STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Mentor	8881 Schaefer St Mentor, OH 44060

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews, the facility failed to timely notify Resident #84's family of the resident's hospitalization. This affected one resident (#84) of three residents reviewed for change in condition. The facility census was 80.Findings include:Review of the medical record for Resident #84 revealed an admission date of 06/19/25. Diagnoses included chronic obstructive pulmonary disease (COPD), displaced fracture neck of the left femur, open wound to the left hip, diabetes, presence of left artificial hip, peripheral vascular disease. The resident was discharged to another facility on 07/16/25.Review of the Five-Day Minimum Data Set (MDS) assessment, dated 06/23/25, revealed Resident #84 had intact cognition. Review of the nurses note on 06/21/25 at 7:00 A.M. revealed at around 4:00 A.M. Emergency Medical Services (EMS) arrived at the facility stating they got a call from a female resident that did not know where she was and was afraid. Upon entering room, Resident #84 was on the phone with 911. The resident's call light was not on. The resident had no complaints of pain, no signs or symptoms of respiratory distress, just stated she was scared. EMS asked the resident if she wanted them to take her to the hospital for evaluation and resident stated yes. Resident #84 was taken to the hospital for evaluation.Review of the nurses note on 06/21/25 at 7:10 A.M. revealed Resident #84's spouse was notified of the transfer and he voiced understanding.Review of Resident #84's medical record revealed emergency contact number one was the granddaughter/the Power of Attorney (POA), emergency contact number two was the daughter, the spouse was emergency contact number three. There was no documented evidence to Resident #84's POA/granddaughter was notified she was taken to the hospital.Review of Resident #84's medical record revealed no change of condition form was completed.Interview on 09/29/25 at 12:53 P.M. the Director of Nursing (DON) verified no change of condition form was completed and timely notification to the resident's POA was not made.This deficiency represents non-compliance investigated under Complaint Number 2572360.

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
	366015	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Mentor	8881 Schaefer St Mentor, OH 44060

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Mentor	8881 Schaefer St Mentor, OH 44060

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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review and interview, the facility failed to adequately monitor Resident #85's condition including bowel and bladder elimination to timely identify and treat infection and constipation. This affected one resident (#85) of three residents reviewed for change in condition. The facility census was 80. Actual harm occurred on 06/25/25 after Resident #85 who had cystitis (inflammation of the bladder), reflux, diabetes, impaired cognition and mobility, a high risk for constipation and infection, and a history of sepsis (a life-threatening response to an infection) failed to receive sufficient monitoring to timely treat constipation and infection. The resident developed progressive symptoms throughout the day including an upset stomach, diaphoresis (heavy sweating), vomiting fecal matter, a firm and distended abdomen, hypoxemia (low blood oxygen), a change in mental status, a high heart rate and pallor before being transferred to the hospital and admitted with aspiration pneumonia and a possible small bowel obstruction. Findings include:Review of the closed medical record for Resident #85 revealed an admission date of 04/21/21. The resident was discharged to the hospital on [DATE]. Resident #85 had diagnoses including diabetes, hemiplegia, reflux, epilepsy, aphasia, cystitis, and schizophrenia.Review of the plan of care dated 04/29/21 revealed Resident #85 was at risk for constipation related to decreased mobility. Interventions included to administer medications as ordered, consult dietary for assistance in meeting dietary needs, encourage exercise as tolerated, and encourage fluids if diet and medical diagnosis permit. The care plan identified the resident's risk of infection which was initiated on 06/05/23 for a history of urinary tract infection, but it did not include the risk of infection from diagnoses of reflux, cystitis or a history of sepsis. Interventions included assessments for signs and symptoms of infection including foul smelling or cloudy urine, urine sediment, and decreased urine output, and report findings to the physician, educating on techniques to prevent infection, encouraging fluids, and obtaining labs as ordered.Additional review of the medical record revealed on 02/04/25, Resident #85 completed a kidney ultrasound prior to a urology appointment on 03/11/25. Thereafter on 04/18/25, the resident received a cystoscopy with visual internal urethrotomy (a procedure to open a stricture or scar tissue in the urethra). After the procedure, Resident #85 had an indwelling urinary catheter for three weeks and received a course of oral antibiotics. The catheter was to be removed in the urologist's office at a follow-up appointment scheduled on 05/13/25.Review of a nurse's note dated 05/13/25 at 5:27 A.M. revealed Resident #85 was sent to the hospital for evaluation due to a high heart rate and elevated temperature. The resident complained of feeling chills and was very shaky.Review of a nurse's note dated 05/13/25 at 8:33 A.M. revealed Resident #85 was admitted to the hospital for sepsis and tachycardia (an elevated heart rate). Additional review of the medical record revealed Resident #85 returned to the facility on [DATE] at 8:11 P.M. There was no evidence of comprehensive assessments for infection monitoring as identified in the resident's plan of care after returning from the hospital on [DATE].Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/21/25, revealed Resident #85 had impaired cognition, and was dependent on staff for toileting and transfers. The assessment revealed the resident used a wheelchair for mobility and was occasionally incontinent of bowel and bladder.Review of the Medication Administration Record (MAR) from April to May 2025 revealed Resident #85 had active as needed (PRN) orders related to a risk of constipation which included oral Milk of Magnesia if no bowel movement (BM) after three days (step one), a Dulcolax suppository if no results from Milk of Magnesia (step two) and an enema (step three) if still no results. The records indicate no history of recurrent constipation as evidenced by the unused PRN suppository and enema. Record review revealed the oral laxative, milk of magnesia was administered once on 04/05/25. Review of Resident #85's physician orders effective June 2025 revealed an order to straight catheterize the resident for possible urine retention, and if no bowel movement (BM) after following steps one, two and three to notify the physician. Review of Resident #85's MAR and bowel tracking record for June 2025 revealed Resident #85 had no BM on 06/21/25, 06/22/25, 06/23/25 or 06/24/25. There were no PRN interventions administered for either step one, two or three. On 06/25/25, the resident received a step two suppository, and thereafter had a medium sized loose BM. Per staff stated protocol (interview with Assistant Director of Nursing [ADON] #269 on 09/30/25) and physician orders, step one was not administered on day three of no BM (on 06/23/25), followed by step two if no result and additionally step three if still no result. Review of a nurse's note dated 06/24/25 at 11:01 P.M. revealed Resident #85 was medicated with the analgesic acetaminophen PRN for pain. Review of a nurse's note dated 06/25/25 at 6:33 A.M. revealed Resident #85

