

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Hampton Woods Nursing Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 East Western Reserve Road Poland, OH 44514	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and family interview, staff interview, review of facility medication incident report, record review, and facility policy review, the facility failed to ensure residents were free of significant medication errors. This affected one resident (Resident #9) out of four residents reviewed for medication administration. The facility census was 53. Findings include: Review of the medical record for Resident #9 revealed an admission date of 05/23/25 with diagnoses including hypertension, hypothyroidism, hyperlipidemia, anemia, history of falls and history of fracture of right femur.</p> <p>Review of the facility document titled Medication Incident Report dated 07/14/25 at 10:45 A.M. revealed Registered Nurse (RN) #805 gave Resident #9 the wrong medications during their 9:00 A.M. medication pass. RN #805 did not verify she had the right resident and RN #805 administered the following wrong medications: Amlodipine (treats high blood pressure), Bupropion (antidepressant), Lisinopril (treats high blood pressure), Paxil (antidepressant) and Prednisone (corticosteroid). RN #805 stated in a written statement that she went into the residents' room and stated, I have your medicine and proceeded to give Resident #9 the medications. The statement additionally said when RN #805 attempted to give Resident #9 a Lovenox (blood thinner) shot, Resident #9 stated I have never been given a shot since I have been here, it was at that point RN #805 questioned herself and went out to check the medications and realized she was in the wrong room and administered Resident #9 the wrong medications.</p> <p>Review of Resident #9's progress notes dated 07/14/25 at 3:02 P.M. authored by the previous Director of Nursing #700 revealed at 11:00 A.M. she contacted the Nurse Practitioner and reviewed and discussed Resident #9's morning medications and received a new order to monitor her vital signs every two hours for 12 hours.</p> <p>Review of Resident #9's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition, needed substantial to maximal assist for Activities of Daily Living (ADLs), was independent with eating and required staff assistance with medication administration.</p> <p>An interview on 01/29/26 at 9:20 A.M. with Resident #9 revealed she confirmed in July 2025 she was given the wrong medications. She stated the nurse, who she had never seen before and had not seen since this incident, came in her room and stated, I have your medicine. Resident #9 stated she took the medications, and then when the nurse attempted to give her a shot, she questioned the nurse stating, I have never been given a shot here. The nurse left the room and did not return. Resident #9 stated the DON at the time came in the room later in the afternoon and told her what happened and that she had been given the wrong medications.</p> <p>An interview on 01/29/26 at 12:22 P.M. with Resident #9's family revealed their mother called them</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 366329
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>in July and stated she was given the wrong medications. She stated this type of incident has not happened since July but was worried it could happen again.</p> <p>An interview on 01/29/26 at 1:10 P.M. with the current Director of Nursing #701 revealed she confirmed RN #805 did give Resident #9 the wrong medications.</p> <p>Review of the facility policy titled Medication Administration last revised July 2025 revealed the individual administering the medications were to verify the resident's identity before giving the resident his/her medications.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 2580337.</p>		