 02/03/26, 02/05/26, 02/10/26, 02/12/26, 02/17/26, 02/25/26, 02/26/25.

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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, interview review of the Stand Up (Chorus) Patient Lift Manual and facility policy review, the facility failed to provide adequate supervision/assistive devices to prevent avoidable accidents/falls. This affected one resident (Resident #10) out of four reviewed for accidents/falls. This had the potential to affect 48 residents (Resident # #3, #4, #5, #6, #10, #11, #14, #15, #17, #18, #19, #20, #23, #25, #26, #28, #30, #31, #32, #36, #38, #39, #41, #44, #46, #50, #52, #55, #57, #60, #61, #65, #70, #71, #73, #75, #77, #80, #82, #83, #84, #85, #87, #89, #95, #96, #103, #106) that required a Chorus (operated lift designed to safely transition individuals with limited mobility from sitting to standing for transfers) or mechanical lift for transfer. The facility census was 92.Findings include:Record review revealed Resident #10 admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling.) to the left buttock, neuromuscular bladder, tremor, unspecified convulsions, repeated falls, mild vascular dementia, and cognitive communication deficit.Review of the physician orders dated 01/12/22 revealed Resident #10 required a Chorus lift with two staff assistance for transfers and a wheelchair for mobility.Review of the Fall Risk Evaluation V2 dated 11/11/25 and completed by Former Licensed Practical Nurse (LPN) #483 revealed Resident #10 was at high risk for falls as he was confined to a chair, unable to stand, had diagnoses that placed him at high risk for falls as well as was on medications that increased his risk of falls.Review of the nurse's note dated 12/01/25 and completed by LPN #318 revealed Resident #10 had a witnessed fall and was lowered to the ground by Agency Certified Nurse Aide (CNA) #480. LPN #318 was informed by Agency CNA #480 that while transferring Resident #10 from the bed to the wheelchair, he lost strength and she was unable to hold him up and had to lower him to the floor. The nursing note revealed he had no injuries and/or signs of pain. Review of the fall investigation dated 12/01/25 and completed by LPN #318 revealed Resident #10 lost strength in his upper extremities during transfer and was lowered to the floor by Agency CNA #480.Review of the Kardex (brief overview of each resident) dated 12/01/25 revealed Resident #10 was to have two staff assist with the Chorus lift transfers.Review of CNA Transfer Inservice dated 12/23/25 and completed by Staff Development/ Registered Nurse (RN) #329 revealed education was provided to follow transfer orders in the Kardex in the electronic medical record or ask the nurse if needed.Review of the nurse's note dated 01/11/26 and completed by LPN #318 revealed Resident #10 had a witnessed fall when Agency CNA #481 lowered him to the floor due to him not being able to maintain balance while using the Chorus lift. The nursing note revealed he had no injuries and/or signs of pain. Review of the fall investigation dated 01/11/26 and completed by LPN #318 revealed Resident #10 was lowered to the floor by Agency CNA #481 due to not being able to maintain his balance. LPN #318 was called to the room and observed the resident sitting on the floor on his buttocks in front of his wheelchair. Resident #10 stated his footing was not correct and while transferring he was unable to hold on.Review of the Kardex dated 01/11/26 revealed Resident #10 was to have two staff assist with the Chorus lift transfers.Review of the email from Assistant Director of Nursing (ADON) #394 to Agency CNA #481 dated 01/12/26 revealed instructions to check the Kardex or ask staff for transfer status of residents. Agency CNA #481 responded she did ask for help, but everyone was busy. ADON #394 replied she would need to wait for help and follow the orders in the Kardex.Review of Physical Therapy Evaluation and Treatment Plan and completed by Physical Therapist (PT) #375 dated 01/29/26 revealed Resident #10 was performing bed mobility with physical therapy; the resident had not attempted out of bed activity.