STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on observation, interview, record review and review of facility policy, the facility did not ensure all shower rooms used by residents were maintained at comfortable temperatures. This affected four residents (Residents #4, #9, #23 and #26) and had the potential to affect all residents in the facility excluding 37 residents (#1, #2, #3,#8, #10, #12, #13, #15, #16, #17, #21, #24, #25, #27, #34, #35, #38, #42, #43, #46, #50, #51, #54, #56, #58, #59, #61, #62, #64, #66, #70, #72, #73, #77, #78, #80, and #84) the facility identified as having personal showers in their resident rooms. The facility census was 87. Findings include: 1. A facility tour was conducted on 03/24/25 at 10:30 A.M. with Maintanence Director (MD) #257 and revealed the facility had two shower rooms for resident use. The first shower room observed was between the 400 and 500 unit hallways. MD #257 took the ambient temperature in the shower room and stated it was 64.8 degrees Fahrenheit (F). The second shower room observed was between the 200 and 300 unit hallways. MD #257 took the ambient temperature in the shower room and stated it was 55.9 degrees F. MD #257 verified the temperatures at the time of the observation. A review of the Resident Council meeting minutes, dated 01/16/25 and 02/20/25, revealed a complaint the shower rooms were too cold. On 03/25/25 at 10:38 A.M. an interview with the Assistant Director of Nursing #210 verified the Resident Council meeting minutes and the complaints within stating shower rooms were too cold. 2 A review of medical records for Resident #4 revealed a date of admission of 08/17/23 with diagnoses including chronic obstructive pulmonary disease (COPD)and the need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 was cognitively intact, and required substantial to maximal assistance with bathing. Review of the care plan dated 01/24/25 revealed Resident #4 had an activity of daily living (ADL) self-care performance deficit and required assistance to bathe. (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
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/25 at 12:30 P.M. an interview with Resident #4 revealed the shower rooms were sometimes cold. 3. A review of medical records for Resident #9 revealed an admitted [DATE] with diagnoses including cerebral infarction, metabolic encephalopathy and the need for assistance with personal care. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #9 was cognitively intact and required substantial to maximal assistance for bathing. Review of the care plan dated 03/14/25 revealed Resident #9 had an ADL self-care performance deficit and required assistance to bathe. On 03/25/25 at 12:35 P.M. an interview with Resident #9 revealed the shower rooms were a little bit cold. 4. A review of medical records for Resident #23 revealed a date of admission of 12/29/23 with diagnoses including COPD and the need for assistance with personal care. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact and required substantial to maximal assistance for bathing. Review of the care plan dated 03/13/25 revealed Resident #23 had an ADL self-care performance deficit and required assistance to bathe. On 03/25/25 at 12:40 P.M. an interview with Resident #23 revealed the shower rooms were chilly. 5. A review of medical records for Resident #26 revealed a date of admission of 06/16/21 with diagnoses including obesity, muscle wasting, need for assistance with personal care, encounter for surgical aftercare following surgery on the nervous system, polyneuropathy, and chronic lymphocytic leukemia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #26 was cognitively intact and dependent for bathing. Review of the care plan dated 03/13/25 revealed Resident #26 had an ADL self-care performance deficit and required assistance to bathe. On 03/24/25 at 1:05 P.M. an interview with Resident #26 revealed the shower rooms were ice cold. A review of the policy titled Physical Environment, dated 06/14/19, revealed the facility will provide residents comfortable and safe temperature levels. The facility will maintain temperatures between 71 and 81 degrees F. This deficiency represents non-compliance investigated under Complaint Number OH00163927.

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(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	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** 48565 Based on record review, staff interview, and facility policy review, the facility failed to timely report an allegation of misappropriation of narcotic medications to the appropriate state agency. This affected two residents (#33 and #65) of three residents reviewed for misappropriation. The facility identified an additional 21 residents (#7, #14, #17, #18, #24, #26, #28, #31, #32, #59,#60, #68, #69, #74, #75, #76, #77, #80, #81, #83 and #85) as having physician orders for narcotic medications. The facility census was 87. Findings include: 1. A review of medical records for Resident #33 revealed a date of initial admission of 01/29/24, and a readmitted [DATE] with diagnoses including cirrhosis of the liver, chronic obstructive pulmonary disease (COPD), chronic viral hepatitis, hepatomegaly (liver enlargement) and cognitive communication deficit. Review of physician orders revealed orders for Norco oral tablet 5-325 milligrams (a synthetic opioid and painkiller), give one tablet by mouth every six hours as needed for pain, and fentanyl transdermal patch (a potent synthetic opioid medication used for pain) 72-hour 12 micrograms per hour, apply one patch transdermally (on the skin) one time a day every three days for pain. