STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366214	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Villa of Alliance	1785 Freshley Avenue Alliance, OH 44601

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. THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on interviews, record review and employee file review the facility failed to ensure all wound dressing were completed as ordered. This affected one of three residents (Resident #66) reviewed for wound care. The facility census was 66.Findings Include: Review of the closed medical record for Resident #66 revealed an admission date 10/11/25 and was admitted on hospice. Diagnosis included malignant neoplasm of prostate, chronic obstructive pulmonary disease and history of stroke.Review of the plan of care dated 10/11/25 for impaired skin integrity to left great toe and left lower shin revealed complete skin assessments per facility policy, encourage out of bed activities, inspect skin during routine skin care, pressure reducing mattress and complete treatments as ordered.Review of the admission Minimum Data Set (MDS) 11/20/25 revealed intact cognition and a maximum to total assist for activity of daily living (ADLs).Review of the physician order dated 11/24/25 revealed cleanse lower outer leg with normal saline, pat dry and apply calcium alginate and non-bordered super absorbent dressing and secure. Treatment order for left great toe revealed cleanse area to left great toe with normal saline apply calcium alginate and non-bordered super absorbent dressing and secure with kerlix every night shift ordered on 11/24/25.Review of wound note dated 11/24/25 revealed upon admission Resident #66 had multiply abrasions (left great toe, measuring 2.0 centimeters (cm) by (x) 2.0 cm x 0.2 cm and left lower lateral leg, venous ulcer measuring 1.8 x 7.5 x 0.1 cm) due to multiple falls and was being followed by the wound nurse practitioner.Review of the Treatment Administration Record (TAR) for November 2025 revealed the treatment to the left lower outer leg and left great toe had been initialed by the assigned nurse as completed (signed off) on 11/28/25 and 11/30/25 by Licensed Practical Nurse (LPN) #456 and on 11/29/25 by Register Nurse (RN) #468. Interview on 01/29/26 at 9:00 A.M. with the Director of Nursing (DON) confirmed Registered Nurse (RN) #468 documented care that had not been provided to the resident, by placing her initials on the TAR for 11/29/25 and LPN #456 on 11/28/25 and 11/30/25. However, on 12/01/25 during wound rounds completed by the Wound Nurse Practitioner #464 and Wound Nurse/LPN #453 it was confirmed the dressing to Resident #66's left great toe and her left outer, lower leg had not been changed daily and was dated 11/27/25. This observation verified the dressing had not been changed per orders by LPN # 456 and RN #468. The DON stated LPN #453 verified all treatments/dressings, in the facility, had been completed per orders.Interview on 02/25/26 at 2:00 P.M. with LPN #417 stated she had taken care of Resident #66 the day the treatments not being completed was identified. She stated you are to sign off treatments when you complete them as well as write the date and your initials on the new dressing when you apply it. LPN #417 stated on 12/01/25 she went to complete her dressing change for Resident #66 and noticed he still had the same dressing on that she had applied, on 11/27/25, for Resident #66's leg and great toe.Interview on 02/25/26 at 3:57 P.M. with LPN #453 verified she was the wound nurse. On 12/01/25 she was notified by LPN #417 that the dressings for Resident #66 had not been changed since (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/27/25.Attempts to reach LPN #456 during the onsite survey were unsuccessful Review of the personnel file for RN #468 revealed a hire date of 10/24/25 and termination date of 12/02/25 for poor performance issues. On 12/02/25 a Discipline form was completed and revealed the nurse was signing off treatments for Resident #66 that had not been completed. The DON completed the form. Review of LPN #456's personnel file revealed date of hire 11/02/22. A Disciplinary Action form dated 12/01/25 was noted for failure to meet reasonable standards/expectations of performance or unsatisfactory work. This was the first written disciplinary action. Treatments are to be completed as ordered. She signed on the Treatment Administration Record (TAR) on 11/28/25 and 11/30/25 that treatments had been completed. Dressing was changed on 12/01/25 and the old dressing was dated 11/27/25. This document was completed by the DON.The deficient practice was corrected on 12/20/25 when the facility implemented