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively intact. He was dependent on staff for rolling and required maximum assistance for bed mobility. Resident #10 was dependent on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff for sit-to-stand and transfers.Review of the Care Plan dated 02/19/26 revealed Resident #10 was at risk for falls related to impaired mobility, impaired balance, medication use, diagnoses of morbid obesity, COPD, congestive heart failure (CHF), anxiety, depression, and tremors. Interventions included monitoring and medicating for pain, monitoring for signs of dizziness, pharmacy review of medications monthly, referring to physical and occupational therapy to evaluate and treat as needed.Review of Quarterly Fall Risk Evaluation V2 dated 02/19/26 and completed by MDS/ LPN #324 revealed Resident #10 continued to be at high risk for falls, was confined to a chair, unable to stand, had diagnoses that placed him at high risk for falls as well as was on medications that increased his risk of falls.Review of the nurse's notes dated 02/22/26 authored by LPN #318 revealed Resident #10 had a witnessed fall with Agency CNA #482 who yelled for help when attempting to transfer Resident #10 from the bed to the wheelchair. He was unable to stand and began sliding down. Resident #10 was lowered to the ground by Agency CNA #482 and LPN #318. Staff then assisted him off the floor with use of a mechanical lift (used to safely transfer residents who cannot bear weight and limited mobility between positions) into his wheelchair with two staff assist. The nursing note revealed he had no injuries and/ or signs of pain. Review of the fall investigation dated 02/22/26 revealed Agency CNA #482 yelled for someone to assist her. LPN #318 arrived at Resident #10's room and observed the resident on the edge of his wheelchair still attached to the Chorus lift. Agency CNA #482 stated she was attempting to transfer Resident #10 from his bed to his wheelchair when he was unable to continue to stand and began sliding down. LPN #318 and Agency CNA #482 lowered Resident #10 to the ground.Review of the Kardex dated 02/22/26 revealed Resident #10 required two staff assistance for all Chorus lift transfers.Review of the physician's order dated 02/22/26 revealed Resident #10 was changed from a Chorus lift to a mechanical lift for transfers.Review of Physical Therapy (PT), PT Recert, Progress Report and Updated Therapy Plan dated 03/02/26 signed by PT #375 revealed transfers and sit/stand not attempted due to medical or safety concerns. Interview with Resident #10 on 03/02/26 at 10:00 A.M. and on 03/03/26 at 9:16 A.M. revealed he had fallen three times because the agency aides were not locking the wheelchair causing the chair to move back as he went to sit down, and he stated only one staff member assisted him each time instead of two. He revealed he does not want to use the mechanical lift as he wanted to continue to utilize the Chorus lift.Interview with Director of Rehab #466 on 03/03/26 at 11:01 A.M. revealed Resident #10 had always required either a mechanical lift or a Chorus lift to transfer. She verified Resident #10 was to be have two staff assist for both types of transfers for this resident.Interview with the Director of Nursing (DON) 03/03/26 at 12:42 P.M. verified Resident #10 was to have two-staff assist with the Chorus lift. She verified that only one staff member had transferred him on 12/01/25, 01/11/26, and 02/22/26 and that he had fallen and/or was lowered to the floor. Interview with LPN #318 on 03/03/26 at 2:45 P.M. revealed she was working when Resident #10 fell on [DATE], 01/11/26 and 02/22/26 and verified only one aide went into the room to transfer Resident #10 with Chorus lift each time. She verified aides have access to and are supposed to check the Kardex prior to resident care. She stated all three aides were from agency. She revealed she attempted to give report to aides before they do resident care but sometimes, they get into the room before she was done with nursing report from the previous shift. She revealed Resident #10 was lowered to the ground each time and did not complain of any injuries. She stated one of the three incidents was because the aide did not lock the wheelchair. Review of undated facility policy, Falls Prevention Program revealed the purpose of the program is to identify the root cause of a fall, so that an intervention being put in place is effective. Falls risk assessment to be completed and falls weekly meeting held. There was nothing in the policy in regard to the facility monitoring that interventions per physician orders and/ or in their plan were implemented. Review of the Stand Up (Chorus) Patient Lift Manual dated 05/07/18 revealed individuals that use the patient sling must be able to support the majority of their own weight; otherwise injury may occur.This deficiency represents non-compliance investigated under Master Complaint Number 2747582.

