STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366334	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Nursing Home, Inc	626 34th Street, NW Canton, OH 44709

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure residents and/or responsible parties were informed of the risk of antipsychotic use prior to administration. This affected two (Residents #48 and #88) of six residents reviewed for medication use. The facility census was 73.Findings include: 1.Review of Resident #88's medical record revealed diagnoses including muscle wasting and atrophy of multiple sites, difficulty walking, urinary tract infection, cellulitis, chronic venous hypertension with an ulcer of bilateral lower extremities, and congestive heart failure. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 was able to make herself understood and was able to understand others. Resident #88 was assessed as moderately cognitive impaired with a Brief Interview of Mental Status (BIMS) score of 11 (on a scale of 0-15). No behavioral symptoms were indicated but Resident #88 rejected care one to three days during the lookback period. Review of a behavior note dated 01/01/26 at 2:30 A.M. revealed Resident #88's physical and verbal aggressive behavior ceased after a 12:00 P.M. dose of intramuscular Haldol (an injectable antipsychotic medication) was administered. At 2:15 P.M., Resident #88 became severely agitated and began loudly screaming that someone was trying to kill her and her son. Resident #88 attempted several times to get out of bed without staff assistance. An attempt was made to administer a dose of Ativan (an anti-anxiety medication) ordered on an as-needed (PRN) basis, but Resident #88 spit the Ativan out. Physician #500 was notified at 3:30 P.M. with a description of Resident #88's state of agitation. Physician #500 was informed of Resident #88's behaviors from earlier in the day, the order for the 12:00 P.M. dose of Haldol from Nurse Practitioner (NP) #501, and Resident #88's refusal to take scheduled oral medications or Ativan that were ordered on a PRN basis. A verbal order was received for a second one-time dose of Haldol 1 milligram (mg). Resident #88's son was notified of the order. Resident #88 then rested peacefully. A behavior note dated 01/01/26 at 12:00 P.M. indicated NP #501 visited Resident #88 that morning. Resident #88 was agitated, physically aggressive to staff and verbally aggressive to staff and her son. Resident #88 was refusing all oral medications. NP #501 ordered a dose of Haldol 1 mg to be administered on a one-time basis. The order was discussed with Resident #88's son. A behavior note dated 01/01/26 at 12:03 P.M. indicated Resident #88 was screaming out at the nurse and son, physically pushing the nurse's hands away, removing her clothing, telling people to get out of her room, and refusing to take ordered medications. NP #501 ordered Haldol 1 mg to be administered intramuscularly. Resident #88's son was present and informed of the order. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An addendum to a note by NP #501 on 01/01/26 indicated after her visit Resident #88 was noted to be very distressed, disrobing, paranoid, and screaming she wanted to be naked. Resident #88 was unable to be redirected with non-pharmacological interventions, refusing all oral medications despite multiple attempts. Resident #88 was given Haldol 1 mg due to acute paranoia that was very distressful for her and at risk of harming self or others. A visit note from NP #502 on 01/02/26 revealed Resident #88 was noted to have increased agitation, severe paranoia and delusions, and refusing all medications and care from staff. An attempt had been made to initiate oral antipsychotic medication, but no doses had been received due to refusals. Resident #88 required two doses of Haldol on 01/01/26 and once in the morning of 01/02/26 which were mildly effective. Resident #88 was refusing to eat and drink and was combative with staff while attempting care. No other medical concerns were identified. The family was informed the facility had no other interventions for staff to initiate in the nursing facility setting and Resident #88 would benefit from transfer to a geriatric psych facility. On 03/18/26 at 3:55 P.M., Corporate Nurse #503 verified she had been unable to locate any documentation indicating risks of Haldol use was discussed with Resident #88 or her son. 2. Review of the closed medical record for Resident #48 revealed an admission date 01/28/26 and a discharge date [DATE]. Diagnoses included unspecified fracture of upper end of the left humerus, pain in left shoulder, muscle weakness, metabolic encephalopathy, abnormal gait and mobility, history of falling, heart disease, and parkinsonism. Review of the care plan dated 01/30/26 for psychoactive medications revealed Resident #48 was at risk for complications related to psychoactive medication use secondary to diagnosis of insomnia. Interventions included observing for signs and symptoms of adverse side effects related to medication use and notifying physician and monitor for behaviors related to medication use. Review of the closed admission MDS dated [DATE] revealed Resident #48 had a BIMS score of 15 indicating intact cognition. Resident #48 requires setup for meals and