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	04/16/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, email correspondence review and facility policy review, the facility failed to release a deceased resident to the correct funeral home. This affected one resident (#58) of three residents reviewed for resident rights. The facility census was 55.Findings include:Review of the medical record for Resident #58 revealed he was admitted to the facility on [DATE] with diagnoses that included aftercare following joint replacement surgery, dementia, and type two diabetes. Resident #58 expired and was discharged from the facility on [DATE].Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 had a death in the facility.Review of the care plan dated [DATE] revealed Resident #58 had a long-term placement in the facility and had an advanced directive of Do-Not-Resuscitate Comfort Care Arrest (DNR-CCA) with interventions that included providing comfort, dignity, safety and providing funeral arrangements as needed.Review of the physician order dated [DATE] revealed an order for DNR-CCA.Review of the physician orders dated [DATE] revealed an order to notify hospice care of all concerns, condition changes and/or symptom management. Review of Resident #58's face sheet in the electronic medical record revealed he had end of life care provided through hospice, had a Guardian in place, and had a pre-arranged funeral agreement with a funeral home.Review of the hospice admission document dated [DATE] revealed Resident #58 had a start of care dated [DATE] with a funeral home in place to receive his body at the time of his death. Review of the hospice Client Coordination Note Report (CCNR) dated [DATE] revealed Licensed Social Worker (LSW) #418 completed an initial assessment that revealed Resident #58 was a DNR-CCA and a crematorium was on record to receive his body at the time of death. Review of the progress note dated [DATE] at 12:57 P.M. revealed Licensed Practical Nurse (LPN) #903 confirmed the funeral home was the correct funeral home on file with Resident #58's Guardian. Review of the progress note dated [DATE] at 6:42 P.M. revealed LPN #405 documented Resident #58 had a time of death of 6:40 P.M. and Medical Director (MD) #421 and hospice were notified. Hospice was to notify Resident #58's Guardian and the funeral home. Review of the progress note dated [DATE] at 7:50 P.M. revealed LPN #704 released Resident #58's body to the crematorium. Review of the email correspondence dated [DATE] at 10:21 A.M. revealed Social Services Designee (SSD) #909 contacted hospice Staff Member (HSM) #420 regarding why hospice called the crematorium to pick up Resident #58's body when there were previous arrangements with the funeral home in place. Review of the correspondence revealed the funeral home was calling the facility requesting the body of Resident #58.Interview on [DATE] at 11:42 A.M. with hospice Registered Nurse (RN) #419 revealed Resident #58 was to be released to the crematorium and the information was confirmed with Resident #58's Guardian. RN #419 revealed all communication regarding Resident #58's plan of care was documented in his hospice file. RN #419 was unable to provide documentation regarding an agreement with the crematorium. Interview on [DATE] at 11:58 A.M. with the funeral home Office Manager (OM) #416 revealed Resident #58 was supposed to be released to the funeral home at the time of his death. Resident #58 had pre-arrangements in place, a designated plot, and was not to be cremated. Resident #58's pre-arrangements had been in place since 1987 and was paid (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	in full. Interview on [DATE] at 12:07 P.M. with LPN #903 revealed for residents that were admitted to hospice care, staff nurses were responsible to contact hospice companies at the time of resident's death. Resident #58 was admitted to hospice and had a guardian in place. LPN #903 stated she confirmed with Resident #58's Guardian that the funeral home was in place and was to be contacted at the time of his death. LPN #903 had never spoken to or heard of the crematorium and that she was present in the building at the time of Resident #58's death, but she did not make the call to the funeral home or the crematorium. Interview on [DATE] at 12:17 P.M. with Resident #58's Guardian revealed hospice and the funeral home were in place for end-of-life care for Resident #58. She was never aware of the crematorium until she received a call from them requesting paperwork. Resident #58's Guardian informed the crematorium that Resident #58's body was to be transferred to the funeral home, and he should never have been released to the crematorium. Interview on [DATE] at 12:29 P.M. with LSW #418 revealed she met Resident #58 one time during an initial assessment and confirmed with Resident #58's Guardian that the crematorium was the correct funeral home to be utilized at the time of his death. LSW #418 revealed