STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366203	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orrville Pointe	230 South Crown Hill Road 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a skin alteration was comprehensively assessed, monitored and a treatment was ordered after a fall. This affected one (Resident #45) of three residents reviewed for falls. Facility census was 44.Findings include: Review of the medical record revealed former Resident #45 was admitted on [DATE] with diagnoses that included chronic kidney disease, dysphagia, disorders. Resident #45 expired on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #45 had severe cognitive impairment.A nursing progress note dated [DATE] at 4:46 P.M. revealed Resident #45 was observed lying on the floor in front of her bed. The resident stated she rolled out of bed. Resident #45's right elbow was bleeding. The resident's elbow was cleansed with normal saline and steri-strips were applied and covered with dry clean dressing. Review of the treatment administration record (TAR) for June and July revealed no evidence of treatments being completed to Resident #45's right elbow. Review of the progress notes revealed no further documentation of the skin tear to the resident's right elbow. An interview on [DATE] at 10:12 A.M. the Assistant Director of Nursing (ADON) verified there were no treatments ordered or documented after Resident #45 received the skin tear on [DATE]. The ADON also verified there was no documentation of the size of the skin tear or any monitoring of the skin tear. This deficiency represents non-compliance investigated under Complaint Numbers 2572467 and 1399215.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews, review of the facility assessment, and staff schedule review the facility failed to ensure a full time Director of Nursing (DON) was employed by the facility and involved in direct oversight of nursing services. This had the potential to affect all residents in the facility. The facility census was 44.Findings include: Review of the staff schedule from 04/06/26 through 04/12/26 revealed the interim DON, Registered Nurse/DON #450, was in the facility for 11 hours on 04/07/26.An interview on 04/13/26 at 8:34 A.M. with the Assistant Director of Nursing (ADON) (a Licensed Practical Nurse) revealed DON #500 was terminated in February for a bunch of different reasons. DON #450 was the DON at another building but came to the facility once or twice a week to assist the ADON. Clinical Registered Nurse (RN) #104 was the RN in the building for eight hours Monday through Friday. There were RNs that were weekend workers to ensure there were RNs seven days a week, but none were the facility DON. Interview on 04/14/26 at 10:25 A.M. with DON #450 revealed she was in the facility one to two days a week since the last DON was terminated on 02/09/26. She reported the plan was for the ADON to take over as the full time DON once she finished nursing school next year.Interview on 04/14/26 at 11:46 A.M. with the Licensed Nursing Home Administrator (LNHA) verified the facility did not have a full-time DON. She reported the plan was to move the ADON into the DON position when she finished school (RN degree) next year. The LNHA also verified there were no company job descriptions for positions held in the facility.Interview on 04/15/26 at 8:45 A.M. with Licensed Practical Nurse (LPN) #120 revealed the facility did not have a full-time DON. The current/interim DON was in the facility one to two times a week. She reported if issues arose she contacted the Assistant DON.Interview on 04/15/26 at 9:00 A.M. with LPN #112 revealed the facility did not have full-time DON. The current DON (DON #450) was in the facility one to two times a week. She reported if issues arose she contacted the Assistant Director of Nursing (ADON) who was a Licensed Practical Nurse (LPN).An interview on 04/15/26 at 9:36 A.M. with Registered Nurse (RN) #104 confirmed he was not the facility DON, interim DON or functioned in the DON capacity.The facility did not have a job description for the Director of Nursing or Assistant Director of Nursing.Review of the facility assessment with the most recent update of 03/2026 and the assessment was reviewed in Quality Assurance Performance Improvement/QAPI was 03/26/26 revealed no DON listed as persons involved in completing the assessment. Further review revealed the interdisciplinary team (IDT) consisted of the Director of Nursing (DON) who assisted in the review of all referrals to the facility and the IDT members must agree that the resident's placement is appropriate on that the facility has access to and/or the available resources required to ensure the care needs and expectations for the standard of can be reasonably met. Under facility resources needed to provide competent support and care for our resident population every day and during emergencies the facility agreement expressed the facility did not use any agency staff nor does it carry any staffing waivers. All direct care and/or supportive staff are employed directly by the facility (this does not include contracted services such as hospice). At a minimum, the facility will provide staff to ensure care needs are met, the physical plant is maintained in a safe and sanitary manner, food is appropriately prepared, managed and served, psychosocial needs are addressed and daily administrative operational tasks are accomplished. Staff classification necessary to meet the aforementioned task(s) are as follows: Administrator and administrative support personnel (business office and general reception); DON; Infection Preventionist; MDS Coordinator; Social Service Designee; Environmental Services, RN, LPN, Certified Nursing Assistants (CNA); Culinary Personnel; Activities Staff; Therapy Staff; Registered Dietician and Contracted Staff (Medical Control, Pharmacy Services, Hospice and ancillary providers).This deficiency represents non-compliance investigated under Complaint Number 2565095.