dependent for toileting, showers and transfers uses wheelchair. The resident was not noted to receive antipsychotic medication. Review of the orders for February 2026 revealed an order dated 02/19/26 for Haloperidol Lactate (an antipsychotic medication, also known as Haldol) 0.5 mg injection intramuscularly (IM) one time and again on 02/26/26 another order for a one-time use was ordered. Review of the progress notes revealed on 02/19/26 at 1:00 A.M. under behavior note revealed Resident #48 was awake trying to crawl out of bed, unable to reorient, belligerent and paranoid. The resident believed he was being held without permission and was attempting to call 911. Resident #48 was on the phone with the daughter at 12:45 A.M., refusing to take by mouth (PO) medication. Nurse Practitioner (NP) #502 was notified and gave an order for Haldol 0.5 mg IM, one time for safety. Will monitor for effects and will update wife in the morning. No other note related to behaviors was documented. On 02/26/26 at 4:36 A.M., a behavior note revealed Resident #48 was very paranoid, belligerent, was kicking and hitting staff and was untrusting of staff. Emotional support given prior to medication given. NP #502 notified of behaviors and an order for Haldol 0.5 mg given IM at 3:25 A.M. continued with one on one for safety and observe for effectiveness, will update physician on call in the morning. Review of the statement written from NP #502 on 02/26/26 revealed she was the provider on call on (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/25/26 through 02/26/26. Around 3:00 A.M. on 02/26/26, the nurse on duty called her and stated Resident #48 was attempting to get up unassisted and kicking and hitting staff. Staff tried multiple nonpharmacological measures that were not effective. Resident #48 was paranoid of staff and had refused his Trazodone. There were concerns of Resident #48 physically and verbally aggressive with staff and himself. So, an order was given for Haldol 0.5 mg IM times one dose. Review of the Grievance Report dated 02/27/26 revealed a family concern was brought forward regarding use of IM Haldol for an acute change in behavior. Education was provided to nursing staff regarding use of medications. The nurse was removed from patient's care per family request. Nurse educated on procedure and conversation with provider. Review of the informed consent for psychotropic medication dated 02/27/26 revealed Resident #48 was ordered Trazodone at bedtime for insomnia and anxiety. Potential side effects were gone over at this time. The consent was signed by Resident #48's wife. There was no documentation about Haldol side effects that had been discussed with the resident's wife. Interview on 03/18/26 at 1:00 P.M. with Unit Manager (UM) Registered Nurse (RN) #393 verified Resident #48's family did not want Resident #48 to receive any antipsychotic medication injections after the first administration was given. On 03/18/26 at 3:55 P.M., Corporate Nurse #503 verified she had been unable to locate any documentation indicating risks of Haldol use was discussed with Resident #48 or his wife prior to Resident #48 receiving Haldol. This deficiency represents noncompliance investigated under Complaint Number 2794115.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, record review and policy review, the facility failed to ensure residents received timely assistance with meals and received showers per schedule. This affected three residents (Resident #22, #34 and #75) of five residents reviewed for assistance during mealtimes and one resident (Resident #37) of three residents reviewed for being offered showers per schedule. The facility census was 73. Findings Include: 1. Review of the medical record for Resident #22 revealed an admission date 07/01/21. Diagnosis included dementia, difficulty in walking, chronic kidney disease stage 3, anxiety, on hospice and solitary pulmonary nodule. Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed impaired cognition. Resident #22 required substantial/maximal assistance for eating and dependent for all other activities of daily living (ADL's). Review of the meal intake for Resident #22 for the last 30 days revealed Resident #22 ate 26-50 % of meals from 02/15/26 to 02/25/26. from 02/26/26 Resident #22 declined to 0-25% and on 03/14/26 declined and not eating. Observation on 03/10/26 at 8:53 A.M. Resident #22 was waiting for breakfast to be served in the dining room. At 9:15 A.M. meal trays were brought to the dining room on an open cart. At 9:32 A.M. Resident #22's breakfast was uncovered and set in front of her but staff did not sit down to assist her until 9:58 A.M. Certified Nursing Assistant (CNA) #326 offered Resident #22 drinks and food. Resident #22 consumed about 10-20 percent (%) of her meal. CNA #326 did not offer to warm up her meal. 2. Review of the medical record for Resident #34 revealed an admission date 05/19/16. Diagnosis included cerebral atherosclerosis, atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs and adult failure to thrive. Review of the Significant change in status MDS dated [DATE] revealed Resident #34 has impaired cognition. Resident #34 required setup or clean-up assistance with eating and dependent for all other ADLs. Review of the care plan dated 02/26/26 for weight loss or malnutrition related to advanced age, chronic disease, failure to thrive and dysphagia. Interventions included encouragement to eat, record meal percentage intake, give supplements as ordered. Observation on 03/10/26 at 9:35 A.M. of Resident #34's revealed his breakfast tray was placed in front of him and was not covered. At 9:53 A.M. CNA #326 sat down to start assisting Resident #34 with his meal. Resident #34 took one bite of his breakfast and then he did not want to eat anymore. CNA #326 did not offer to warm up his food or get him anything else to eat. Resident #34 did require assistance with eating, as he was unable to feed himself. 