all information regarding Resident #58's plan of care was confirmed, documented and located in his hospice file. LSW #418 was unable to provide documentation regarding an agreement with the crematorium. Interview on [DATE] at 12:48 P.M. with the crematorium Coordinator (COD) #417 revealed the crematorium picked up Resident #58's body from the facility after the facility contacted them. COD #417 verified there were no agreements, paperwork, pre-arrangements, burial plots, or plans regarding Resident #58. Resident #58's Guardian contacted the crematorium after being informed that the funeral home never received his body at the time of Resident #58 death. Resident #58 was in the crematorium's care for approximately three days before being released to the correct funeral home. COD #417 offered Resident #58's Guardian burial services but was informed services would not be switched. Follow-up interview on [DATE] at 2:51 P.M. with the funeral home OM #416 revealed Resident #58 was to be released to the funeral home upon his death and had pre-arrangements in place. Resident #58 was to be buried instead of cremated, and it further caused confusion because a burial plot was his wish per Resident #58 and his mother. SSD #909 informed the funeral home that the nurse at the time of Resident #58's death could not locate the paperwork regarding what funeral home to contact, so she contacted the nearest funeral home to the facility. OM #416 stated there was no documentation in Resident #58's medical record, hospice service agreement or crematorium agreement that stated he was to be released to the crematorium. Interview on [DATE] at 3:26 P.M. with LPN #405 revealed Resident #58 expired ten minutes before her shift ended. She contacted hospice and was informed hospice would make all the appropriate notifications including contacting the funeral home. LPN #405 stated she left prior to the pick-up of Resident #58's body. Interview on [DATE] at 3:50 P.M. with the Administrator and Director of Nursing (DON) revealed Resident #58 had pre-arrangements upon his death with the funeral home and it was well documented in his medical record. Interview with the Administrator and DON revealed the facility released Resident #58's body to the wrong funeral home and confirmed and verified the above information at the time of the interview.Review of the facility document titled Hospice Program undated, revealed the facility had a policy in place that collaboration with identified hospice services would coordinate care plans for residents receiving hospice services that would reflect the resident's goals and wishes, as stated in his and/or her advance directives and during ongoing communication with the resident and/or representative. Review of the facility document titled Resident Rights undated, revealed the facility had a policy in place that all residents would be treated with kindness, respect, dignity and had a right to a dignified existence, participate and his and/or her care planning and treatment, and exercise his and/or her rights as a resident. This deficiency represents non-compliance investigated under Master Complaint Number 2972803.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interviews, and review of a Self-Reported Incident (SRI), facility incident log, email correspondence, and facility policy, the facility failed to thoroughly investigate an injury of unknown origin. This affected one resident (#59) of three residents reviewed for abuse. The facility census was 55.Findings include:Review of the medical record for Resident #59 revealed she was admitted to the facility on [DATE] with diagnoses that included heart failure, pulmonary fibrosis, and dysphagia. Resident #59 was discharged from the facility on 01/16/26. Resident #59 had a designated Power of Attorney (POA), representative, and care conference person in place.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had a memory problem, modified independence regarding tasks of daily life, and was dependent on staff for activities of daily living (ADLs).Review of the care plan dated 10/31/25 revealed Resident #59 was a long-term resident and at risk for falls due to a history of falls with interventions that included encouraging family visits, participation in interdisciplinary meetings and providing assistance with ADLs.Review of the physician orders dated 01/12/26 revealed Resident #59 was a two-person mechanical lift for transfers and to turn and reposition every two hours as tolerated.Review of the incident log dated from January to April 2026 revealed Resident #59 had an unknown incident dated on 01/16/26.Review of the progress note dated 01/16/26 at 7:32 A.M. revealed at approximately 8:30 P.M. Resident #59 started complaining of pain in the left knee, after she had been checked and changed. Resident #59 was adamant about it and contacted her POA. The POA called and requested Resident #59 be sent to the emergency room (ER) for evaluation. Mobile x-ray