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Mentor	8881 Schaefer St Mentor, OH 44060

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Mentor	8881 Schaefer St Mentor, OH 44060

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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical review and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to promote healing and to prevent a decline and infection in pressure ulcers. This affected one resident (#87) of three residents reviewed for pressure ulcers. The facility census was 80.Actual harm occurred beginning on 04/30/25 when Resident #87, who was admitted to the facility with two Stage IV (a severe open sore that has penetrated through all layers of the skin and underlying tissue exposing muscle, tendon or bone) pressure wounds was noted to have a deterioration in wound status (green drainage indicative of infection and increase in size). Wound cultures were not obtained until 05/15/25. On 06/06/25 Resident #87 requested to go to the hospital due to complaints of not feeling well (the resident's family had identified the resident had experienced new onset confusion and lethargy during the week prior). The resident was admitted to the hospital for treatment of osteomyelitis. Findings include:Review of the closed medical record for Resident #87 revealed an admission date of 12/17/24 with diagnoses including unspecified injury at C7 level of the cervical spinal cord, injury at C5 level of the cervical spinal cord, chronic obstructive pulmonary disease, quadriplegia, protein-calorie malnutrition, emphysema, neuromuscular dysfunction of the bladder, osteomyelitis (06/04/25), fusion of the spine, contracture of the muscle, and neurogenic bowel. The resident was transferred to the hospital on [DATE] and did not return to the facility. Review of the admission nursing assessment dated [DATE] identified Resident #87 was admitted with a wound with depth on the right buttock and an open wound with depth on the left buttock.Review of the plan of care dated 12/18/24 revealed Resident #87 was at risk for impaired skin integrity/pressure ulcers related to altered sensations, fragile skin, and quadriplegia. Interventions included to apply barrier cream/ointment after each incontinent episode as needed, to elevate heels off the mattress, encourage fluids, encourage to be out of the wheelchair at least two hours daily as tolerated, the nurse to ensure the resident goes to bed timely just before or after dinner, to inspect the skin during routine daily care, peri care after each incontinent episode, pressure reduction devices as ordered, and treatments per order.Review of the plan of care dated 12/19/24 revealed Resident #87 had an actual pressure ulcer, Stage IV right ischium and Stage IV left ischium. Interventions included administering medications per physician orders, explaining all procedures prior to care, monitoring for signs and symptoms of infection, notifying the physician of wound deterioration, providing wound care per physician orders, and referring to the wound physician as needed. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #87 had two Stage IV pressure ulcers/wounds which were present on admission. Review of the plan of care dated 01/27/25 revealed Resident #87 was non-compliant related to wound care and supplements for wound healing, non-compliant with a preventative pressure reduction mattress, and non-compliant with off-loading the buttocks from the wheelchair throughout the day. Interventions included to document educational attempts made with resident in relation to compliance, and educate the resident, family or responsible party on negative outcomes related to non-compliance. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #87 dated 03/26/25 revealed the resident was cognitively intact. The resident used a wheelchair and was assessed to have limited range of motion (ROM) on both sides. The assessment revealed the resident required substantial (staff) assistance with oral hygiene, dressing, personal hygiene, rolling left and right, and sitting to lying. The resident was dependent on staff for toileting, bathing, sitting to standing, chair to bed transfers, and toilet transfers. The assessment indicated the resident had two Stage IV pressure ulcers present on admission. Review of Resident #87's physician orders from admission through March 2025 revealed to encourage floating heels off the mattress when in bed, a pressure reducing mattress to bed, encouraging oral fluids, heel protection boots while in bed or as needed, encouraging to be out of the wheelchair at least two hours daily as tolerated, and the nurse to ensure resident goes to bed timely just before or just after dinner. Review of Resident #87's treatment orders revealed on 04/09/25 the right and left ischium were dressed with collagen silver calcium alginate (used for managing moderate to heavy draining wounds with antimicrobial protection) followed by a bordered foam dressing daily and as needed (PRN). Review of Nurse Practitioner (NP) #307's wound note dated 04/14/25 revealed the status of both Resident #87's wounds, the right and left ischium, were stable with both measuring 1.0 centimeters (cm) length (L) by 2.0 cm width (W) by 1.0 cm depth (D) for a calculated area of 2.0 square (sq) cm. Review of the NP #307's wound note dated 04/23/25 revealed the status of both Resident #87's wounds, the right and left ischium