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 had moderate cognitive impairment and was to be on scheduled and as needed pain medications. Pain was noted in the last five days that was occasional in frequency. Review of the care plan dated 01/12/25 revealed Resident #33 was at risk for pain related to a history of hepatomegaly with ascites (a retention of fluid in the abdomen related to liver disease) and generalized discomfort. Interventions included administer analgesia (pain medication) per order, evaluate the effectiveness of pain interventions, review for compliance, alleviation of symptoms, dosing schedules and resident satisfaction with results on functional ability. Monitor and record pain characteristics, frequency, location, duration, type of pain, and precipitating and relieving factors. The care plan also revealed resident #33 was able to call for assistance when in pain, ask for medication, tell how much pain they experience, and express what increases or alleviates pain. A review of a narcotic count sheet dated 01/14 25 for hydrocodone (Norco) 5-325 milligram revealed one tablet signed out as given on 01/21/25 at 2:48 P.M. by Licensed Practical Nurse (LPN) #331. A review of the Medication Administration Record (MAR) for Resident #33 dated 01/01/25 through 01/31/25 revealed there was not a hydrocodone pill administered at 2:48 P.M. on 01/21/25. A review of progress notes revealed no documentation that a hydrocodone pill was administered at 2:48 P. M. on 01/21/25 for complaints of pain to Resident #33. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of medical records for Resident #65 revealed an admitted [DATE] with diagnoses including cervical root disorder, generalized arthritis, and radiculopathy of the cervical region (a pinched or irritated nerve in the neck causing pain, numbness or weakness radiating into the chest or arm). Physician orders included tramadol (an opioid pain medication used to treat moderate to severe pain) 50 mg, one tablet every six hours as needed for pain, and morphine sulfate (a potent opioid medication used to treat pain) 15 mg take one tablet by mouth every 12 hours as needed for chest pain. Review of the quarterly MDS dated [DATE] revealed Resident #65 had severe cognitive impairment and received as needed pain medication. There was occasional pain noted in the last five days of the look back. The pain intensity was rated at four on a scale of one to ten. Review of the care plan dated 01/07/25 revealed Resident #65 was at risk for unrelieved or untreated pain related to impaired cognition with a history of cervical neuropathy and spinal stenosis. Interventions included administer analgesia as ordered, evaluate the effectiveness of pain interventions after one hour and location, duration, type of pain, precipitating and relieving factors, and monitor and record symptoms of nonverbal pain. The care plan also revealed Resident # 65 was able to call for assistance when in pain, reposition self, and ask for medication. A review of the narcotic count sheet for Morphine 15 mg dated 01/20/25 revealed on 01/27/25 at 9:22 A.M. one tablet was signed out as given by LPN #331. A review of the MAR for Resident #65 dated 01/01/25 through 01/31/25 revealed no Morphine 15 mg signed out as given at 9:22 A.M. on 01/27/25. A review of progress notes revealed no documentation a Morphine pill was administered on 01/27/25 at 9:22 A.M. for complaints of pain to Resident #65. A review of the narcotic diversion investigation completed by the facility dated 02/05/25 revealed LPN #331 was sent for a drug screen on 02/05/25 and the instant drug test was positive. The specimen was then sent out for further testing. LPN #331 was suspended pending investigation. The final result was received 02/26/25. LPN #331 had a positive result for opiates, morphine, hydrocodone, oxycodone, and oxymorphone. LPN #331 was terminated and reported to the Board of Nursing. A review of the Ohio Department of Health (ODH) Certification and Licensure website revealed no self-reported incident (SRI) was reported to ODH by the facility in regard to the alleged drug misappropriation by LPN #331. On 03/24/25 at 10:15 A.M. an interview with the Administrator and the Director of Nursing (DON) revealed the facility had one nurse (LPN #331) suspected of taking resident narcotics as there were residents being medicated that normally do not complain of pain. The Administrator and the DON stated they were unable to prove a misappropriation of narcotics after an investigation, as residents did receive pain medications. Both verified an SRI was not filed regarding possible misappropriation of narcotics. The Administrator and DON verified LPN #331 had tested positive for multiple narcotics, so was reported to the Board of Nursing for further investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/17/22, revealed misappropriation was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of residence belongings or money without the resident's consent. The policy also stated allegations involving neglect, exploitation, mistreatment, or misappropriation of resident property and injuries of unknown source are reported to the Ohio Department of Health immediately, but no later than 24 hours from the time the incident or allegation was made known to the staff member. This deficiency represents non-compliance investigated under Complaint Number OH00163927.