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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366123 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/04/2025 |
| NAME OF PROVIDER OR SUPPLIER Accord Care Community Orrville LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 Lynn Drive Orrville, OH 44667 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</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

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Based on record review, observation and interview, the facility failed to maintain Resident #34's heel protector boots to prevent the development of pressure ulcers and failed to obtain laboratory tests and a wound clinic referral to manage Resident #52's wounds in a timely manner. This affected two residents (#34 and #52) out of three residents reviewed for wound care. The facility census was 57. Findings include: 1. A review of Resident #52's clinical record revealed an admission date of 10/23/25 and re-admission date of 11/18/25 with diagnoses including gastrointestinal hemorrhage, nontraumatic subarachnoid hemorrhage, trouble swallowing, diabetes mellitus, high blood pressure, anemia, heart failure, neuromuscular dysfunction of the bladder, sacral pressure ulcer, malnutrition, alcohol abuse, anxiety, depression, gastroesophageal reflux disease, peripheral vascular disease, hydrocephalus disease, aneurysm, cerebrovascular vasospasm, Cushing's disease (rare endocrine disorder where a benign pituitary tumor secretes too much, causing too much adrenocorticotrophic hormone, causing the adrenal glands to overproduce the stress hormone cortisol), constipation, obstructive and reflux uropathy. A review of Certified Nurse Practitioner (CNP) #91's progress note dated 11/04/25 indicated she wrote an order to obtain a referral to the wound clinic and to recheck laboratory test for a comprehensive metabolic panel (CMP). On 11/09/25 CNP #91's progress note indicated a referral was made on 11/04/25, and the facility had failed to call the wound clinic for the referral and had not obtained the laboratory test for the CMP as ordered on 11/04/25. Resident #52's wound documentation dated 12/01/25 indicated the presence of an unstageable pressure ulcer (a deep wound where the true depth and extent of tissue damage can't be determined because the base is covered by yellow (slough) or black/brown (eschar) dead tissue) on the sacrum measuring 12.1 centimeters (cm) long by 10.9 cm wide and 1.3 cm deep. An interview with CNP #91 on 12/03/25 at 9:51 A.M. verified the facility had not obtained the wound clinic referral and laboratory tests CNP #91 had ordered on 11/04/25. An interview on 12/03/25 at 3:35 P.M. with Regional Director of Clinical Operations (RDCO) #92 verified the above findings and agreed the staff had failed to draw the CMP laboratory test or submit a referral for the wound clinic to manage Resident #52's wounds. 2. Review of the medical record for Resident #34 revealed an admission date of 06/27/23 and a readmission date of 09/05/23. Diagnoses included diabetes mellitus, chronic kidney disease, and polyneuropathy. A review of Resident #34's care plan initiated on 06/30/25 indicated Resident #34 had potential for skin breakdown and required protective/preventative skin care maintenance to both heels. Interventions on the care plan included maintaining heel protector boots while in bed. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 09/22/25, revealed Resident #34 had moderately impaired cognition and was dependent on staff for activities of daily living (ADL). Review of the physician's orders for December 2025 revealed that Resident #34 was ordered bilateral heel protector boots while in bed as tolerated two times a day. Observation on 12/03/25 at 8:56 A.M. revealed that Resident #34 was lying in bed, her heel protector boots were lying against the wall. Resident #34 stated that her boots should have been on. This was verified by Licensed Practica Nurse (LPN) #56 at time of observation. LPN #56 stated that the boots should have been on Resident #34. This deficiency represents non-compliance investigated under Complaint Number 2667793.</p> | | |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, record review and interview, the facility failed to have a restorative program in place to prevent a decline residents' functional abilities and failed to ensure Resident #10's hand splints or rolled washcloths were maintained. This affected one resident (#10) out of three residents reviewed for contractures and had the potential to affect all residents who had therapy services. The facility census was 57. Findings include: A review of Resident #10's clinical record revealed an admission date of 11/21/24 and a readmission date of 04/08/25 with diagnoses including acute/chronic respiratory failure, high heart rate, bipolar disorder, anxiety, depression, obesity, epilepsy, herpes viral infection of urogenital system, chronic migraines, post-traumatic stress disorder, convulsions, persistent vegetative state, quadriplegia, anoxic brain injury, and contractures of the right and left hands. A review of Resident #10's physician order dated 04/08/25 indicated to apply a rolled washcloth to both hands two times a day for contractures. A review of Resident #10's care plan initiated on 03/06/25 and revised on 07/14/25 indicated an alteration in musculoskeletal status related to contractures due to quadriplegia. The goal of the care plan revealed Resident #10 would remain free of injuries or complications through the review date. Interventions on the care plan included applying rolled washcloths to both hands. An observation on 12/02/25 at 2:31 P.M. revealed Resident #10 had contractures of both hands. Resident #10's hands were clenched in a tight-fisted position without splints or rolled washcloths applied. Licensed Practical Nurse (LPN) #81 verified the absence of the splints (washcloths) at the time of the observation. An interview on 12/02/25 at 2:17 P.M. with LPN #90 stated the facility did not have a restorative program system in place to address range of motion exercises and/or restorative therapy recommendations. An interview with Therapy Director (Certified Occupational Therapist (COTA)) #27 on 12/02/25 at 2:31 P.M. stated the therapy department did not provide restorative recommendations for the nursing staff to implement to prevent a decline in a resident's functional ability because the facility did not have a restorative program system in place. COTA #27 agreed the residents who had therapy services were at risk for declining after their therapy services were discontinued because there was no restorative services implemented after discontinuation of the therapy services. COTA #27 stated the facility would have the physician order an evaluation for the need for therapy services when a resident had a decline in their functional abilities. Observation on 12/03/25 at 2:17 P.M. with Assistant Director of Nursing (ADON) #85 verified that Resident #10 was not wearing her splints (washcloths) in her hands. ADON #85 verified the facility did not have a restorative program in place to prevent a decline in a resident's functional ability. This deficiency represents non-compliance investigated under Complaint Number 2661672.</p> | | |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 observation and staff interview, the facility failed to maintain a clean, sanitary, and safe environment. This affected three residents (#34, #57, and #36) of three residents reviewed for physical environment and had the potential to affect all 57 residents residing in the facility. Findings include: Observation on 12/03/25 at 8:56 A.M. revealed that Resident #34 was lying in bed, her comforter was dirty, the thermostat had no cover on it. This was verified by Licensed Practical Nurse (LPN) #56 at time of observation. Observation on 12/03/25 at 9:01 A.M. revealed Resident #57 had dirty sheets, the thermostat cover was off, and the strip of molding that belonged on the sink was leaning up against the wall in the bathroom. Resident #57 stated that he did not know how long the cover was missing but the molding for the bathroom sink was a couple of weeks. This was verified on 12/03/25 at 9:09 A.M. by Housekeeping Supervisor (HS) #64. Observation on 12/03/25 at 9:05 A.M. revealed Resident #36 had dirty sheets, and the cover was off the thermostat. This was verified on 12/03/25 at 9:05 A.M. by HS #64. Observation on 12/03/25 at 9:06 A.M. revealed Resident #42 had the strip of molding that belonged on the sink was leaning up against the wall in the bathroom. This was verified on 12/03/25 at 9:07 A.M. by HS #64. Interview on 12/03/25 at 9:33 A.M. with Regional Facilities Manager (RFM) #200 revealed that the former maintenance director resigned without working his notice out. RFM #200 stated that he did not know that molding was off the sinks or thermostat covers were missing. This deficiency represents noncompliance investigated under Complaint Numbers 2667793 and 2661672.</p> |