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Mentor	8881 Schaefer St Mentor, OH 44060

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review and interview, the facility failed to timely collect a urine sample and start an antibiotic for a urinary tract infection (UTI). This affected one (Resident #84) of three residents reviewed for timely lab work. The facility census was 80.Findings include:Review of the medical record for Resident #84 revealed an admission date of 06/19/25. Diagnoses included chronic obstructive pulmonary disease (COPD), displaced fracture neck of the left femur, open wound to the left hip, diabetes, presence of left artificial hip, peripheral vascular disease. The resident was discharged to another facility on 07/16/25.Review of the Five-Day Minimum Data Set (MDS) assessment, dated 06/23/25, revealed Resident #84 had intact cognition. The resident required partial/moderate assistance for toileting hygiene, upper body dressing, to roll left and right, and sit to laying. The resident required substantial/maximal assistance for lower body dressing, sit to stand, chair to bed to chair transfer, and toilet transfer.Review of the nurse's note dated 07/07/25 at 7:10 A.M. revealed the previous shift nurse notified this nurse that resident's daughter requested a urinalysis for culture and sensitivity (UA C&S) due to increased confusion. Later in shift, this nurse went to answer the resident's call light, and Resident #84 stated she doesn't know what she is doing, and she thought she had lost her mind. The nurse attempted to collect urine at that time, but the resident stated she had just gone to the restroom. The oncoming nurse was made aware to the need to attempt to collect urine.Review of the social service's note dated 07/07/25 at 1:17 P.M. revealed Resident #84 had a UA C&S ordered due to the resident's increased confusion and daughter's concern.Review of the nurse's note dated 07/11/25 at 7:00 A.M. revealed Resident #84 had positive UA results with the C&S pending.Review of the nurse's note dated 07/14/25 at 1:25 P.M. revealed Resident #84's granddaughter called for updates on UA C&S and labs. The nurse made the granddaughter aware the physician had not given any orders at this time but told the granddaughter she would reach out to the physician and call her with an update.Review of the nurse's note dated 07/14/25 at 3:51 P.M. revealed Resident #84's granddaughter was updated regarding new orders for Macrobid (antibiotic) and iron.Review of physician orders identified orders for Macrobid oral capsule 100 milligrams (mg). Give one capsule by mouth two times a day for UTI for seven days. The order was dated 07/15/25 at 7:00 A.M. (It took eight days for treatment to begin after Resident #84's daughter originally requested a UA C&S).Interview on 09/26/25 at 8:52 A.M. with the Director of Nursing (DON) confirmed the urine sample was not obtained timely, and the antibiotic was not ordered timely. This deficiency represents non-compliance investigated under Complaint Number 2572360.