STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366062	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caprice Health Care Center	9184 Market St North Lima, OH 44452

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record reviews, resident interviews, staff interviews, and facility policy review, the facility failed to ensure call lights were within reach of residents. This affected two residents (#11 and #12) of seven residents reviewed for call lights. The facility census was 69.Findings include: 1. Review of the medical record for Resident #11 revealed he was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, spinal stenosis of the lumbar region with neurogenic claudication, and discitis.Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had moderate cognitive impairment. Resident #11 was impaired on one side of upper extremities and was dependent on staff for activities of daily living (ADLs).Review of the care plan dated 09/26/25 revealed Resident #11 was at risk for falls related to decreased physical mobility, weakness, Alzheimer's disease, and a history of falling with interventions that included, but not limited to, encourage use of call light to ask for assistance, explain use of call light, and keep call light within reach at all times when in room.Review of the physician orders dated 09/25/25 revealed an order for safety checks every two hours.Review of the physician orders dated 10/15/25 revealed an order for the left side of bed to always be against the wall and offer Resident #11 to lay down in bed after meals for rest periods.Review of the physician orders dated 01/16/26 revealed an order for Hoyer lift (mechanical lift) for all transfers (two staff member assistance).Interview and observation on 03/09/26 at 9:15 A.M. revealed Resident #11 sitting up in bed with his call light was not visible. Resident #11 stated What is that? when questioned where his call light was.Interview and observation on 03/09/26 at 9:18 A.M. with Licensed Practical Nurse (LPN) #612 revealed Resident #11 was total care, dependent on staff for ADLs and his call light should always be within reach. Upon entering Resident 11's room, he was sitting up in bed with his call light not visible or in reach. LPN #612 was then observed following the cord connected to the wall outlet designated for the call light, around the privacy curtain, around the bedside table, which was located approximately five feet away, tucked beneath various items on Resident #11's recliner. LPN #612 stated Oh, this shouldn't be here, and clipped the call light to Resident #11's shirt. Resident #11 was then observed asking LPN #612, What is this? So, they can come in? after explanation of use of call light. Resident #11 then stated, I think they brought this in the beginning when I got here, then it slowly drifted away day by day and I never seen it again. LPN #612 confirmed and verified the above findings at the time of observation. 2. Review of the medical record for Resident #12 revealed she was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, tracheostomy, dependence on respirator ventilator, and dysphagia.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had a memory problem and was severely impaired for decision making regarding tasks of daily living. Resident #12 was dependent on staff for ADLs.Review of the care plan dated 12/24/25 revealed Resident #12 was at risk for falls related to decreased physical mobility with interventions that included, but not limited to, encourage use of call light to ask for assistance, explain use of call light, and keep call light within reach at all times when in room.Review of the physician orders dated 12/23/25 revealed an order for safety checks every two hours.Review of the physician orders dated 12/23/25 revealed an order for Hoyer (continued on next page)

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
	366062	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caprice Health Care Center	9184 Market St North Lima, OH 44452

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lift for all transfers (two staff member assistance) every day and night shift for safety.Observation on 03/09/26 at 9:03 A.M. revealed Resident #12 lying in bed with the call light not visible. When asked where her call light was, Resident #12 was observed to shrug her shoulders. Interview and observation on 03/09/26 at 9:06 A.M. with Certified Nursing Assistant (CNA) #508 revealed Resident #12 required assistance from staff for ADLs. CNA #508, upon entrance into Resident #12 room, revealed she did not know where Resident #12's call light was. Resident #12 was observed lying in bed without the call light within reach or visible. CNA #508 was then observed following the cord connected to the wall outlet designated for the call light and located the call light on the floor behind the cart of supplies, approximately five feet away. CNA #508 was observed placing call light near Resident #12 hand. CNA #508 confirmed and verified the above findings at the time of observation.Review of the facility policy labeled, Answering the Call Light, undated, revealed the facility had a policy in place to explain and demonstrate the call light and its use and ensure the call light was within reach of the resident.