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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. **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 comfort measures were utilized for Resident #12. This affected one resident (#12) of three residents reviewed for pain management. The facility census was 92.Findings include:Record review revealed Resident #12 was admitted [DATE] with diagnoses of radiculopathy lumbar region, type II diabetes with diabetic neuropathy, pain in the left ankle and joint, and pain in the right shoulder.Review of the care plan initiated on 10/15/25 and revised on 10/27/25 revealed Resident #12 suffered daily from pain in the legs, toes, right shoulder, and neck and has diagnoses of osteoarthritis and lumbar radiculopathy. Interventions included administering pain medications as order for pain relief, assessing effectiveness of pain medication, and assessing and monitoring for non-verbal signs of pain. The care plan did not include an intervention for an arm sling.Review of the care plan dated 10/15/25 and revised on 02/05/26 revealed resident #12 had an activity of daily living self-care deficit related to diagnosis of cerebral vascular accident (CVA). An intervention included left arm sling for comfort dated 1/18/25. Review of the physician's orders revealed Resident #12 had an order for a left arm sling for comfort every shift with a start date of 11/17/25.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was cognitively intact and required maximal assistance with toileting hygiene, showers, and personal hygiene and was dependent on staff for dressing. Section J of the MDS revealed Resident #12 received non-medical intervention for pain.Review of the treatment administration record (TAR) for 03/03/26 revealed it was documented Resident #12 received the arm sling during the day shift. Observations on 03/03/26 at 8:40 A.M., 12:52 P.M., and 3:41 P.M. revealed Resident #12 was not wearing an arm sling as ordered or documented. Interview on 03/03/26 at 12:52 P.M. with Resident #12 revealed she had not yet been given an arm sling but was supposed to have it. Interview on 03/03/26 at 12:55 P.M. with Licensed Practical Nurse (LPN) #402 revealed Resident #12 had frequent complaints of arm pain and the sling was ordered for comfort.Review of the undated Pain Management Policy revealed the policy did not address non-pharmacological treatment interventions but did state that all pain interventions would be documented on the plan of care, the medication administration record/treatment administration record, and/or nurses notes.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, review of the facility Controlled Mediation Shift Change Log and facility policy review, the facility failed to ensure accurate records for the receipt and disposition of controlled drugs for one of one medication cart (400 long hall) narcotic records reviewed. This had the potential to affect all residents receiving narcotic medications. The facility census was 92.Findings include:Observation on 03/03/26 at 7:30 A.M. of the narcotic count reconciliation between the night shift Licensed Practical Nurse (LPN) #477 and the day shift Registered Nurse (RN) #364 for the 400 Long Hall, revealed the pharmacy document titled, Controlled Medication Shift Change Log had missing second nurse signatures for the dates of 02/23/26, 02/24/26, 02/26/26, 03/02/26, and 03/03/26.Review of the facility two-sided document titled, Controlled Medication Shift Change Log revealed note additions and deletions on reverse side. Discrepancies are to be reported to nursing administration. There were two signatures required labeled, signature 1 and signature 2 for each entry.Interview on 03/03/26 at 7:30 A.M. with LPN #477 verified the missing signatures on the Controlled Mediation Shift Change Log for the dates of 02/23/26, 02/24/26, 02/26/26, 03/02/26, and 03/03/26. LPN #477 revealed when a nurse accepted a new narcotic or destroyed a narcotic, the nursing supervisor or a second nurse verified the receipt or disposal of a narcotic with a second signature. Interview on 03/03/26 at 7:30 A.M. with RN #364 verified the missing nursing signatures on the Controlled Mediation Shift Change Log for the dates of 02/23/26, 02/24/26, 02/26/26, 03/02/26, and 03/03/26.Interview on 03/03/26 at 11:27 A.M. with Assistant Director of Nursing (ADON) #394 revealed the procedure when accepting or returning a narcotic card from the pharmacy is to have two nurse signatures witness the receipt or removal of the medication. ADON #394 verified the missing signatures on the Controlled Mediation Shift Change Log for the dates of 02/23/26, 02/24/26, 02/26/26, 03/02/26, and 03/03/26 Review of the undated facility policy titled, Dispensing and Narcotic Count Policy, revealed a complete narcotic count must be performed at every shift change between the oncoming and outgoing nurse. Wasted narcotics must be performed by two licensed nurses.