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, interview and review of facility policy the facility did not ensure Resident #26 received adequate supervision and assistance by staff when being transferred with a mechanical lift, and did not ensure adequate supervision was provided, fall interventions were in place at all times, and complete and thorough post-fall investigations including root cause analysis were done to prevent falls for Resident #77. This affected two residents (Residents #26 and #77) of three residents reviewed for falls. The facility census was 87. Findings include: 1. Record review was conducted for Resident #26 who was admitted to the facility on [DATE] with diagnoses including non-traumatic extradural hemorrhage, atrial fibrillation, anxiety, depression, neuromuscular dysfunction of bladder, fracture of unspecified part of neck of left femur dated 10/31/24, panic disorder, obesity, muscle wasting, need for assistance with personal care, encounter for surgical aftercare following surgery on the nervous system, polyneuropathy, and chronic lymphocytic leukemia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had no cognitive impairment and had no falls in the previous quarter. Review of the care plan dated 03/13/25 revealed Resident #26 was at risk for falls related to diagnosis of non-traumatic extradural hemorrhage, decreased strength, endurance, and balance, and required use of a mechanical lift for transfers. Interventions include apply nonskid pad to wheelchair, ensure call light was within reach, and resident requires transfers via full lift with two staff assist dated 02/10/2025. Resident #26 had a prior intervention for transfers via stand lift assist with two staff members dated 10/02/24. Other interventions included follow facility fall protocol, ensure resident wearing appropriate footwear, perform fall risk assessment on admission, quarterly and with any significant change or after any fall. Review of a physical therapy (PT) note dated 11/12/24 revealed Resident #26 was being seen for a pathological fracture of the left hip which was an incidental finding when Resident #26 was hospitalized for a urinary tract infection and hemorrhagic cystitis. The PT note also revealed per the orthopedic doctor, there may not be a fracture but an MRI (magnetic resonance imaging) test could not be performed to confirm due to the presence of a pacemaker. The orthopedic doctor recommended activity as normal. The PT note revealed the daughter of Resident #26 wanted the resident returned to a sit-to-stand mechanical lift transfer status. The note revealed the PT reached out to the doctor for a sit-to-stand transfer order. Review of physician orders for Resident #26 revealed an order dated 06/07/24 for a sit-to-stand lift (type of mechanical lift) with two staff assistance and an order dated 11/12/24 for a Hoyer lift (mechanical lift) with two staff assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 02/08/25 at 8:15 P.M. and authored by Licensed Practical Nurse (LPN) #203 revealed Resident #26 had to be lowered to the floor. Resident #26 was observed in the shower still attached to a sit-to-stand lift and sitting on her knees. There were no injuries noted, and Resident #26 was assisted back to her wheelchair using a Hoyer lift with two assistants. A review of the fall investigation that was undated and authored by the Director of Nursing (DON) revealed Resident #26 was being transferred via a sit-to-stand lift when her feet came off the stand lift and Resident #26 had to be lowered to the floor. The investigation also revealed Resident #26 was a sit-to-stand lift with two assists for transfers. Further review of the fall investigation documentation revealed a witness statement authored by Certified Nurse Assistant (CNA) #233 which stated CNA #233 was with Resident #26 at the time of the fall. The witness statement revealed Resident #26's feet were not all the way on the sit-to-stand lift. The witness statement also revealed she was the only staff member with Resident #26 at the time of the fall. An interview with the Assistant Director of Nursing (ADON) #210 and Registered Nurse (RN) #239 on 04/03/24 at 2:00 P.M. verified Resident #26 had orders for two person assistance with a mechanical lift. ADON #210 also verified CNA #233 was alone with Resident #26 and tried to perform the mechanical lift transfer by herself with no other staff present during the transfer. An interview