STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility policy and staff interview, the facility failed to report injury of unknown origin to the State Survey Agency as required. This affected one (Resident #313) of one resident reviewed for an injury of unknown origin. The facility census was 60.Findings include:Review of Resident #313's medical record revealed an admission date of 01/07/22 with diagnoses including local infection of the skin and subcutaneous tissue, acute on chronic systolic (congestive) heart failure, pulmonary fibrosis, dysphagia, hypoxemia, hypertensive heart disease with heart failure, gout, anemia, age-related osteoporosis, major depressive disorder, generalized anxiety disorder, hypothyroidism, chronic pain syndrome, chronic kidney disease, acute respiratory failure with hypoxia, myocardial infarction, osteoarthritis of knee, cognitive communication deficit, chronic obstructive pulmonary disease (COPD), repeated falls, and legal blindness.Review of Resident #313's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 00 which indicated severe cognitive impairment. Further review of the MDS also revealed the resident was dependent on staff for all activities of daily living (ADL) and mobility.Review of Resident #313's progress note dated 06/05/25 revealed she was complaining of pain in her right knee, and x-rays of her right knee were subsequently ordered. The x-rays were performed on 06/06/25 and results revealed a broken osteophyte in superior margin of patella, likely chronic, moderate osteoarthritis of right knee joint.Interview with the Director of Nursing (DON) #623 on 01/08/25 at 2:17 P.M. revealed staff was unaware how Resident #313's knee injury occurred. The DON also revealed an investigation was conducted, but no facility self-reported incident was submitted to the State Survey Agency as required.Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised April 2021, revealed if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not result in abuse or result in serious bodily injury. This deficiency was an incidental finding identified during the complaint investigation.

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
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the hospital records and facility policy review, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent the worsening of pressure ulcers, ensure timely and accurate assessments were completed, ensure treatments were implemented timely, and ensure nutritional interventions were implemented as ordered for Resident #313.Actual Harm occurred beginning on 10/07/25 when Resident #313 who was dependent on staff for toileting hygiene, bathing, bed mobility, and transfers returned from the hospital with a Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) to the coccyx which was not measured or described and had no treatment orders were put in place until 10/13/25 when it was assessed as a worsening 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 and tunneling). The facility failed to access the coccyx wound consistently and failed to have documented evidence treatments were completed from 11/08/25 through 11/20/25. On 11/21/25 the wound had further deteriorated and was assessed as an unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) pressure ulcer. The resident was transferred to the hospital on [DATE] for further evaluation of the worsening unstageable coccyx wound and admitted with a worsening decubitus/pressure ulcer.This affected one resident (#313) of three residents reviewed for pressure ulcers. The facility census was 60. Findings include:Review of the medical record revealed Resident #313 was admitted to the facility on [DATE] with diagnoses including legal blindness, osteoarthritis of the bilateral shoulders, dysphagia (04/12/22), nonrheumatic aortic valve stenosis (04/12/22), hypertensive heart disease with heart failure (12/03/22), repeated falls (01/26/23), chronic diastolic congestive heart failure (07/10/23), chronic obstructive pulmonary disease (07/30/24), iron deficiency anemia (07/30/24), cognitive communication deficit (08/27/24), presence of urogenital implants (05/05/25), Non-ST elevation myocardial infarction (10/01/25), chronic kidney disease (Stage three (10/01/25), major depressive disorder, generalized anxiety disorder, hypothyroidism, acute respiratory failure (10/31/25).Review of the care plan initiated on 12/08/23 revealed Resident #313 had impaired skin integrity: bruises easily due to diagnoses of chronic kidney disease, anemia, and Vitamin D deficiency with interventions including provide pressure relieving devices to bed and chair, nutritional interventions per dietary recommendations, identify potential causative factors and eliminate/resolve as possible, notify family and physician of changes, and medications per orders. Review of