was contacted but because of the winter weather could not proceed, so Resident #59 subsequently left the facility at 9:30 P.M. and was admitted to the hospital with a diagnosis of distal fracture of the femur and a urinary tract infection (UTI).Review of the progress note dated 01/26/26 at 6:08 P.M. revealed Resident #59 was transferred to a hospital Intensive Care Unit (ICU).Review of the progress note dated 01/30/26 at 3:13 P.M. revealed Resident #59's POA informed the facility that she would not be returning to the facility.Review of the SRI #269875 dated 01/26/26 revealed an allegation and/or suspicion of an injury of unknown origin after Resident #59 complained of knee pain and was found to have a femur fracture on 01/16/26. Resident #59 complained of left knee pain after receiving personal care from staff and as a result, Resident #59's POA requested she be sent to the hospital for evaluation. Resident #59 was subsequently diagnosed with a distal fracture of the femur and a UTI. Resident #59 started complaining about knee pain approximately 20 minutes after routine night care. Resident #59's roommate, Resident #29, revealed during the check and change, Resident #59 was yelling out and shortly after she was sent out. Certified Nurse Assistant (CNA) #902, who was present at the time of the alleged incident, revealed during check and change she rolled Resident #59 and she started resisting and pushing back and screaming. CNA #902 revealed she then rolled Resident #59 on her back and 20 minutes later she complained of knee pain. According to the SRI, Resident #59's closed fracture of the distal end of the left femur was assessed as most likely secondary to underlying chronic disease processes rather than acute trauma with no reported history of falls or physical injury. Further review of the SRI investigation revealed Resident #59 presented to the ER for left knee pain after being moved by a CNA; however, Resident #59 revealed her leg was pulled back and believed her leg was broken.Review of the email correspondence dated 01/21/26 at 4:31 P.M. revealed the Administrator informed Resident #59's POA that the facility's SRI investigation was completed and no incidents or trauma occurred and the fracture was pathological in nature. However, a contrasting hospital note dated 01/15/26 at 10:59 P.M. revealed Resident #59 had an acute, impacted distal femoral metaphyseal fracture that indicated a recently broken bone due to a specific trauma or injury with recommendation for surgery.Review of a follow-up nursing home note documented by Medical Director (MD) #421 dated 02/01/26 revealed Resident #59 had a recent fall (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	with a fracture to her distal left femur. Resident #59 was provided with a knee immobilizer after declining the recommendation for surgery.Interview on 04/13/26 at 10:34 A.M. with the Director of Nursing (DON) revealed she was unaware how Resident #59 sustained a fracture. The DON revealed that before Resident #59 was sent out to the hospital, she complained about pain and did not have a fall to her knowledge. The DON revealed Resident #59 had been pushing against her bed while care was being provided. The DON, after being questioned on a documented fall and acute fracture in hospital paperwork, revealed MD #421 sometimes got behind on his notes and/or was inaccurate in documenting events. The DON revealed she would reach out to MD #421 for clarification.Follow-up interview on 04/13/26 at 2:30 P.M. with the DON revealed she spoke with MD #421 regarding documenting Resident #59 having a fracture after sustaining a fall in her medical record. The DON revealed MD #421 stated, So, she didn't have a fall? when questioned and was unable to confirm or deny if Resident #59 had a fall. The DON revealed she was unable to provide any other documentation regarding the SRI, the documented fall, and the ambiguity between an acute and/or pathological fracture. The DON confirmed and verified the above findings at the time of the interview.Review of the facility document titled Abuse, Neglect, Exploitation or Misappropriation- reporting and Investigating undated, revealed the facility had a policy in place that all allegations would be thoroughly investigated.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interviews, and facility policy review, the facility failed to provide bed hold notifications. This affected two residents (#28 and #59) of three residents reviewed for bed hold notices. The facility census was 55.Findings include:1. Review of the medical record for Resident #28 revealed he was admitted to the facility on [DATE] with diagnoses that included atherosclerosis heart disease, post-laminectomy syndrome, and hypertension. Resident #28 had a designated representative, and care conference person in place.