the following corrective actions: Review of the whole house audit for all residents with dressing changes revealed all wound dressing were completed as ordered. The audit was completed on 12/01/ 25 by the DON.House wide wound audits were completed two times weekly by LPN #453/wound nurse beginning on 12/02/25 for one month to ensure nurses were completing dressing changes per orders. No concerns were identified.Review of the Nursing Deptartment Meeting, presented in person by the DON on 12/16/25 revealed all nurses (11 LPN's and 5 RN's) were in attendance. The in-service provided the following education: Dressings were to be changed timely and per physician orders. If a dressing was found to have not been changed per order, report it to the DON or wound nurse immediately. Nurses were directed to date and sign their initials on the dressing. LPN #456 was in attendance.Review of the in-person nurses meeting notes on 02/20/26 held by the DON revealed dressing changes/ dating/initialing/reporting was addressed during the meeting. There were 11 LPN's and 5 RN's that attended the meeting and signed in on the sign in sheet. Results of audits and ongoing concerns will be address through QAPI. This deficiency demonstrated non-compliance investigated under Complaint Number 2692772.

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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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, observation, staff interview and policy review the facility failed to ensure residents were transferred properly while using a mechanical lift This affected one resident (Resident #12) of one residents reviewed for mechanical lift transfer. There were seven residents identified as needing a mechanical lift transfer.Findings include: A review of the medical record for Resident #12 revealed an admission date of 07/26/24. Diagnosis for Resident #12 included left side hemiplegia, atrial fibrillation, seizures, and peripheral vascular disease. A review of the quarterly minimum data set assessment dated [DATE] for Resident #12 revealed that she had no evidence of cognitive impairment and required moderate assistance to total dependence upon staff for activities of daily living. A review of the plan of care for Resident #12 revealed that she required a total mechanical lift (Hoyer lift) for transfers. Review of the General Investigation of the incident dated 12/04/25 at 7:15 A.M. revealed Resident #12 hit her head during transfer with CNA #406 and CNA #466, when the lift tipped, revealed the following investigation: Review of the original copy of the neurological assessment flowsheet for Resident #12 dated 12/04/25 revealed neuro checks were completed, resident complained of a headache at first, then had no complaints. Review of the 72-hour Post incident monitoring dated 12/04/25 for Resident #12 revealed Resident #12 hit her head on the lift. Review of the incident assessment marked other dated 12/04/25 at 7:15 A.M. revealed the nurse was notified by CNA #406 that Resident #12 bumped her head on the metal bar. Resident #12 stated I hit my head Vital signs were taken. No bruising, redness or edema noted to forehead. Review of the statement from LPN #418 dated 12/04/25 revealed she was in the hall preparing, another residents medications. She heard CNAs yelling her name. She went into Resident #12's room. Resident #12 was in the lift sling above wheelchair. The lift was tipped and she yelled for more help. Staff were able to get Resident #12 in her wheelchair safely and the lift detached. The resident stated she hit her head during this. There was no redness, bruising or edema noted. Lift education for staff and staff monitor head placement during transfers. Review of the incident statement dated 12/04/25 from CNA #406 stated they were getting the resident in her wheelchair with the lift, CNA #466 and herself. We pushed her (Resident #12) back to get her in the wheelchair and the lift tipped over. Resident #12 stated the lift hit her in the head. We yelled for help and LPN #418 came with other staff to assist with getting the resident unhooked from the lift. LPN #418 then stated they were telling aides not to put residents in their chairs sideways, but CNA #466 and herself, did not remember that. Review of the statement from CNA #466 dated 12/04/25 revealed two aides were using the lift to transfer Resident #12 into her wheelchair from her bed at about 7:30 A.M. on 12/04/25. As they were over (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the chair the lift tipped and the other aide and I hollered for help and help came. We safely got the chair and lift tipped back up and got the