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	365937	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohman Family Living at Briar	15950 Pierce St Middlefield, OH 44062

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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 record review, observation and interview, the facility failed to ensure an accurate medical record for Resident #34. This affected one resident (#34) of five residents reviewed for medication orders. The facility census was 92.Findings include: Resident #34 was admitted on [DATE], with diagnoses of hemiplegia (loss of muscle function) and hemiparesis (weakness), dysarthria (speech disorder), diabetes mellitus type two, dysphagia (difficulty swallowing), hypertension (high blood pressure), major depression disorder, insomnia, and anxiety disorder.Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #34 had a Brief Interview for mental Status (BIMS) score of 13, indicating intact cognition.Review of the electronic medical record Skilled Nurses Progress Note authored by Licensed Practical Nurse (LPN) #441 dated 02/19/26 at 5:00 P.M., revealed the gastrostomy tube was removed by the physician that day.Review of Resident #34's electronic medical record Order Summary Report and medication administration record (MAR) for March 2026, revealed medications Ambien (sedative) 5 milligrams (mg) 0.5 tablet as needed (PRN) via gastrostomy tube (g-tube), Ambien 5 mg at bedtime via g-tube, Amlodipine Besylate (beta blocker to treat hypertension and chest pain) 10 mg one time a day via g-tube, Carvedilol (lowers blood pressure and heart rate) 6.25 mg twice a day via g-tube, Escitalopram Oxalate (antidepressant) 5 mg one time a day via g-tube, Hydralazine HCL (vasodilator) 25 mg three times a day via g-tube, Lisinopril (treats high blood pressure and heart failure) 20 mg two times a day via g-tube, Melatonin (supplement to aid in sleep) 3 mg one time a day via g-tube, Senna S (laxative) 8.6-50 mg two tablets one time a day for constipation, and Silodosin (treats benign prostatic hypertrophy) 4 mg one time a day via g-tube. Oral medications included Acetaminophen (analgesic) 650 mg by mouth every six hours PRN, Chloraseptic mouth throat liquid (topical anesthetic) one spray by mouth every eight hours PRN, hydrogen peroxide mouth/through solution 5 milliliters (ml) by mouth every eight hours PRN, and Lidocaine Viscous HCL (topical anesthetic) 5 ml by mouth very eight hours PRN.Observation of medication administration on 03/03/26 at 8:55 A.M, revealed Resident #34 received the following medications orally by Registered Nurse (RN) #364: amlodipine 10 mg, carvedilol 6.25 mg, escitalopram 5mg, lisinopril 20 mg, and silodosin 4 mg. Interview at the time of the observation with RN #364 verified she gave the medications orally, verified the medication order route was via g-tube on the MAR, and that Resident #34 had the g-tube discontinued a few weeks ago and had been taking the medications by the oral route since the g-tube was discontinued. Interview on 03/03/26 at 8:57 A.M. with Resident #34 revealed that she had been taking her medications by mouth for quite some time. They took out my tube a long time ago.Interview on 03/03/26 at 11:27 A.M. with the Assistant Director of Nursing (ADON) #394 verified Resident #34's March 2026 MAR medication orders for the g-tube route. ADON #394 verified the g-tube was discontinued for Resident #34, and the facility procedure is to correct the orders in the electronic medical record to the correct route, so the MAR reflects the correct administration route.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **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 a call light was functioning for Resident #26. This affected one resident (#26) of one resident who was investigated for a functioning call light. In addition, the facility failed to ensure the call light was within reach for Resident #3. This affected one resident (#3) of one resident who was investigated for call lights within reach. The facility census was 92. Findings include:1. A review of Resident #26's medical record revealed an admission date of 08/05/25 and pertinent diagnoses included diabetes mellitus type II, chronic pain syndrome, hemiplegia and hemiparesis following cerebral infarction, Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle; slough may be present on some parts of the wound bed) of the left heel, Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining) of the right heel, Post-Traumatic Stress Disorder (PTSD), major depressive disorder, generalized anxiety disorder and insomnia. A review of Resident #26's Minimum Date Set (MDS) 3.0 assessment dated [DATE] revealed a Basic Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. Further review of the MDS revealed Resident #26 required set-up and clean up with oral hygiene and eating, substantial to maximum assistance with toileting, bathing, upper body dressing, and was dependent on staff with lower body dressing and partial to moderate assistance with personal hygiene. Resident #26 required substantial to maximum assistance with bed mobility and was dependent on a mechanical lift for safe transfers. An observation on 03/03/2026 at 11:26 A.M. revealed Resident #26 sitting up in bed, awake and watching a movie. He stated he pressed his call light so that he could be helped into his chair and go to therapy, but no one was coming in to help him. This observation also revealed Resident #26 was holding his call button and pressing it with his thumb, but the indicator light above his door in the hallway was not activated or enabled. This was verified with Activities Aide #322. An interview on 03/04/26 at 11:14 A.M. with Plant Operations and Maintenance Director #339 revealed routine audits to check for functioning call lights were not conducted and further stated he was notified of issues through electronic work orders or by word of mouth. Plant Operations and Maintenance Director #339 further stated the turnaround time for call light repairs is quick because the residents can't be without a call lights. A review of the facility's policy titled Call Light Policy and dated 03/2025 revealed if a Resident's call light is not functioning it will be replaced with an alternative means of notifying staff until it is repaired. Maintenance will be notified through TELS or verbally of the nonfunctioning call light. 