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of seven, that indicated he was alert and oriented with cognition impairment. Resident #28 was impaired on both sides of the upper extremities and dependent on staff for activities of daily living (ADLs).Review of the care plan dated 03/08/26 revealed Resident #28 was a long-term resident and was not determined to return to the community.Review of the progress note dated 08/02/25 at 3:28 P.M. revealed Resident #28 was sent to the hospital via emergency services after a change in condition.Additional review of Resident #28's medical record revealed bed hold notifications of days remaining were not provided to Resident #28 and/or representative upon discharge and/or transfer to the hospital for 08/02/25.2. Review of the medical record for Resident #59 revealed she was admitted to the facility on [DATE] with diagnoses that included heart failure, pulmonary fibrosis, and dysphagia. Resident #59 was discharged from the facility on 01/16/26. Resident #59 had a designated Power of Attorney (POA), representative, and care conference person in place.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had a memory problem, modified independence regarding tasks of daily life, and was dependent on staff for ADLs.Review of the care plan dated 10/31/25 revealed Resident #59 was a long-term resident and was not determined to return to the community.Review of the progress note dated 09/18/25 at 8:35 A.M. revealed Resident #59 was sent to the hospital via emergency services after a change in condition.Review of the progress note dated 11/28/25 at 11:02 A.M. revealed Resident #59 was sent to the hospital via emergency services after a change in condition.Additional review of Resident #59's medical record revealed bed hold notifications of days remaining were not provided to Resident #59 and/or representative upon discharge and/or transfer to the hospital for 09/18/25 and 11/28/25.Interview on 04/13/26 at 10:19 A.M. with Admissions Director (AD) #801 revealed residents that were sent to the hospital and were returning to the facility under Medicaid, received a bed hold notice detailing insurance covered days to hold their bed. All bed hold policies and bed hold notices were in the resident's medical record. AD #801 revealed initially Resident #59 was informed of remaining bed hold days and once her cognition declined, Resident #59's POA was notified thereafter. AD #801 stated Resident #59 and Resident #59's POA were informed of remaining bed hold days for all discharge and/or transfers to the hospital; however, upon review of Resident 59's medical record with AD #801 present, it revealed there were no bed hold notifications for the dates of 09/18/25 and 11/28/25. AD #801 confirmed and verified the above findings at the time of the interview.Review of the facility document titled [NAME]-[NAME] Bed Hold Policy undated, revealed the facility had a policy in place that upon admission and any discharge and/or transfers thereafter, residents and/or representatives would be provided a bed hold letter and policy outlining days remaining.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interviews, and review of email correspondence, insurance statement and facility policy, the facility failed to ensure the physician did not falsely document and bill for services not provided. This affected one resident (#59) of ten residents reviewed for false billing. The facility census was 55.Findings include:Review of the medical record for Resident #59 revealed she was admitted to the facility on [DATE] with diagnoses that included heart failure, pulmonary fibrosis, and dysphagia. Resident #59 discharged from the facility on 01/16/26.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had a memory problem, modified independence regarding tasks of daily life, and was dependent on staff for activities of daily living (ADLs).Review of the care plan dated 10/31/25 revealed Resident #59 was a long-term resident and was not determined to return to the community.Additional review of Resident 59's medical record revealed she transferred to the hospital on [DATE] for a change in condition and did not return to the facility. The facility stopped billing on 01/30/26.Review of the progress note dated 01/30/26 at 3:13 P.M. revealed Resident #59 was not returning to the facility following her transfer to the hospital on [DATE].Review of the after-visit summary dated 02/01/26 (approximately 16 days after Resident #59 transferred to the hospital without returning and two days after being officially declared discharged from the facility) revealed Resident #59 was examined by Medical Director (MD) #421 in the facility. Resident #59 discussed with MD #412 her closed fracture of the distal end of the left femur, urinary tract infection, acute kidney injury, low sodium levels, pressure ulcer of sacral region, atrial fibrillation, depression, anemia, chronic kidney infection, osteoarthritis, gout, blood clot in legs, hypothyroidism, and her risk for falls. MD #421 recorded Resident #59's blood pressure reading of systolic 128 and diastolic 82, temperature