on 04/03/25 at 2:30 P.M.with CNA #233 verified she was the only staff member with Resident #26 at the time of the fall. 2. Record review was conducted for Resident #77 who was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, repeated falls, dementia classified mild with psychotic disturbance, difficulty walking and other symbolic dysfunctions. Review of physician orders for Resident #77 revealed an order dated 02/03/25 for nonskid socks on at all times, an order dated 02/24/25 and timed 7:00 A.M. for a body pillow to open side of bed every shift and an order dated 02/24/25 and timed at 7:00 A.M. for a floor mat to open side of bed. Review of the change of condition Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating Resident #77 had severe cognitive impairment. Active diagnoses within the MDS included Parkinson's disease and repeated falls. The MDS also revealed , Resident #77 has had falls since admission. Two or more falls occurred since admission with no injury and two or more falls occurred since admission with injury. Review of the care plan initiated on 12/24/24 and updated on 03/28/25 revealed Resident #77 was at risk for falls related to history of falls, Parkinson's with tremors and rigidity, decreased functional status with impaired strength balance and safety impairments. Interventions included body pillow to open side of bed to be used when in bed dated 02/23/25, nonskid socks on at all times originally dated 12/24/24 and updated on 03/28/25, floor mat to open side of bed per order dated 03/28/25, follow facility fall protocol 12/24/24, resident requires two staff assist with transfers medical lift as needed with two assist originally dated 12/31/24 and updated 03/28/25, and perform fall risk assessment on admission, quarterly, with any significant change or after fall. The care plan also revealed Resident #77 had Parkinson's disease dated 12/24/24. Interventions included monitor risk for falls refer to fall protocol. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission fall assessment dated [DATE] revealed a score of 13 indicating a moderate risk for falls. A review of the incident log dated 01/02/25 through 03/24/25 revealed Resident #77 had falls on 02/03/25 , 02/22/25, 02/23/25 at 4:00 A.M. and 02/23/25 at 2:24 P.M., 03/06/25, and 03/16/25. A review of the fall investigation summary including the facility forms titled Personnel QAPI Statement for Falls dated 02/03/25 and authored by the Director of Nursing (DON) revealed Resident #77 slid off the side of the bed at 12:40 P.M. while trying to get out of bed. The summary also revealed Resident #77 was not wearing proper footwear as dated in the care plan 12/24/24. There was no root cause analysis completed within the investigation to determine how best to prevent further falls. A review of a fall assessment dated [DATE] revealed a score of 15 indicating a high risk for falls. A review of the fall investigation including the facility forms titled Personnel QAPI Statement for Falls dated 02/22/25 and authored by the DON revealed Resident #77 rolled out of bed and hit the right side of her head at 2:26 P.M. There was no root cause analysis completed within the investigation to determine how best to prevent further falls. A body pillow to the open side of the bed was the intervention put in place. Review of the facility fall investigation including the facility forms titled Personnel QAPI Statement for Falls, dated 02/23/25 revealed on 02/23/25 at 4:00 A.M. CNA #214 heard Resident #77 yelling out from her room and was found on the floor next to her bed. The body pillow was in place and the resident had non-skid socks on her feet. The resident sustained a scratch on her nose. A fall mat to the open side of the bed was the intervention put in place. This form indicated a QAPI 5 Whys - Root Cause would be completed yet this section was not filled out. Review of the Summary authored by the DON revealed a floor mat was placed to the side of the bed and the resident was sent to the emergency room (ER) for an evaluation. There was no documentation of a root cause analysis to determine how best to prevent further falls. The conclusion simply stated Resident #77 was attempting to get out of bed unassisted and slipped. She landed on her buttocks on the floor on the side of her bed. She scratched her nose on the bedframe. Review of the facility fall investigation including the facility forms titled Personnel QAPI Statement of Falls, dated 02/23/25 revealed on 02/23/25 at 2:00 P.M. Resident #77 had a witnessed fall by CNA #304 in her room. CNA #304 indicated on the document she had just toileted/changed the resident, the resident was in her bed in low position, non-skid socks were on, and a body pillow was in place. The resident stated she was reaching for something and fell out of bed hitting the back of her head. The resident was in severe pain and was sent to the ER. This form indicated a QAPI 5 Whys - Root Cause would be completed yet this section was not filled out. Review of the Summary authored by the Director of Nursing (DON) revealed the call light was in reach, non-skid socks on both feet, the reacher was next to the resident and the