the nurses note dated 09/18/25 revealed Resident #313 was transferred to the hospital for difficulty breathing and admitted to with diagnoses of pneumonia and possible, myocardial infarction and pulmonary embolism. Review of the re-admission note dated 10/01/25 revealed Resident #313 was readmitted from the hospital with a Stage II pressure ulcer on her coccyx. There were no measurements or descriptions of the wound. Review of the October 2025 treatment administration record (TAR) revealed an order dated 10/02/25 to cleanse Resident #313's coccyx, pat dry and apply zinc to the open area, cover with gentle border foam dressing every Monday, Wednesday, and Friday. The order was not signed off as completed 10/02/25 or 10/03/25.Review of the Medicare 5-Day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #313 had severe cognitive impairment, was dependent on staff for toileting hygiene, bathing, bed mobility, and transfers, had an indwelling urinary catheter and was frequently incontinent of bowel. The assessment revealed the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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: The nursing home is disputing this citation.	resident had no pressure ulcers (however, she had a Stage II pressure ulcer to the coccyx) and was at risk for pressure ulcer development. Per the assessment, the resident had a pressure-reducing device to the bed and chair and no nutritional or hydration intervention to manage skin problems.Review of the nurse's note dated 10/03/25 revealed Resident #313 was transferred to the hospital for shortness of breath. The resident was admitted (to the hospital).Review of the re-admission note dated 10/07/25 revealed Resident #313 was readmitted to the facility with a Stage I pressure ulcer to her sacrum (coccyx) measuring 1.5 centimeters (cm) by 1.5 cm by 0 cm. There was no description of the wound. The resident had an indwelling urinary catheter. Review of the physician's orders revealed an order dated 10/11/25 to cleanse Resident #313's coccyx with normal saline solution (NSS) and apply protective padded dressing Monday, Wednesday and Friday for the open area. (The treatment was not documented as completed on 10/11/25 or 10/12/25). Review of the weekly wound summary dated 10/13/25 (first description of the wound since return from the hospital on [DATE]) revealed a Stage III pressure ulcer to the sacrum (coccyx) measuring 2.0 centimeters (cm) length by 1.0 cm width with an undetermined depth due to the presence of 100% white slough tissue with surrounding skin red and non-blanchable. The certified nurse practitioner (CNP) was updated on the appearance of the wound and would assess it tomorrow. Referral to Wound NP. Per Wound NP Santyl (debriding ointment) and foam dressing daily, air mattress, Prostat 30 milliliters (ml) twice daily (BID). (The Prostat was discontinued on 10/16/25 due to refusals).Review of the medical record revealed Resident #313 was hospitalized from [DATE] through 10/24/25 for acute respiratory failure and hypercapnia. Review of the re-admission assessment dated [DATE] revealed Resident #313 was re-admitted with a Stage II pressure ulcer to the coccyx measuring 2.5 cm by 2.0 cm with no depth measurement or description noted. The resident also had a left buttock suspected deep tissue injury (SDTI) (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear) measuring 1.0 cm by 2.0 cm.Review of the physician's orders revealed an order dated 10/24/25 to cleanse Resident #313's sacral (coccyx) wound with NSS or wound cleaner, apply nickel thick amount of Santyl to wound and cover with alginate. Apply zinc to the surrounding area and cover with foam dressing once daily. (The wound care was signed off as completed 10/25/25 through 10/31/25). Review of the weekly wound summary dated 10/31/25 revealed resident #313's coccyx wound was a Stage III pressure ulcer measuring 2.5 cm by 3.0 cm by 0.3 cm. The wound was noted to appear worse in appearance and measurement. The right buttock (location corrected from left buttock on 10/24/25) was described as a SDTI measuring 2.5 cm by 4.0 cm, skin intact and non-blanchable. CNP updated on appearance and worsening of wound. She had seen it this week during rounds. The dietitian was notified of the wound on 10/27/25 and recommended Boost nutritional supplement three times a day (TID). Review of the TAR for November 2025 revealed physician's orders dated 10/24/25 through 11/07/25 to cleanse the sacral (coccyx) wound with NSS or wound cleanser, apply nickel thick amount of Santyl to wound and cover with alginate, apply zinc to the surrounding area and cover with a foam dressing daily. There was not treatment ordered or signed off to the sacrum (coccyx) from 11/08/25 until 11/21/25. There was an order dated 11/07/25 through 11/21/25 to cleanse Resident #313's right buttock