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, incident report review, and policy review, the facility failed to ensure Resident #37 received medication labeled with Resident #37's name. This affected one (Resident #37) of three residents reviewed for medication administration. The facility census was 44.Findings include: Review of the medical record revealed Resident #37 was admitted on [DATE] with diagnoses that included dementia with behavioral disturbance, metabolic encephalopathy, mood disorder, history of traumatic brain injury, and catatonic disorder. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #37 had severe cognitive impairment. Review of physician orders revealed Resident #37 was ordered clonazepam (benzodiazepine) one milligram (mg) at 6:00 P.M. and 12:00 A.M. Resident #37 was also ordered clonazepam 0.5 mg at 12:00 P.M. A nursing progress note dated 03/24/26 at 9:24 P.M. revealed Resident #37 received clonazepam one mg instead of 0.5 mg as ordered. Review of the facility investigation of Med Error: Wrong dose dated 03/24/26 revealed Resident #37 received clonazepam one mg dose instead of a 0.5 mg dose as ordered. An interview on 04/15/26 at 9:31 A.M. Assistant Director of Nursing (ADON) verified Registered Nurse (RN) #104 administered clonazepam one mg to Resident #37 as ordered but the clonazepam was taken from Resident #31's controlled medication card. An interview on 04/15/26 at 9:36 A.M. RN #104 stated he did not make a medication error because Resident #37 received the correct dose of clonazepam. RN #104 stated at first he thought it was a medication error because Resident #37 was ordered clonazepam 0.5 mg at 12:00 P.M. RN #104 verified he administered clonazepam one mg at 6:00 P.M. as ordered but took the clonazepam one mg from Resident #31's supply of controlled medications. RN #104 stated the error was caught at shift change when the controlled medication count was incorrect for Resident #31 and #37. RN #104 verified the five rights of medication administration included the right resident and the right medication. Administering Medications policy (no date) revealed the individual administering medications verify the resident's identity before giving the resident their medication. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method before giving the medication. This deficiency represents non-compliance investigated under Complaint Numbers 2565095 and 1399215.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on personnel record review, and interview, the facility failed to be effectively and efficiently administered in a manner that allowed all residents to attain or maintain their highest level of well-being when the administrator failed to ensure concerns regarding Director of Nursing (DON) #500's (who was part of the facility administration) performance and allegations of DON #500 working under the influence of alcohol were thoroughly investigated and timely and necessary protective measures were implemented to safeguard the residents. This had the potential to affect all 44 residents who resided in the facility.Findings include: Review of the personnel file for Director of Nursing (DON) #500 revealed she was hired on 04/30/25 and terminated on 02/09/26. The personnel file revealed no evidence of reference checks being completed. In addition, there was no written job description for the Director of Nursing (DON) in the employee's file nor was a job description available to review during the onsite survey. Record review revealed there were no termination documents located in the personnel file and no written information related to the reason for DON's termination was provided during the onsite survey.Review of DON #500's personnel file revealed an associate performance appraisal was completed by the Administrator on 09/19/25 (a three month evaluation). Goals and/or projects included ensuring the schedule was done properly, keeping reaching out to support systems when there were questions, continuing to want to learn and improve, staying up to date with State Survey Agency regulations and documentation for survey, and continuing to work on staffing/retention. The evaluation noted, as the DON, you have a challenging group to manage, keep your open-door policy. How your department performs reflects your leadership. Record review revealed no indication for how the DON's performance would be monitored for these goals and/or projects following the evaluation period.A typed statement dated 01/13/26 by Social Service Designee (SSD) #116 to the Administrator revealed over the last couple of months there had been a lack of communication, support, and attendance by DON #500. SSD #116 had to answer challenging questions and step up to manage residents' medical questions/concerns. DON #500's lack of communication and follow through with issues/concerns with family members was concerning because it showed more of the disconnect in the facility. The past couple months had been challenging with lack of communication. SSD #116 had been transparent with the lack of communication for clinical matters including falls, specifically for the fall screens for the therapy department. There had been no fall reports for the last couple of months. In addition, the statement revealed on 12/30/25, DON #500 had a stench of alcohol and showed up for work at 11:00 A.M. The typed statement continued indicating there was so much SSD #116 could go on about with orders, advanced directives, and concerns brought to DON #500's attention that were ignored. DON #500 stated she was too busy to deal with situations. There