resident had two falls in the past day. There was no indication in the investigation that the fall mat was in place at the time of the fall. There was also no documentation of a root cause analysis to determine how best to prevent further falls. A review of a fall assessment dated [DATE] revealed a score of 21 indicating a high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility fall investigation including the facility forms titled Personnel QAPI Statement of Falls, dated 03/06/25 and authored by CNA #304 who was assigned to the resident this day, revealed on 03/06/25 at 1:00 P.M. Resident #77 sustained a fall. The description of the fall was she was laying on the floor beside her bed. R stated she was trying to get to the sink. The rest of the form was blank except for the CNA's signature so there was no information pertaining to when the resident was seen by staff, when she was last toileted, any fall interventions in place, details of the physical environment nor any information pertaining to the QAPI 5 Whys - Root Cause to determine circumstances involved with the fall. Review of the Summary authored by the DON revealed the resident was found laying on the floor in her room on her left side parallel to the bed with no obvious injuries. The resident stated she got up to go to the sink. The call light was in reach. She is able to self-propel her wheelchair but leans forward when doing so and does not stay in a common area for staff to monitor. Interventions included notification to doctor and daughter and she will be observed every hour for her whereabouts and doings. There was no information in the summary to identify if she had on proper footwear, and did she fall from her bed or the wheelchair. There was also no mention of the conditions of the physical environment in her room nor a root cause analysis to determine how best to prevent further falls. A review of a fall assessment dated [DATE] revealed a score of 21 indicating a high risk for falls. Review of the facility fall investigation including the facility forms titled Personnel QAPI Statement of Falls dated 03/16/25 and authored by CNA #293, revealed on 03/16/25 at 2:10 P.M. she heard an abnormal sound and found the resident in her room sitting on the floor. The resident was last seen in her wheelchair and had on shoes. There was no mention by CNA #293 if any fall interventions were in place. Another statement of falls dated 03/16/25 and authored by RN #274 revealed she became aware of the fall by an abnormal sound. The resident was in her room, laying on her left side, feet at the middle of the bed and her head on the recliner. The resident had been in a wheelchair since 11:00 A.M., was last repositioned and toileted at 2:00 P.M. and was also seen at 11:45 A.M., 12:00 P.M. and 1:45 P.M. The resident had on shoes. Devices listed included floor mat and non-skid pad to the wheelchair. The problem statement and reasons why the fall occurred included: resident leans to the left side, resident refused to go with activities and refused to leave the room - hit and pinched staff. It was noted a pillow was placed to the left side. Review of the Summary authored by the DON revealed the fall occurred on 03/16/25 at 2:10 P.M. The resident was found on the floor laying on her left side. An area of purpura opened on her left hand measuring 0.5 centimeters (cm) by 0.5 cm by 0.1 cm. The resident was unable to state what happened. She had a tendency to lean forward in her wheelchair. She cannot self-propel her wheelchair recently. She was wearing shoes. The wheelchair was tipped on its left side. A pillow was placed on her left side prior to the fall to try and prevent her from leaning to her left. She refused to leave her room prior to the fall and was hitting and pinching staff. The conclusion was that she tipped over her wheelchair by leaning to the left side reaching for something. The purpura on her left hand rubbed the floor causing it to open. Interventions included notification to doctor and daughter, vital signs and assessment and resident to be up in Broda chair for positioning. There were no further details regarding whether the fall was witness or unwitnessed or if the resident was supervised or unsupervised in her wheelchair in her room. A review of a fall assessment dated [DATE] revealed a score of 20 indicating a high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Treatment Administration Record (TAR) dated 02/01/25 to 02/28/25 revealed the body pillow to the open side of the bed and the fall mat were not documented as in place until 02/24/25. On 04/01/25 at 4:00 P.M. an interview with ADON #210 verified the fall investigations dated 02/03/25 , 02/22/25, 02/23/25 at 4:00 A.M., 02/23/25 at 2:00 P.M., 03/06/25, and 03/16/25 lacked completed Personnel QAPI Statement of Falls and complete root cause analyses to prevent future falls. ADON #210 also verified the floor mat to the side of the bed that was listed as an immediate intervention for the fall on 02/23/25 at 4:00 A.M. was not ordered for Resident #77 until 02/24/24 and the fall occurring for the second time on 02/23/25 at 2:00 P.M. when documented made no mention of the fall mat being in