with NSS, apply collagen with sacral dressing along with coccyx wound dressing daily. Review of the medical record revealed no further assessments of the wounds until 11/13/25. Review of the TAR for November 2025 revealed there was no treatment to the coccyx ordered or signed off from 11/08/25 through 11/13/25.Review of the weekly wound progress note dated 11/13/25 revealed Resident #313's sacrum (coccyx) was a Stage III pressure ulcer per provider measuring 2.0 cm by 2.0 cm by 0.3 cm with 90% slough and 10% granular tissue. Right buttock has a Stage II pressure ulcer measuring 23 cm by 2.5 cm by 0.1 cm, 100% (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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: The nursing home is disputing this citation.	epithelial tissue. Treatment was to cleanse the wound to the coccyx NSS or wound cleanser, apply nickel thick Santyl to coccyx wound and cover with alginate (this treatment to the Stage III pressure area on the coccyx was not transcribed or signed off as completed), apply collagen to right buttock wound and cover entire area with sacral foam or six by six foam dressing daily, air mattress to bed, Boost Plus TID, Magic cup (nutritional supplement) daily, and multivitamin daily, Previous wound care Nurse Practitioner # 699 in to assess and no new orders noted. Improved in measurements. Appearance remains the same. Resident #313's daughter updated by phone on improvement, and wound NP #699 being in with no new orders. Also, told her new wound company would be starting next Friday and would follow weekly.Review of the TAR for November 2025 revealed there was no treatment to the coccyx ordered or signed off from 11/13/25 through 11/20/25.Review of the facility weekly wound summary dated 11/21/25 revealed Resident #313's coccyx wound was now unstageable measuring 2.4 cm by 2.0 cm by 0.4 cm, no drainage sacrum. Orders to cleanse area with NSS, place 1/4 strength Dakin's (antimicrobial)-soaked gauze to wound bed, cover with gentle border dressing BID. Doxycycline (antibiotic) 100 milligrams (mg) BID for 10 days. Sacrum x-ray to rule out osteomyelitis.Review of the Healing Partners skin and wound note dated 11//21/25 authored by Wound NP #601 revealed information necessary for today's visit was obtained from nursing staff, per patient's medical record, the patient. Reason for visit: new skin and wound consult on current resident. First Evaluation of existing wound by new provider. The wound care team was consulted for the following wound: left buttock pressure ulcer Stage II acquired 10/24/25; coccyx pressure ulcer unstageable, previous Stage III. Undergoing wound care treatment as ordered. Air mattress in place. On nutritional supplements. Resident #313 has lost almost 20 pounds since August. At the time of visit, the resident was awake and alert, resting in bed. Of report, resident's daughter is Power of Attorney (POA), who is actively involved with her care. Upon today's assessment, the coccyx wound presents with 100% slough, redness and warmth to the peri-wound area. Sharp debridement is warranted. Nursing staff called daughter and obtained verbal consent for sharp debridement with request pain med to be given prior to debridement. Pain med was given. The wound care team came back for debridement. Nursing reports that daughter refused palliative care/hospice care. Pre-debridement measurement of the coccyx wound was 2.1 cm by 2.0 cm by 0.4 cm; post-debridement measurement was 2.1 cm by 2.0 cm by 0.8 cm. A selective debridement was performed. Removal of biofilm/necrotic tissue using forceps, scalpel, scissors was performed to keep the wound in an active state of healing. No bleeding noted. The site was cleaned and dressing was applied. The nursing staff were given detailed ulcer care instructions and asked to monitor the ulcer for any signs or symptoms ofprolonged bleeding or debridement intolerance. The patient tolerated the procedure well with no noted complications at the time of encounter. Treatment to the left buttock was cleanse with NSS, apply collagen to the base of the wound, secure with sacral dressing, change three times a week and as needed. Treatment to the coccyx wound was cleanse with NSS apply Barrier cream to peri-wound, 1/4 Dakin's moistened gauze to base of the wound, and secure with gentle border dressing. Serial debridement expected. Stage IV expected as more necrotic tissue is debrided. Workup for osteomyelitis: Complete Blood Count (CBC) w/differential, complete metabolic panel (CMP) on Monday 11/24/25. Add Erythrocyte Sedimentation Rate (ESB) and C-Reactive Protein (CRP). X-ray of sacrum/coccyx rule out osteomyelitis. Doxycycline 100 mg BID for 10 days and Probiotic to prevent C-Diff.Review of the Doctor/CNP note dated 11/21/25 revealed the CNP was notified of the x-ray results: the visualized sacrococcygeal segments are in good alignment. Degenerative changes are identified. No osseous erosions are present. The sacroiliac joints are normal. No acute abnormalities.Review of the Doctor/CNP note dated 11/22/25 revealed spoke with Resident #313's daughter, and she was concerned about nausea as of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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: The nursing home is disputing this citation.	