2. Review of the medical record for Resident #3 revealed a date of admission of 03/15/24. Significant diagnoses included Multiple Sclerosis, chronic respiratory failure, diabetes mellitus type two, dependence on respirator ventilator and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #3 was cognitively intact. The MDS also indicated impairment to both upper and lower extremities. Resident #3 was noted to be dependent on staff for all activities of daily living and always incontinent of bowel. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan dated 01/05/26 revealed Resident #3 had a communication problem related to inability to speak due to having a tracheostomy. It indicated that she could mouth words and nods her head. Interventions included keeping call light under her hand. Observation on 03/02/26 at 9:57 A.M. revealed a push pad call light activation devise in the center of Resident #3's chest. Resident #3 was noted to have bilateral upper extremity contractures. A care sign was noted over Resident #3's bed stating to keep call light under hand. Resident #3's spouse was in the room at the time and stated keeping the call light in reach was an issue. When Resident #3 was asked if there were any issues with her care, she mouthed the words call light. Observation on 03/03/26 at 9:54 A.M. revealed the push pad call light activation devise in the middle of Resident #3's chest. Resident #3 was asked if she could reach her push pad call activation signal. Resident #3 moved her right contracted arm in an attempt to activate push pad and was unable to do so. Certified Nurse Aide (CNA) #371 verified the push pad call activation devise was in the middle of Resident #3's chest at the time of the observation. CNA #371 placed the push pad call activation devise partially under the hand of Resident #3 and verified the sign over the bed stating to keep call light under hand. Resident #3 was asked to activate her call light and she could not. CNA #371 then asked Resident #3 if she needed the call light placed deeper. Resident #3 mouthed the word yes. The push pad call light activation devise was then placed completely under the right hand of Resident #3. Resident #3 was able to activate the call light. Observation on 03/04/26 at 7:47 A.M. revealed the push pad call light activation devise in the middle of Resident #3's chest. Resident #3 was asked if she could reach her push pad call activation signal. Resident #3 moved her right contracted arm in an attempt to activate push pad and was unable to do so. Respiratory Therapist (RT) #444 verified the aforementioned findings at the time of the observation. RT #444 also verified the sign above the bed of Resident #3 stating to keep the call light under the hand. Interview on 03/04/25 at 2:25 P.M. with the Director of Nursing verified Resident #3 was able to use the push pad call light activation device. A review of the undated facility document titled; Call Light Assessment revealed each resident, including ventilator or track patients will have proper access and ability to use a call light in their room. The clinical liaison in director of respiratory therapy will complete a bedside physical assessment as needed prior to patient arrival at the facility period the clinician will notify the admission team floor staff and maintenance to set up the proper equipment and ensure on arrival equipment is working and patient is able to properly and safely use the device. If patients cannot activate call light further steps will be needed in order to ensure patient has proper call light. A review of the facility policy titled: Call Light Policy dated 03/2025 revealed the call light is used by a resident to notify staff of the facility that the resident has a need that they would like addressed. The policy further stated staff will ensure that a resident is in a comfortable position and that the call light is within reach of the resident prior to leaving the room.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to provide a sanitary environment for Resident #26. This affected one resident (#26) of three residents who were investigated for physical environment. The facility census was 92.Findings include:A review of Resident #26's medical record revealed an admission date of 08/05/25 and pertinent diagnoses included diabetes mellitus type II, chronic pain syndrome, hemiplegia and hemiparesis following cerebral infarction, Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle; slough may be present on some parts of the wound bed) of the left heel, Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining) of the right heel, Post-Traumatic Stress Disorder (PTSD), major depressive disorder, generalized anxiety disorder and insomnia.A review of Resident #26's Minimum Date Set (MDS) 3.0 assessment dated [DATE] revealed a Basic Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. Further review of the MDS revealed Resident #26 required set-up and clean up with oral hygiene and eating, substantial to maximum assistance with toileting, bathing, upper body dressing, and was dependent with lower body dressing and partial to moderate assistance with personal hygiene. Review of the MDS also revealed Resident #26 required substantial to maximum assistance with bed mobility and was dependent on a mechanical lift for safe transfers.An observation on 03/02/26 at 11:00 A.M. at Resident #26's bedside revealed small white flakes all over his floor. An interview with the resident during the observation revealed the flakes were dead skin particles from the daily dressing changes to the wounds on his bilateral heels. This was confirmed with Licensed Practical Nurse (LPN) #445 during the observation. LPN #445 and Resident #26 were unable to say when the floor in the resident's room was last cleaned or mopped.An additional observation and interview on 03/03/26 at 11:26 A.M. revealed Resident #26 stated that there were more flakes of dry skin from his feet after that morning's dressing changes. Resident #26 further stated his frustration that the excessive amount of dry skin ended up all over his clothes, bedding and his floor and he didn't want his personal space to be unsanitary. Resident #26 again stated he was unsure when his floor was last swept or mopped.Review of the housekeeping policy titled Daily Resident Room Cleaning Checklist and revised 11/22/24 revealed residents' floors are to be swept and mopped daily.