place when the resident fell . On 04/01/25 at 1:00 P.M. an interview with Registered Nurse (RN) #239 revealed she was the nurse called to the room on 02/03/25. RN #239 could not recall if Resident #77 had any altered mental status the day of the fall. RN #239 verified Resident #77 slipped out of bed trying to get up unassisted. RN #239 verified Resident #77 was high risk for falling. On 04/01/25 at 1:30 P.M. an interview with Licensed Practical Nurse (LPN) #242 revealed she was the nurse called to the room on 02/22/25. LPN #242 stated Resident #77 was slightly agitated on that day and she placed Resident #77 on hourly checks. LPN #242 also stated Resident #77 would often swing legs over the side of the bed, and confirmed Resident #77 was high risk for falling. On 04/01/25 at 4:15 P.M. an interview with RN #274 revealed she was the nurse assigned to Resident #77 on 03/16/25. RN #274 stated Resident #77 was very agitated on 03/16/24 and was unattended by staff when she fell from the wheelchair at 2:10 P.M. RN #274 confirmed Resident #77 was a high fall risk. A review of the policy titled Falls Protocol, dated 11/13/25, revealed for an individual who has fallen staff will attempt to find possible causes within 24 hours of the fall. Causes refer to factors that are associated with or that directly result in a fall. If the cause of the fall is unclear, if the fall may have a significant medical cause such as stroke or an adverse drug reaction, or if the individual continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes. Many categories of medications, and especially combinations of medications in several of those categories, increased the risk of falling. The staff and physician will continue to collect and evaluate information until either the cause of falling is identified, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of the fall in fall risk. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risk of serious consequences of falling. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. If the individual continues to fall, the staff and physician will reevaluate the situation and consider other possible reasons for the residents falling and will reevaluate the continued relevance of current interventions. As needed, the physician will document the presence of uncorrectable risk factors, including reasons why any additional search for causes is unlikely to be helpful. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Numbers OH00163927, OH00163893, and OH00163881.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	04/07/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, interview and policy review, the facility failed to ensure medications remained in original packaging. This affected one resident (Resident #77) of three residents reviewed for medication administration. The facility census was 87. Findings include: A review of medical records for Resident #77 revealed a date of admission of 12/19/24 with diagnoses including Parkinson's disease, repeated falls and dementia with mild psychotic disturbance. Review of physician orders dated 12/19/24 revealed an order for nuplazid (a medication used to treat hallucinations and delusions associated with Parkinson's disease psychosis) 34 milligrams one capsule by mouth daily to start on 12/20/24. Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #77 had severe cognitive impairment. There were no hallucinations, delusions or behaviors noted. On 03/24/25 at 12:02 P.M. an interview with the daughter of Resident #77 revealed she obtained the nuplazid from a specialty pharmacy for Resident #77. On 03/25/25 at 1:32 P.M. an interview with the Director of Nursing (DON) revealed during a review of Resident #77's nuplazid medication administration by the nurses, the DON discovered Licensed Practical Nurse (LPN) #231 was taking any remaining nuplazid pills from a currently opened bottle and pouring them into the newest bottle of nuplazid brought into the facility by Resident #77's daughter so the bottles of nuplazid were being combined into one bottle. The DON verified this was not proper medication storage, as each bottle should have been maintained separately. On 03/25/25 at 3:55 P.M. an interview with the daughter of Resident #77 revealed she had knowledge of the nuplazid pills being combined into one bottle. On 03/26/25 at 8:22 A.M. an interview with Registered Nurse (RN) #255 revealed she counted the nuplazid pills on 03/04/25 with the daughter of Resident #77 and there were 39 pills in the bottle. RN #255 stated the new bottles of nuplazid come in counts of 30. RN #255 stated she knew a nurse combined the bottles. On 03/27/25 at 7:50 A.M. an interview with LPN #231 revealed she had combined two bottles of nuplazid into one when the daughter handed her two bottles of the medication. A review of the policy titled; Medication Storage dated October 2013 revealed medications will be kept in the original packaging dispensed by the pharmacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	04/07/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-complaince identified during the investigation of Complaint Number OH00163893 and Complaint Number OH00163881.