was a big concern with staff because tenured staff were leaving because they could not get their concerns handled. New nurses reported they were unable to get ahold of DON #500 when there were concerns about the residents. DON #500 lied about things being done and being at the facility but leaving early or coming in late. It had come to the point where residents reported that nursing staff refused to give showers. SSD #116 gave showers to decrease the residents' stress. When SSD #116 reported showers were not being given, she was blown off (by DON #500) and told it was a nursing concern and would be handled. Residents were reporting they never saw or knew who DON #500 was. Record review revealed there was no further information regarding specific incidents, residents interviewed or details about the DON's leaving early or coming to work late. In addition, there was no evidence concerns identified on 12/30/25 related to DON #500 were investigated and/or addressed. Review of an undated typed statement from Behavioral Health #325 to the Administrator revealed Behavioral Health #325 was writing to formally express ongoing concerns with DON #500 based on observations and experiences over the past several months. Behavioral Health #325 witnessed a consistent lack of attendance and significant breakdown in communication with staff. As an outside contracted provider, effective and timely (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	communication with the DON was essential to perform Behavioral Health #325's role and ensure appropriate care for the residents. Unfortunately, this had not been possible. I (Behavioral Health #325) personally observed behavior that raises serious concern, including smelling alcohol on DON #500's breath on multiple occasions. The statement included I clearly recall smelling it on 12/30/25. Recently an aide informed me that staff were instructed not to speak to me regarding residents. When I asked who gave this instruction, the aide stated it was DON #500. The statement included as a contracted outside provider, I must be able to communicate with facility staff to fulfill my responsibilities effectively and ethically. (My) residents come first, and any restriction on appropriate communication interfered with their care. Based on my observations, there were serious concerns regarding professionalism, reliability, and the overall work environment. I do not feel I can communicate effectively with DON #500 nor do I feel confident in her availability or conduct. The situation had made it increasingly difficult for me to do my job appropriately within the facility. Record review revealed there was no administrative follow-up provided related to this statement to include dates and/or evidence these ongoing concerns with DON #500 had been investigated or addressed. A typed statement dated 01/15/26 by the Assistant Director of Nursing (ADON) revealed that since stepping into the ADON role there had been a lot of issues. Some of the issues involved DON #500. On the first day of being ADON, DON #500 did not show up. When the Administrator was on vacation, DON #500 was rarely in the building. When DON #500 was at the facility, there were constant breaks to go smoke, lack of follow up, and lack of addressing concerns. When I took this position, I was told I would not be on call. My phone rings at all hours of the day and night because staff are unable to get ahold of DON #500. DON #500 has left the building knowing there were not enough staff. Yesterday, the nurses had called me upset because they were short staffed. DON #500 came in for an hour and a half and then left. We are short again today, it is 10:00 A.M. and DON #500 is not here. Several of the nurses were new and had expressed concern and frustration that if something happens, they cannot get ahold of their leader, the one who was supposed to guide them. DON #500 takes the day off, comes in late, or complains about working the weekend but does not work the weekend. Record review revealed there was no additional information provided regarding additional nurse or staff interviews to identify specific concerns the staff had or dates of reported occurrences. The facility did not have any investigation to provide as requested related to the DON's performance.A performance improvement/reset plan signed by Corporate Human Resource Director, the Administrator and DON #500 on 01/15/26 revealed the following concerns had been substantiated through reports, observation, and leadership feedback: failure to meet state-mandated Registered Nurse (RN) coverage requirements, unreliable physical presence in the building during assigned work hours, removal of self from on-call responsibilities without approval, unprofessional conduct toward staff, including yelling, swearing, and refusal to assist during staffing shortages, creating unsafe staffing conditions resulting in staff working excessive hours, allegations of reporting to work smelling of alcohol, dishonesty and misrepresentation of work activities, retaliation against employees who raise concerns, undermining the chain of command resulting in Certified Nursing Assistant (CNA) insubordination, breakdown in communication with leadership and staff, and loss of nursing staff and risk of additional resignations. Record review revealed following the identification and development of this improvement plan, there was no evidence the Administrator and/or Corporate Human Resource staff implemented a plan to monitor DON #500's performance and/or behavior. An interview on 04/13/26 at 2:01 P.M. Certified Nursing Assistant (CNA) #139 revealed the CNA had smelled alcohol on DON #500 several times. CNA #139 stated if you reported anything about the DON, you could be written up or fired. The CNA stated staff were afraid of the