| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365974 | A. Building<br>B. Wing | 04/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ohio Living Quaker Heights | 514 West High Street<br>Waynesville, OH 45068 |

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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and follow it's abuse policy. This affected one (Resident #1), out of nine residents reviewed for abuse. The facility census was 58 at the time of survey. Findings include:Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included displaced fracture of upper end of left humerus, pain due to internal orthopedic prosthetic devices, unsteadiness on feet, muscle weakness, age-related osteoporosis, hypertensive heart disease, peripheral vascular disease, and nutritional anemia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition with a Brief Interview of Mental Status Score (BIMS) of seven out of 15, had no behaviors, did not reject care, and did not wander. Resident#1 is documented to be frequently incontinent.Interview with Director of Nursing (DON) on 04/01/2026 at 12:45 P.M. revealed on 03/22/2026 Resident #1 complained of a broken arm and pain after care provided by former employee, Certified Nursing Assistants (CNA) #106. CNA #106 reported the complaint to an agency nurse working in the facility, who then directed CNA #106 to call DON and report the complaint. An assessment with no findings was performed by the agency nurse on 03/22/2026. CNA #106 failed to report the complaint to DON or any other appropriate staff member.On 03/23/2026 Registered Nurse (RN) #108 was notified at evening shift change (approximately 7:00 P.M.) that Resident #1 was complaining of pain in her left arm and reported that she was in a fight with a CNA. RN #108 immediately assessed Resident #1 and found bruising and swelling to left arm. DON was immediately notified. RN #108 notified the physician and Resident #1 was sent out to the local emergency department (ED) for further evaluation. Resident #1 was found to have a fracture to the left forearm and orthopedic evaluation recommended nonsurgical management and placemen of a sling.The facility filed an SRI (self-Reported Incident) on 03/23/2026. CNA #106 was suspended following investigation of the incident and employment was subsequently terminated for failing to report the incident. All staff were re-educated on the facility abuse policy on 03/24/2026. Local police were notified of the incident and declined to file a report after interview and investigation.Interview with DON on 04/02/2026 at 12:45 P.M. confirmed that CNA #106 failed to follow the facility abuse policy by failing to report the incident to facility staff.Facility policy titled Abuse, Neglect, Misappropriation and Crime Reporting, dated 08/14/1999, states All allegations of abuse, neglect, and misappropriation will be reported immediately and will be investigated and All staff members are trained to report abuse, including resident-to resident abuse, immediately (means as soon as they have knowledge of the abuse/allegation) to the staff nurse, supervisor in charge, Unit Manage, Director of Nursing or Administrator.This deficiency represents non-compliance investigated under Complaint Number 2968199. |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report allegations of abuse in a timely manner. This affected one (Resident #1) out of nine residents reviewed for abuse. The facility census was 58 at the time of survey.Findings include:Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included displaced fracture of upper end of left humerus, pain due to internal orthopedic prosthetic devices, unsteadiness on feet, muscle weakness, age-related osteoporosis, hypertensive heart disease, peripheral vascular disease, and nutritional anemia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition with a Brief Interview of Mental Status Score (BIMS) of seven out of 15, had no behaviors, did not reject care, and did not wander. Resident#1 is documented to be frequently incontinent.Interview with Director of Nursing (DON) on 04/01/2026 at 12:45 P.M. revealed on 03/22/2026 Resident #1 complained of a broken arm and pain after care provided by former employee, Certified Nursing Assistants (CNA) #106. CNA #106 reported the complaint to an agency nurse working in the facility, who then directed CNA #106 to call DON and report the complaint. An assessment with no findings was performed by the agency nurse on 03/22/2026. CNA #106 failed to report the complaint to DON or any other appropriate staff member.On 03/23/2026 Registered Nurse (RN) #108 was notified at evening shift change (approximately 7:00 P.M.) that Resident #1 was complaining of pain in her left arm and reported that she was in a fight with a CNA. RN #108 immediately assessed Resident #1 and found bruising and swelling to left arm. DON was immediately notified. RN #108 notified the physician and Resident #1 was sent out to the local emergency department (ED) for further evaluation. Resident #1 was found to have a fracture to the left forearm and orthopedic evaluation recommended nonsurgical management and placemen of a sling.The facility filed an SRI (self-Reported Incident) on 03/23/2026. CNA #106 was suspended following investigation of the incident and employment was subsequently terminated for failing to report the incident. All staff were re-educated on the facility abuse policy on 03/24/2026. Local police were notified of the incident and declined to file a report after interview and investigation.Interview with DON on 04/02/2026 at 12:45 P.M. confirmed that CNA #106 failed to report the incident to facility staff.Facility policy titled Abuse, Neglect, Misappropriation and Crime Reporting, dated 08/14/1999, states All allegations of abuse, neglect, and misappropriation will be reported immediately and will be investigated and All staff members are trained to report abuse, including resident-to resident abuse, immediately (means as soon as they have knowledge of the abuse/allegation) to the staff nurse, supervisor in charge, Unit Manage, Director of Nursing or Administrator.This deficiency represents non-compliance investigated under Complaint Number 2968199. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain call lights within reach of residents. This affected two (Residents #4 and #9). The facility census was 58 at the time of survey.Findings include:1.Review of the medical record revealed Resident #4 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, aphasia, muscle weakness, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and Type II Diabetes Mellitus.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed the resident had mildly impaired cognition, had no behaviors, did not reject care, and did not wander. Resident #4 was always incontinent of bowel and bladder.Resident #4 was a two-person physical assist, and was dependent for all activities of daily living (ADL).Review of Resident #4's care plan, dated 01/25/2026 revealed resident has ADL self-care deficit, he is dependent on staff for all ADL's with intervention including Keep call light in reach at all times.Observation on 04/01/2026 at 9:20 A.M. revealed that Resident #4's call light was sitting on a nightstand to the side of the bed, out of reach of the resident.Interview with Nurse Educator #102 on 04/01/2026 at 9:24 A.M. confirmed that Resident #4's call light was placed out of reach and Resident #4 was dependent for all care.2.Review of the medical record revealed Resident #9 was admitted to the facility on [DATE]. Diagnoses included Type II Diabetes Mellitus, vascular dementia, essential hypertension, hyperlipidemia, chronic kidney disease, and celiac disease.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed the resident had severely impaired cognition with a Brief Interview Status (BIMS) of three out of 15, had no behaviors, did not reject care, and did not wander. Resident #9 was frequently incontinent of bowel and bladder.Resident #9 was a one-person physical assist, required partial/moderate assistance for bed mobility, transfers, dressing, toileting, personal hygiene, eating, and locomotion.Observation on 04/01/2026 at 9:58 A.M. revealed that Resident #9's call light was wrapped tightly around a lower side bar on the residents bed unable to be accessed by the resident.Interview on 04/01/2026 at 10:26 A.M. with LPN #105 confirmed that Resident #9's call light was not accessible to the resident.Facility policy titled Responding to Call Lights dated 01/20/2026 states The signal cord or device must be easily accessible to the resident at all times.This deficiency represents non-compliance investigated under Complaint Number 2665706. |

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| | 365974 | A. Building<br>B. Wing | 04/02/2026 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure infection control policies and procedures were followed. This affected Residents #5 and #8. The facility census was 58 at the time of survey.Findings include:1.Review of the medical record revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses included Lennox-Gastaut syndrome (intractable with status epilepticus), non-ST elevation myocardial infarction, acute respiratory failure with hypoxia, dysphagia, and acute kidney failure. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed the resident had moderately impaired cognition with a Brief Interview od Mental Status (BIMS) of 10 out of 15, had no behaviors, did not reject care, and did not wander. Resident #5 had a urinary catheter and was frequently incontinent of bowel.Resident #5 was a two-person physical assist, was dependent for all Activities of Daily Living (ADL's) and received tube feeds for nutrition.Review of the care plan dated 03/11/2026 revealed for Resident #5 Enhanced Barrier Precautions will be maintained per facility/organization policy.Observation on 03/31/2026 at 9:15 A.M. and 04/01/2026 at 7:03 A.M. revealed Resident #5 sitting in common area receiving tube feeds/flushes with the nurse not wearing any personal protective equipment (PPE).Interview with the Director of Nursing (DON) on 04/02/2026 at 7:55 A.M. confirmed tube feeds, flushes and medication administration through Gastrostomy (G)-tube occur regularly for Resident #5 in the common area and the nurses do not wear PPE during care.Enhanced Barrier Precautions signage placed on Resident #5's door states Providers and staff must .Wear gloves and a gown for the following high-contact resident care activities .Device care or use: central line, urinary catheter, feeding tube, tracheostomy.2.Review of the medical record revealed Resident #8 was admitted to the facility on [DATE]. Diagnoses included vascular dementia, anxiety disorder, major depressive disorder, and weakness.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed the resident had severely impaired cognition, had no behaviors, did not reject care, and did not wander. Resident #8 was always incontinent of bowel and bladder.Observation of incontinence care on 04/01/2026 at 9:37 A.M. revealed that CNA #103 did not change gloves after care and picked up Resident #8's call light off of the floor with her still gloved hand and handed it to the resident who promptly put the call light in her mouth.Interview with CNA #103 on 04/01/2026 at 9:50 A.M. confirmed that she did not change or remove her gloves and perform hand hygiene prior to handing Resident #8 her call light. It was further confirmed the call light was picked up off the floor and handed to the resident without being cleaned.Interview with DON on 04/02/2026 confirmed hand hygiene should have been performed and the call light should have been cleaned prior to providing it to resident. |