late. PRN Zofran (antinausea) given with little effects. New order for PRN Phenergan (antinausea). Fluid intake less than usual. The resident took in 200 cubic centimeters (cc) supplement with breakfast, about 120cc of lunch supplement. Solid food bites only for each meal. 240 cc in other liquids taken in at this time. New order for intravenous (IV) D5NS 0.9% 80cc / hour for one liter. Resident states she is having discomfort on the roof of her mouth and tongue. No areas of concern noted on roof of mouth, dry dark patches noted to tongue. New order for nystatin (antifungal).Review of the Doctor CNP note dated 11/24/25 revealed the CNP was notified about abnormal lab results of low Albumin of 3.4, high Blood Urea Nitrogen (BUN) of 36, high Creatinine of 1.30, low sodium of 134, high Chloride of 32, low Red Blood Cell of 3.17, low Hemoglobin of 9.6, a low Hematocrit of 28.8, all other labs within normal limits and concerns from resident's daughter. The following orders were started and Resident #313's daughter notified. New orders: Invanz Injection Solution Reconstituted (Ertapenem Sodium) (antibiotic) use 500 mg intravenously (IV) one time a day related to urinary tract infection (UTI) for two days 100 ml for 30 minutes AND use 500 mg IV one time only related to UTI. Vitamin C, zinc, multivitamin, iron, and aspirin placed on hold for seven days to see if these medications are contributing to nausea. Repeat labs ordered for 11/26/26 (CBC w/ differential and basic metabolic panel (BMP). Suspected bacterial pneumonia and wound infection.Review of the nurse's note dated 11/25/25 at 3:58 P.M. revealed the IV access team called at this time regarding still no nurse out to facility to assess midline. Reported they were going to reach out to nurse assigned and call facility back.Review of the nurse's note dated 11/25/25 at 4:31 P.M. revealed as this nurse was assessing the Midline IV to change the dressing due to soiling, this nurse started to take off the soiled dressing, and the Midline IV came out of resident's arm. Midline IV intact. No bleeding at site noted. No pain reported. The CNP was notified that we were waiting on the IV access team.Review of the Doctor CNP note dated 11/25/25 revealed the CNP was notified of the Midline IV not being intact. Gave verbal order for one dose of Invanz 500 mg (antibiotic) intramuscular (IM) times one dose and to start Invanz 500 mg IV daily times three days to start tomorrow evening.Review of the nurse's note dated 11/25/25 at 6:47 P.M. for urinalysis culture and sensitivity (UA C/S) reordered for tomorrow 11/26/25 due to the previous UA C/S was contaminated. Order faxed over to lab at this time.Review of the nurse's note dated 11/26/25 at 12:27 A.M. revealed a new Midline IV was started. Review of Resident #313's wound assessment report dated 11/27/25 signed by Wound NP #601 revealed the coccyx wound was an unstageable pressure ulcer measuring 2.5 cm by 2.0 cm by 1.1 cm with 100% slough, with undermining 1.2 cm from six o'clock to six o'clock, the peri-wound had erythema, warmth to touch. The treatment was changed to cleanse with NSS, apply barrier cream to peri-wound, and 1/4 Dakin's moistened gauze to the wound with a gentle boarder dressing BID.Review of the TAR for November 2025 revealed the treatment order to the coccyx was signed off as completed from 11/21/25 through 11/27/25.Review of the facility weekly wound summary dated 11/28/25 revealed Resident #313's coccyx would remained unstageable measuring 2.5 cm by 2.0 cm by 1.1 cm with 100% slough, with undermining 1.2 cm from six o'clock to six o'clock, the peri-wound had erythema, warmth to touch. The treatment was changed to cleanse with NSS, apply barrier cream to peri-wound, and 1/4 Dakin's moistened gauze to the wound with a gentle boarder dressing BID. Recommend sending the resident to the hospital for further evaluation for osteomyelitis.Review of the nurse's note dated 11/28/25 at 10:32 A.M. revealed Wound Nurse #600 rounding with Wound NP #601. Per recommendation of the Wound NP, Resident #313 to be sent to emergency department (ED) for further imaging and treatment. Resident denies pain at this time. ADON #671 assisted with paperwork, calling report to ED. ADON #671, wound nurse call and update daughter. Daughter in agreement. Review of the nurse's note dated 11/28/25 at 11:02 A.M. squad in to transport Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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: The nursing home is disputing this citation.	