of 98.2 degrees Fahrenheit, a pulse of 84, and respirations of 18.Review of Resident #59's insurance statement of charges billed dated 03/06/26 revealed MD #421 charged for doctor and nursing home care on 02/01/26 and a payment was processed and received.Interview on 04/13/26 at 10:19 A.M. with Admissions Director (AD) #801 verified Resident #59 was a resident in the facility from 12/30/21 until 01/30/26, with her actual date of leaving the facility being 01/16/26. AD #801 stated Resident #59 should not have been billed for any days after 01/30/26.Interview on 04/13/26 at 10:34 A.M. with the Director of Nursing (DON) revealed sometimes MD #421's documentation was not accurate with dates and sometimes it was off by a few days. The DON confirmed and verified Resident #59 was not in the facility at the time the after-visit was completed and acknowledged the documentation regarding the after-visit was incorrect.Interview on 04/13/26 at 2:45 P.M. with the Administrator revealed MD #421 was in the process of writing a retraction statement confirming and verifying he did not see Resident #59 and was in the process of reimbursing Medicare and/or Medicaid for services billed that did not occur. The Administrator revealed MD #421 did not know why he wrote that he visited Resident #59 on 02/01/26 at the facility when she was no longer a resident at that time.Review of the email correspondence dated 04/13/26 at 3:49 P.M. revealed MD #421 reviewed the date of service of 02/01/26 and confirmed and verified he documented seeing Resident #59 at the facility when she had transferred to the hospital with no return on 01/16/26.Review of the facility document titled Charting and Documentation revised July 2017, revealed the facility had a policy in place to document objective, complete and accurate information in the resident medical record. This deficiency represents non-compliance investigated under Complaint Number 2744637.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 resident record review, staff interviews, and facility policy review, the facility failed to ensure the resident record was documented accurately. This affected one resident (#59) of ten residents reviewed for accurate medical records. The facility census was 55.Findings include:Review of the medical record for Resident #59 revealed she was admitted to the facility on [DATE] with diagnoses that included heart failure, pulmonary fibrosis, and dysphagia. Resident #59 was discharged from the facility on 01/16/26.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had a memory problem, modified independence regarding tasks of daily life, and was dependent on staff for activities of daily living (ADLs).Review of the care plan dated 10/31/25 revealed Resident #59 was a long-term resident and was not determined to return to the community.Additional review of Resident 59's medical record revealed she transferred to the hospital on [DATE] for a change in condition and did not return to the facility. Review of the progress note dated 01/30/26 at 3:13 P.M. revealed Resident #59 was not returning to the facility following her transfer to the hospital on [DATE].Review of the after-visit summary dated 02/01/26 (approximately 16 days after transferring to the hospital without returning and two days after being officially declared discharged from the facility) revealed Resident #59 was examined by Medical Director (MD) #421 in the facility. Resident #59 discussed with MD #412 her closed fracture of the distal end of the left femur, urinary tract infection, acute kidney injury, low sodium levels, pressure ulcer of sacral region, atrial fibrillation, depression, anemia, chronic kidney infection, osteoarthritis, gout, blood clot in legs, hypothyroidism, and her risk for falls. MD #421 recorded a blood pressure reading of systolic 128 and diastolic 82, temperature of 98.2 degrees Fahrenheit, a pulse of 84, and respirations of 18.Interview on 04/13/26 at 10:19 A.M. with Admissions Director (AD) #801 revealed Resident #59 was a resident in the facility from 12/30/21 until 01/30/26, with her actual date of leaving the facility being 01/16/26. Interview on 04/13/26 at 10:34 A.M. with the Director of Nursing (DON) revealed sometimes MD #421 documentation was not accurate with dates and sometimes was off by a few days. The DON confirmed and verified Resident #59 was not in the facility at the time the after-visit was completed and acknowledged the documentation regarding the after-visit was incorrect.Interview on 04/13/26 at 2:45 P.M. with the Administrator confirmed and verified the after-visit summary documented in Resident #59 medical record on 02/01/26 was incorrect.Review of the facility document titled Charting and Documentation revised July 2017, revealed the facility had a policy in place to document objective, complete and accurate information in the resident medical record. This deficiency represents non-compliance investigated under Complaint Number 2744637.