

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Carecore at Mentor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on interview and record review, the facility failed to ensure that facility heating units were maintained in good repair. This affected 20 residents (#8, #23, #30, #37, #39, #41, #42, #43, #49, #55, #58, #60, #65, #70, #72, #75, #81, #85, #86, and #93) of 93 residents residing in the facility. The facility census was 93. Findings include: Record review of the Mentor Fire Department Incident Report #26872, dated 01/31/26 at 4:48 P.M., revealed an incident at the facility involving a blower motor belt smoking and causing excessive heat from the conference room heating unit. On 02/04/26 at 9:41 A.M., an interview with the Administrator revealed on 01/31/26, the facility experienced an issue with the heating unit located in the conference room. The Administrator stated that the motor froze on the heating unit which caused the belt to smoke resulting in excessive heat and the activation of the fire alarm system. A review of a facility document titled Monitoring of Heaters, dated 02/04/26, revealed 18 thermostats were not functioning correctly in the following resident rooms (Rooms 102, 105, 110, 114, 115, 120, 121, 201, 204, 207, 220, 307, 309, 319, 320, 321, 409, and 417) affecting 20 residents living in the rooms (#8, #23, #30, #37, #39, #41, #42, #43, #49, #55, #58, #60, #65, #70, #72, #75, #81, #85, #86, and #93) . A review of Service Quote #0002303, dated 02/05/26, confirmed that 21 thermostats required replacement. On 02/05/26 at 10:10 A.M., an interview with the Administrator revealed the day following the incident on 01/31/26, a heating company inspected all heating units in the facility. The Administrator stated the company identified 21 thermostats in need of replacement, including two thermostats located in non-resident areas (medical records and conference room). On 02/05/26 at 11:00 A.M., an interview with the Administrator confirmed that the rooms listed on the Monitoring of Heaters document were resident rooms identified during the heating unit inspection conducted on 02/01/26. A review of the policy titled Quality of Life- Homelike Environment dated 05/2017 revealed residents are provided a safe, clean, comfortable and homelike environment. The policy further revealed the facility staff and management shall maximize to the extent possible the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary, and orderly environment including comfortable and safe temperatures. The deficiency represents noncompliance identified during investigation of Complaint Number 2733141.</p>		

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
---	-------	-----------