#313 to ED.Review of the nurse's note dated 11/28/25 at 6:57 P.M. revealed Resident #313 was admitted to the hospital for wound care and antibiotics. Review of the hospital records revealed Resident #313 was admitted to the hospital for a sacral wound infection measuring 3.0 cm by 2.0 cm. Mild erythema around the wound edges. No significant pus draining from the wound. Packing removed and replaced with a wet to dry dressing. CT scan confirmed interval worsening of her decubitus ulcer from 10/09/25. Impression Stage IV decubitus ulcer. No obvious active infection. Chronic wound with eschar. Agree with Dakin's quarter percent solution to wound and cover with foam border dressing daily. Will reevaluate and consider bedside removal of eschar. Eventual DuoDERMdressing based on the patient's overall condition. No indication for surgical intervention at this time. Urinalysis was negative for UTI. Review of the plan of care created on 12/01/25 (first plan of care regarding wounds) revealed Resident #313 re-admitted from the hospital with a Stage III pressure ulcer related to immobility and decline in condition. On 11/21/25 wound downgraded to unstageable wound. Interventions included foam cushion when up in Broda chair, administer medications as ordered and monitor/document for side effects and effectiveness, apply bilateral foot pillows when in bed, assess/record/monitor wound healing at least every week, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the physician, follow facility policies/protocols for the prevention/treatment of skin breakdown, inform the resident/family/caregivers of any new area of skin breakdown, monitor dressing frequently to ensure it is intact and adhering, report lose dressing to treatment nurse, monitor nutritional status, serve diet as ordered, monitor intake and record, obtain and monitor lab/diagnostic work as ordered, report results to physician and follow up as indicated, resident requires: supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing, treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort, and utilize low loss air mattress with siderailsReview of the re-admission note dated 12/03/25 revealed resident #313 was readmitted to the facility with orders for IV Vancomycin (antibiotic) for wound infection and bacterial pneumonia. CT scan in the hospital showed worsening of sacral decubitus ulcer and possible pneumonia. Admit for further workup and IV antibiotics. Review of the weekly wound summary dated 12/05/25 revealed the coccyx wound is a 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) measuring 2.1 cm by 1.5 cm by 1.2 cm with 40% granulation and 60% slough. The wound is improving with undermining 2.2 cm from six o'clock to six o'clock. The peri-wound erythema much improved, pink brown skin, hyperpigmentation, no warmth. No new orders. Treatment barrier cream to the peri-wound, Santyl, calcium alginate rope gently place to the wound bed and undermining, cover with a foam dressing daily. Review of the plan of care revised on 12/09/25 revealed Resident #313 re-admitted from the hospital with a Stage III pressure ulcer related to immobility and decline in condition. On 11/21/25 wound downgraded to unstageable wound. On 12/05/25 wound upgraded to Stage IV per provider. No new interventions were listed.Review of the weekly wound summary dated 12/12/25 revealed the coccyx wound is a Stage IV measuring 2.1 cm by 1.5 cm by 1.2 cm with 50% granulation and 50% slough. The wound is improving with undermining 2.2 cm from six o'clock to six o'clock. The peri-wound erythema much improved, pink brown skin, hyperpigmentation, no warmth. No new orders. Continue current supplements. Review of the weekly wound summary dated 12/19/25 revealed the coccyx wound was a Stage IV measuring 2.1 cm by 1.2 cm by 1.1 cm with 60% granulation and 40% slough. The wound was improving with delayed wound closure with undermining 2.25 cm from six o'clock to six o'clock. There was a moderate amount of yellow drainage. Treatment was to cleanse the coccyx wound with NSS, apply Medi-honey, alginate roping, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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: The nursing home is disputing this citation.	