

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: 366237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Wadsworth Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 540 Great Oaks Trail Wadsworth, OH 44281	
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 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 record review and staff interview, the facility failed to ensure the service of a Registered Nurse (RN) for at least eight hours a day, seven days a week as required. This had the potential to affect all residents. The facility census was 48. Findings include: Review of the staffing schedule and posted nursing staff information for 07/11/26 revealed the facility did not have eight consecutive hours of RN coverage as required. Review of the staffing tool from 07/06/26 through 07/12/26 revealed there was no RN scheduled to work in the facility on 07/11/26. During an interview on 07/16/26 at 10:27 A.M., the Director of Nursing (DON) verified there were no RNs at the facility on 07/11/26 after night shift left. This deficiency represents non-compliance investigated under Complaint Numbers 2987514, 2807579, and 2616372.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to ensure its kitchen area was maintained in a clean and sanitary condition. This had the potential to affect all 48 residents residing in the facility. Findings include: Observation of the kitchen area with Dietary Aide #223 on 07/13/26 beginning at 9:15 A.M. revealed the walk-in freezer had one bag of chicken patties and two bags of sausage patties unlabeled and undated. Review of the general kitchen area revealed it was sticky around the can opener, the microwave was dirty, the areas around the sinks and by the dish machine needed wiped down, and the floor needed a deep clean. Dietary Aide #223 verified the findings at the time of the observation. Regional Dietitian #290 verified the findings again around 10:00 A.M. Continued observation of the kitchen on 07/14/26 starting at 12:25 P.M. revealed cracked floor tiles, grout coming out between the floor tiles, the grid around the ceiling vent was rusty, and multiple light panels had dust, debris, and what appeared to be dead bugs in them. The findings were verified by Regional Dietitian #290 at the time of the observations.		

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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 record review, interview and policy review, the facility failed to ensure residents were notified to spend down their balance. This affected one resident (#56) of five residents reviewed for resident funds. The facility census was 48. Findings include: Record review revealed Resident #56 was admitted on [DATE] with diagnoses of anxiety disorder, type II diabetes, depression, dementia and cerebral infarction. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively impaired. Record review revealed a Resident #56 had an account balance of \$10,771.93 upon discharge on [DATE]. During an interview with Regional Business Office Manager #295 on 07/15/26 at 3:15 P.M. confirmed spend-down notifications were not sent to Resident #56's Power of Attorney (POA), only the quarterly statement. Regional Business Office Manager #295 confirmed Resident #56 had an account balance of \$10,771.93 upon discharge on [DATE]. Regional Business Office Manager #295 stated Resident Fund Management Services mails out the quarterly statements and mails the facility a copy of them as well. Review of the facility policy titled RFMS-Resident Fund Management, revised on 03/11/26, revealed the community must notify all Medicaid residents/responsible parties once their account balance is within \$200.00 of the state specific asset limit. This deficiency represents non-compliance investigated under Master Complaint Number 3078476.		