

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Brethren Care Village Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Center St Ashland, OH 44805	
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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interviews, review of a facility policy, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure proper infection control practices were maintained for residents in isolation. This affected one (#86) of one residents reviewed for transmission-based precautions with the potential to affect all seven (#19, #27, #48, #49, #83, #87, and #88) additional residents that resided on the skilled unit. The facility census was 64. Findings include: Review of the medical record revealed Resident #86 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage, pneumonia, and dementia. Review of Resident #86's physician orders for June 2026 revealed on 06/16/26 the resident was placed on contact isolation for Clostridioides difficile (C. diff, a highly contagious bacterium that infects the large intestine causing diarrhea and colitis). Review of the care plan dated 06/16/26 for Resident #86 revealed she had C. diff with interventions including placing the resident on contact precautions. Observation and interview on 06/23/26 at 9:35 A.M. revealed Certified Occupational Therapist Assistant (COTA) #900 used hand sanitizer instead of washing her hands when she left Resident #86's room. COTA #900 touched Resident #900's door handle and was carrying a bag of linens in her hand. COTA #900 stated she did not know that she had to wash her hands instead of using hand sanitizer. COTA #900 stated that she would wash her hands after she dropped off the bag. Interview on 06/25/26 at 1:50 P.M. with the Director of Nursing (DON) revealed that hands must be washed with soap and water for C. diff and hand sanitizer did not work. Review of the facility policy titled, Standard Precautions Policy and Procedure- Point of Care Risk Assessment, revealed regardless of a resident's transmission-based (isolation) precautions, hand hygiene must be performed after personal protective equipment removal and before leaving the room. Review of the Centers for Disease Control and Prevention (CDC) guidelines for preventing C. diff revealed washing hands with soap and water was the best way to prevent the spread of C. diff from person to person.		

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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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of resident trust statements, review of a written check, and staff interview, the facility failed to ensure resident funds were conveyed for final accounting of resident funds within 30 days of death. This affected one (#89) of one residents reviewed for personal funds final conveyance. The facility census was 64. Findings include: Review of the medical record for Resident #89 revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic pulmonary disease, diabetes mellitus, and kidney disease. Further review of the medical record revealed Resident #89 expired at the facility on [DATE]. Review of Resident #89's personal funds account balance as of [DATE] revealed the resident had \$300.06 in the account. Review of Resident #89's personal funds account balance as of [DATE] revealed the resident had \$300.17 in the account. Review of a checked dated [DATE] revealed [DATE] revealed \$300.17 was written to the Attorney General office to close Resident #89's account. Interview on [DATE] at 1:15 P.M. with Business Office Manager (BOM) #415 verified the lack of timely conveyance of funds for Resident #89.		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of a facility policy, the facility failed to ensure a care plan was initiated to provide interventions for a resident with post-traumatic stress disorder. This affected one (#8) of one residents reviewed for post-traumatic stress disorder. The census was 64. Findings include: Review of the medical record for Resident #8 revealed an admission date of 03/13/22. Diagnoses included post-traumatic stress disorder (PTSD), Parkinson's disease, Alzheimer's disease, hypertension, and heart failure. Review of Resident #8's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with PSTD as a diagnosis and was cognitively impaired. Review of Resident #8's comprehensive care plan initiated on 07/19/22 revealed no evidence of PTSD being addressed. Review of the psychiatric evaluation dated 12/18/25 revealed Resident #8 was being seen because staff stated he was having flashbacks and had been more tearful about the war. Resident #8 was experiencing increased symptoms of depression and had been anxious. PTSD was added as a diagnoses. Interview on 06/25/26 at 10:30 A.M. with MDS Nurse #402 and MDS Nurse #504 revealed PTSD would be addressed in the admission Assessment. Interview on 06/25/26 at 12:47 P.M. with Master of Social Work (MSW) #505 revealed Resident #8 initially denied any history of PTSD upon initial admission. MSW #505 stated in December 2025, the resident mentioned concern about being in the war. MSW #505 stated the other social worker addressed concern with him immediately with a referral to psychiatric services. MSW #505 verified there was no PTSD assessment or admission Assessment to select from under the Assessment tab; however, she believed there used to be an option for that. MSW #505 verified Resident #8's PTSD was not addressed in his care plan. Review of the undated facility policy titled, Trauma Informed Care, revealed it was the policy of the facility to closely monitor all residents who exhibit signs/symptoms of trauma. The facility would produce, document, and implement trauma informed care plans for residents identified as having experienced and been adversely affected by trauma in their lives.		