lift pad unhooked from the Hoyer. Review of the provider note dated 12/08/25 revealed Resident #12 was seen due to bumping her head without negative findings. An interview on 01/21/26 at 10:58 A.M. with Resident #12 revealed that she was transferred by staff with the Hoyer lift. There was one time that the Hoyer lift tipped and she hit her head. An interview on 01/22/26 at 11:30 A.M. with the DON revealed that there was an incident where the mechanical lift tipped but the resident did not fall. There were two staff members present during the transfer, and additional staff were needed to get the lift back to a standing position. The lift was immediately taken out of service. The DON verified the two CNAs had not followed protocol when they were using the mechanical lift to transfer the Resident #12 to her wheelchair. Staff had been educated on not approaching on the side of the wheelchair when transferring a resident with the lift. All transfers into a wheelchair were to be completed from the front. An interview on 01/27/26 at 1:56 P.M. with the Administrator revealed the lift that tipped had maintenance work completed after 12/04/26. It was taken out of service immediately after tipping with Resident #12 being transferred by Certified Nurse Assist (CNA) #406 and CNA #466. After maintenance deemed the facility lift was safe for use it was put back into service. Interview on 02/25/26 at 12:47 P.M. with DON stated she did not do a fall investigation at the time of the incident because she did not feel the transfer resulted in a fall but she initiated a general investigation. As a result of the investigation, it was determined the CNAs did not follow facility procedure regarding the appropriate techniques when using the mechanical lift. Interview on 02/25/26 at 1:36 P.M. with Licensed Practical Nurse (LPN) #418 stated she heard yelling and went into Resident #12's room and Resident #12 was right above the chair, in the mechanical lift and she believed the legs of the lift were separated. Interview on 02/25/26 at 2:03 P.M. with Certified Nurse Assistant (CNA) #406 stated her and another aide were trying to get Resident #12 to her chair, using a mechanical lift. Due to the resident's size we had to go into the wheelchair from the side, so we could put her back in her chair all the way, and we opened the legs of the lift. When we pulled her back, the lift tipped and Resident #12 hit the back of the wheelchair, making the back of the wheelchair lay back, hitting the dresser that was behind the wheelchair. The lift tipped sideways when we pulled her back against the back of the wheelchair and Resident #12 landed in her wheelchair. The CNA stated they had to lean the wheelchair back, back so they could finish putting the resident in the chair. CNA #406 stated they had to stand on the lift (feet) to keep it from falling on Resident #12 until more staff showed up to assist with getting Resident #12 unhooked from the lift. Review of the facility procedure How to use a Hoyer lift, not dated revealed the boom of the lift does not swivel. The resident ' s weight must be centered over the base legs at all times. Do not attempt to lift resident with the mast/boom assembly swiveled to either side. Always keep Resident facing the attendant operating the lift. The deficient practice was corrected on 12/11/25 when the facility implemented the following corrective actions: (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 in person, in-service record dated 12/04/25 revealed 36 staff members were present for training on Hoyer lift for all nursing staff. CNA #406 and CNA #466 signed the training log. This was provided by the DON. Both CNAs had evidence of a mechanical lift competency, CNA #406 on 12/10/25 and CNA #466 on 12/11/25. Review of the In person lift training/competency completed by DON/or Designee on 12/09/25 revealed all CNAs had completed the training/competency and provided return demonstration on lift transfers. Review of the lift audits completed by the DON/Designee from 12/07/25 through 02/15/26 revealed audits were completed twice a week for four weeks and then once a week to be continued for four weeks and then continue to monitor as needed. Review of lift inspection logs dated 12/01/25 completed by Maintenance Director #410 revealed that mechanical lift transfers were documented as inspected at least monthly during the past twelve months. Any required maintenance or repairs completed at the time of inspection was also documented on the log. On-going compliance will be monitored in Quality Assurance Performance Improvement. This deficiency demonstrates noncompliance investigated under Complaint Number 2692772.