DON. An interview on 04/14/26 at 7:37 A.M. SSD #116 revealed concerns with DON #500 being at work and smelling like alcohol which had been previously reported to the Administrator and Corporate staff. SSD #116 revealed most recently (in December 2025) this concern was reported Corporate Human Resource Director (the Administrator was on vacation). SSD #116 revealed both she and MDS Coordinator #122 (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	noted the smell of alcohol on DON #500. SSD #116 revealed she was performing resident showers because the staff were not doing scheduled showers. SSD #116 stated there were a lot of things DON #500 did not report, including falls. The nurses could leave medications in resident rooms and cut corners on care and DON #500 would not address the infractions. SSD #116 stated DON #500 came to the facility initially as the ADON. DON #500 was friends with the person who was the DON at that time. That DON left and DON #500 became the facility DON. SSD #116 stated she believed the Administrator had reached out to corporate staff for guidance on how to address the concerns with DON #500. SSD #116 revealed the DON would terminate staff or not schedule them to work if anything negative was said about the DON. The SSD revealed staff were afraid of the DON. An interview on 04/14/26 at 10:17 A.M. with CNA #152 revealed they noticed an odor of alcohol on DON #500 when she was passing medications. However, CNA #152 could not recall the date or time of this incident. An interview on 04/14/26 at 2:42 P.M. with LPN #122 revealed she saw DON #500 daily and DON #500 smelled of alcohol whenever the Administrator was not at the facility. LPN #122 stated she reported the concerns to the Administrator. She stated she was told it was a serious accusation to make without proof. LPN #122 stated DON #500 kept missing work and coming in late. On 12/30/25, DON #500 came into work around 11:00 A.M., was slurring her words, and the odor of alcohol could be smelled without being next to DON #500. The Administrator was on vacation and Corporate Human Resource Director was notified but DON #500 left before anyone could request DON #500 go to the hospital for drug/alcohol testing. LPN #122 stated in January 2026 DON #500 was still erratic and the concerns were again reported. However, the LPN did not feel Corporate Human Resource Director did much to help the Administrator with handling the situation. LPN #122 stated DON #500 had a driving under the influence charge but had driving privileges for work. People in the community were referring to the facility as the place with the drunk DON. Sometime after the incident was reported in December, DON #500 left the facility for two hours and returned smelling of alcohol. DON #500 would go sit in her car and smoke for long periods of time. DON #500 would smell of alcohol after smoke breaks. Interview on 04/14/26 at 3:05 P.M. with the Administrator revealed she got statements from SSD #116, MDS Coordinator #122, and Behavioral Health #325 who had concerns about DON #500 in December 2025 but not from any other staff. A reset was discussed with DON #500. However, there was no evidence an investigation was completed or evidence of the DON's performance/behaviors being monitored during this time. During the interview the Administrator revealed DON #500 did not follow the performance improvement plan/reset in various ways, so DON #500 was terminated. The Administrator verified there was no follow up about concerns with DON #500's attendance, clocking in and out, conduct and retaliation towards staff, aggressive behavior, and being free from any impairing substances. The Administrator revealed there were no audits of time punches, schedules, staffing, documentation, or interviews with staff and residents about DON #500 and concerns about her presentation or performance. Record review revealed no evidence the Administrator implemented timely and necessary protective measures to safeguard the residents related to concerns/allegations being made against DON #500.An interview on 04/16/26 at 11:34 A.M. with the Corporate Human Resources Director (CHRD) revealed she received phone call before Christmas that DON #500 reeked of alcohol. SSD #116 and MDS Coordinator #122 were asking for assistance with how to handle the situation since the Administrator was on vacation. CHRD stated she was one and half hours away and it was not feasible for her to drive to the facility. CHRD instructed SSD #116 and MDS Coordinator #122 to send DON #500 and/or have the DON get tested for alcohol if there were signs of impairment. However, MDS Coordinator #122 called the CHRD back and said DON #500 had left the facility before the staff could take DON #500 for testing or offer to drive her home. The CHRD stated she then talked to the Administrator about the incident (after return from vacation) and the Administrator said all she had from staff were rumors (please note, there was no documented investigation or additional follow up with residents or staff regarding the concerns from the staff as noted above). There was no additional information provided from the Administrator regarding increased monitoring of the DON or (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	discussion with the DON regarding concerns until the improvement plan was created. The CHRD stated staff were interviewed and she had a long conversation with the Administrator; however, there was no documentation of this provided as part of the onsite survey investigation. The CHRD revealed DON #500 was ultimately terminated because she did not meet the expectations that were put in place which included lack of performance and profession conduct. This deficiency represents non-compliance investigated under Complaint Numbers 2572467 and 2565095