apply barrier cream to the peri-wound and cover with a foam dressing.Review of the weekly wound summary dated 12/26/25 revealed the wound was a Stage IV measuring 2.1 cm by 1.2 cm by 1.1 cm with 60 % granulation and 40 % slough. The wound was improving with delayed wound closure with undermining from six o'clock to six o'clock . There was moderate amount of yellow drainage. Treatment was to cleanse the coccyx wound with NSS, apply Medi-honey, alginate roping, apply barrier cream to the peri-wound and cover with a foam dressing. No new orders. Resident # 313 was medicated one hour prior to wound care. Review of the weekly wound summary dated 01/02/26 revealed the coccyx wound was a Stage IV measuring 2.2 cm by 1.0 cm by 1.1 cm with 70% granulation and 30% slough. The wound is improving with delayed wound closure with undermining 2.5 cm from six o'clock to six o'clock. There was a moderate amount of yellow drainage. Treatment was to cleanse the coccyx wound with NSS, apply Medi-honey and pack with Hydrofera Blue (wet with NSS). Apply barrier cream to the peri-wound and cover with a foam dressing times three days Monday, Wednesday, Friday and as needed. Resident #313's wound could not be observed as she was admitted to the hospital on [DATE] and not available during the survey.Interview on 01/07/26 at 9:42 A.M. with the Director of Nursing (DON) revealed the facility did not have an in-house wound care team from July or August 2025 until November 2025. Licensed Practical Nurse (LPN) #600 was assessing all facility wounds with the assistance of Registered Nurse (RN) #638. The DON revealed orders were being managed by Medical Director #697 and Nurse Practitioner (NP) #698 or previous Wound NP #699 for wound care until Healing Partners started in November. The DON verified orders were not transcribed and a lapse of treatment did occur while transitioning of wound care team.Interview on 01/07/26 at 11:05 A.M. with LPN #600, the facility wound care nurse, revealed Resident #313 was very well known to her. However, she was unable to stage wounds and completed rounds with RN #638 to provide assessment and staging wounds. Wound care orders were followed from current Wound NP #698 or previous Wound NP #699. Interventions included and air mattress, every two hour turns, and Broda chair to relieve pressure, supplements Boost/Med pass, foot pillows, and continued lab work. LPN #600 revealed an x-ray was done on 11/21/25 in the facility to rule out osteomyelitis, and Resident #313 was sent to hospital on [DATE] for further (wound care) treatment. LPN #600 stated she noticed the wound worsening around one of the re-admissions from hospital. She notified the resident's daughter of the wound condition and plans to treat. LPN #600 proceeded to treat per orders from Wound NP #698 or hospital. Two incidents of bedside debridement by Wound NP #601 on 12/26/25 and 01/02/26 occurred. Resident #313 had increased pain during debridement and pain medication was administered one hour prior to debridement.Interview with Dietitian #665 on 01/07/26 at 11:59 A.M. revealed Resident #313 had numerous changes to supplements. Resident #313 would be ok for a few days and then decide she didn't like them. She had gone round and round about what she would accept and what she wouldn't. Resident #313 was hospitalized a lot recently and had been declining, but Resident #313's weight had stabilized, intakes varied daily, but good approximately about 25-100% with supplements. She was monitoring her weight loss due to fluid changes. Since December, after re-admission from hospital, she had concerns with wounds, which were improving. She had no concerns about staff feeding her and consistency with staff and fed her well. Resident #313 was on fluid restriction, but that was discontinued about three weeks ago. Resident #313 had orders to assess weight weekly for four weeks with each hospitalization and re-admission, but she was weighed more often than that. Dietitian #665 had been concerned about Resident #313's weight since October, and diet orders have been changed to nectar thick liquids, but she was now receiving regular liquids. Dietitian #665 attended weekly discussions at morning meeting and provided the facility with the weight change list. ADON #671 or LPN #600 were notified to enter into the medical record. Resident #313's daughter provided Juven (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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: The nursing home is disputing this citation.	(nutritional supplement) stating, give her Juven if she refuses the others which was not an appropriate substitution for the Ensure. Dietitian #665 indicated Resident #313 would need to eat a lot in order for Juven to work. She indicated that facility staff always follow through with nutritional recommendations. Dietitian #665 feels Resident #313 and her daughter were both barriers to treatment/plan of care.Interview with Wound NP #601 on 01/08/26 at 12:32 P.M. revealed concerns of Resident #313's coccyx wound upon initial assessment on 11/21/25. Wound NP #601 revealed the wound was unstageable and Resident #313 was ordered lab work, x-ray, and antibiotics. Resident #313 was medicated for pain and bedside debridement was performed without issues or concerns. Wound care treatment orders were placed, and coccyx wound was improving. But Resident #313 was sent to hospital for surgical debridement. Wound NP #601 indicated Resident # 313 had chronic complex medical history and poor nutrition contributing to wound care complications. Wound NP #601 did not believe the wound was a Kennedy ulcer.Interview with CNP #698 on 01/08/26 at 1:00 P.M. revealed she was aware of the gap in Resident #313's wound care from the end October to end of November 2025. CNP #698 observed coccyx wound over a two-to-three-week period. Resident #313 had mostly supplements for intake and poor intake. CNP #698 indicated the wound progressed quickly likely in part she believed due to Resident #313's malnutrition and documented refusals to get out of bed per Resident #313 and her daughter's request. CNP #698 encouraged Resident #313 to be out of bed for meals.Review of the facility policy titled Pressure Injuries Prevention, dated April 2020, revealed the facility would conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium trochanter, etc.) This deficiency represents non-compliance investigated under Complaint Number 2701482.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on personnel record reviews and staff interviews, the facility failed to ensure a staff member working in the capacity of a Certified Nursing Assistant (CNA) met the state and federal requirements prior to providing direct resident care. The facility permitted CNA #674 to perform CNA duties without successfully completing the competency evaluation and obtaining an active CNA certification. This had the potential to affect all residents residing in the facility. The facility census was 60.Findings include:Interview with the Human Resources (HR) Director #628 on 01/07/26 at 11:13 A.M. revealed CNA #674 was hired at the facility on 07/26/24. He completed first Nurse Aide Training class on 07/23/24; he later took his test but did not pass the written portion of the test. The HR Director further stated CNA #674 tested again but again did not pass the written portion of the test. The HR Director stated CNA #674 did not show up to take his third test and was unable to test again until he took entire Nurse Aide Training class again. CNA #674 completed the entire Nurse Aide Training class again on 06/17/25 and subsequently failed the written portion of the test again. The HR Director stated CNA #674 was terminated on 01/05/26. Interview with HR Director #628 further revealed CNA #674 was not listed in the Nurse Aide Registry as he had no certification as he was unable to pass the test. CNA #674 was employed at the facility for 17 months and provided care to residents throughout the facility. Review of the personnel record for CNA #674 revealed certificates of completion for two Nurse Aide Training classes but no Nurse Aide Registry check verification.This deficiency represents noncompliance investigated under Complaint Numbers 2603290 and 1387209 (OH00166324).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, facility policy review, review of guidelines from the Centers for Disease Control and Prevention (CDC), the facility failed to ensure staff used appropriate infection control practices for Resident #305 during incontinence care and Resident #337 during wound care. This affected two residents (#305 and #337) of three residents reviewed for infection control and had the potential to affect all 60 residents residing in the facility.Findings include:1. Review of the medical record revealed Resident #305 was admitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, fall on same level, unspecified, subsequent encounter, encounter for other orthopedic aftercare cardiomegaly, muscle weakness (generalized),other symbolic dysfunctions, cognitive communication deficit, need for assistance with personal care, vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, gastro-esophageal reflux disease without esophagitis, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified osteoarthritis, unspecified site, hyperlipidemia, unspecified major depressive disorder, recurrent, unspecified essential (primary) hypertension, presence of cardiac pacemaker other insomnia, low back pain, unspecified, personal history of pulmonary embolism, anemia, unspecified personal history of COVID-19, vitamin D deficiency, unspecified, vitamin B12 deficiency anemia, unspecified disorder, unspecified, other cervical disc degeneration, unspecified cervical region age-related, osteoporosis without current pathological fracture, nonrheumatic mitral (valve) insufficiency, and abdominal hernia without obstruction or gangrene. Review of the Minimum Data Set (MDS 3.0) assessment dated [DATE] revealed Resident #305 has an impaired cognition; she was dependent on staff for activities of daily living (ADL) and always incontinent of bowel and bladder and dependent for continence care. Observation and interview on 01/06/26 from 10:54 A.M. to 11:05 A.M. of Resident #305 for incontinence care revealed Licensed Practical Nurse (LPN) #604 and Certified Nurse Aide (CNA) # 647 placed the supplies on a barrier on the bedside table, pulled the curtain and washed their hands. The procedure was explained and permission granted for observation. Clean gloves were donned, and Resident #305's clothing and soiled brief were removed. LPN #604 explained the procedure and wiped Resident #305 front to back. At 10:58 A.M. Resident #305 was rolled and CNA #647 wiped the resident front to back. A clean brief was applied. At 10:59 A.M. CNA #647 doffed gloves and applied clean gloves without washing her hands to obtain new pair of pants for Resident #305. Pants were applied without difficulty. At 11:01 A.M. LPN #604 doffed soiled gloves and hand hygiene was performed. At 11:02 A.M. CNA #647 removed the soiled linens and removed trash. At 11:04 A.M. LPN #604 confirmed she did not apply clean gloves or use proper hand hygiene between the soiled brief and the clean brief. At 11:05 A.M. CNA #647 confirmed she did not apply clean gloves or use proper hand hygiene between the soiled brief and the clean brief. 2. Review of the medical record revealed Resident #337 was admitted to the facility on [DATE] with diagnoses including hypertensive heart and chronic kidney disease with heart failure and stage I through stage IV chronic kidney disease, or unspecified chronic kidney disease, type II diabetes mellitus with diabetic nephropathy, schizoaffective disorder, depressive type, dependence on renal dialysis, other cord compression, spinal stenosis, cervical region, post-traumatic stress disorder, chronic, atherosclerotic heart disease of native coronary artery without angina pectoris, gastro-esophageal reflux disease without esophagitis, heart failure, unspecified, neuromuscular dysfunction of bladder, unspecified, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, hyperlipidemia, unspecified, hypothyroidism, unspecified, essential (primary) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Geneva	839 W Main Street Geneva, OH 44041

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypertension, arteriovenous fistula, acquired. Review of Resident #337's care plan dated 12/15/25 revealed a goal to promote wound healing. Right lateral wound care orders as follows for wound right lateral ankle pressure ulcer/injury. Cleanse with normal saline, apply Skin-Prep to base of the wound, secure with bordered foam, change three times per week, and as needed (PRN). Review of the physician's orders revealed an order dated 12/15/25 for enhanced barrier precautions (EBP). Review of the Minimum Data Set (MDS 3.0) assessment dated [DATE] revealed Resident #337 was cognitively intact and was independent for all activities of ADL. Resident #337 had one 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 and tunneling) on her right lateral ankle, pressure reduction interventions in place. Observation of wound care on 01/07/26 at 10:55 A.M. though 11:02 A.M. revealed signage on the door for EBP. LPN #600 did not don proper protective equipment (PPE) prior to wound care for Resident #337. At 10:55A.M. the bedside table was sanitized, a barrier was placed and supplies were gathered. At 10:56 A.M. LPN #600 performed hand hygiene, and donned clean gloves. No additional PPE was donned. The soiled dressing with a date of 01/05/26 was removed and discarded. The soiled gloves were doffed and hand hygiene performed, and clean gloves were donned. The right lateral ankle wound was cleansed with normal saline; Skin Prep was applied with foam dressing and dated 01/07/26. The trash was pulled and discarded, gloves doffed, and hand hygiene performed. Interview on 01/07/26 at 11:02 A.M. with LPN #600 confirmed she did not don proper PPE prior to performing wound care for Resident #337. Interview on 01/07/26 at1:03P.M. with the Director of Nursing (DON) confirmed the facility had a policy in place confirming PPE was required to be used for wound care. Review of the undated facility policy titled Standard Precautions revealed when to perform hand hygiene to include before and after direct contact with a resident's intact skin, after contact with body fluids or excretions, and after glove removal. Review of Hand Hygiene in Healthcare Settings, Healthcare Providers, Glove Use, last reviewed 01/08/21, from the Centers for Disease Control and Prevention, located at https://www.cdc.gov/handhygiene/providers/index.html revealed gloves are not a substitute for hand hygiene. Change gloves and perform hand hygiene during patient care if gloves become visibly soiled with blood or body fluids following a task and moving from work on a soiled body site to a clean body site on the same patient. This deficiency was an incidental finding identified during the complaint investigation.