3. Review of the open medical record for Resident #75 revealed an admission date of 07/31/18. Diagnoses included hypertension, diabetes and Alzheimer's disease. Review of the quarterly MDS dated [DATE] revealed Resident #75 had impaired cognition. Resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#75 was dependent on eating and needed staff assistance and was dependent on all ADL's. Review of the care plan dated 01/08/26 for requires assistance with ADLs related to advanced age, chronic health condition, cognitive impairment. Interventions included provide setup only for meals, cueing and reminders for meals to improve intake and provide assistance with feeding for meals. Observation on 03/10/26 at 9:35 A.M. revealed the meal was placed in front of Resident #75 with no cover over the food. At 9:53 A.M. CNA #326 sat down to assist Resident #75. CNA #326 did not offer to warm up the food. Resident #75 picked up her toast and was eating it with encouragement but after the first bite of eggs, Resident #75 refused to eat anything other than her toast. Interview on 03/10/26 at 10:10 A.M. with CNA # 326 stated residents that need assistance with eating, will come to the dining room and are served after they can get everyone into the dining room. This cannot be done until aides are done with serving residents on the unit, so there is no set time for breakfast other than around 9:30 A.M. before staff can get in the dining room to help residents eat. By the time staff serve all the food in the dining room it is 10:00 A.M. before they can sit down to assist residents that need assistance. CNA #326 stated this affected the ability to assist dependent residents with their meals timely. Interview on 03/10/2026 at 10:13 A.M. with CNA #323 verified residents have to wait to be assisted until staff can get all the meals out and, at times, the food is cold by the time staff can sit down to assist a resident with eating. CNA #323 stated there is usually only two staff in the dining room to assist 13 residents for all meals and residents are required to wait to be assisted. Review of the facility policy Dining Room Service, not dated revealed meals will be served promptly to maintain adequate temperature and appearance. Adequate staff should be available in the dining areas to help individuals who need assistance and to handle any situation that may arise. 4.Review of Resident #37's medical record revealed diagnoses including acute kidney failure, history of stroke, cognitive communication deficit, abnormalities of gait and mobility, and dementia. A plan of care initiated 02/08/26 revealed Resident #37 required assistance with her activities of daily living due to advanced age, chronic health conditions and a recent hospitalization. Review of shower/bathing tasks revealed showers were scheduled on day shift on Monday, Thursday and as necessary. Review of shower documentation from 02/16/26 to 03/15/26 indicated during the week of 02/22/26 to 02/28/26, one shower was provided on Thursday, 02/26/26. No refusals were documented. The week of 03/01/26 to 03/07/26, one shower was provided on Thursday, 03/05/26. There was no indication a second shower was offered. The other six days staff documented a bed bath was provided. Documentation indicated Resident #37 refused a shower offered on 03/09/36. On 03/10/26 at 9:43 A.M., Resident #37 was observed sitting in her bed. Resident #37 was not oriented but was alert and her hair had an oily appearance On 03/16/26 at 3:50 P.M., the Administrator stated all showers were documented in the point of care records under the shower task. The Administrator stated she was unable to locate any additional information indicating showers were offered/provided in accordance with schedules. This deficiency demonstrates noncompliance investigated under Complaint Number 2744565.

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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 interviews, record review, observation and review of the facility policy, the facility failed to ensure Hospice documentation was in place for Resident #34 to ensure collaboration between the facility and Hospice services. This affected one Resident, Resident #34 of one resident reviewed for Hospice services. The facility also failed to ensure Resident #32 had routine assessments of a non-pressure skin impairment and failed to ensure Resident #56 had continued monitoring of a skin rash. This affected two residents (Resident #32 and #56) of two residents reviewed for non-pressure wounds of the skin. The facility census was 73.Findings include:1.Record review for Resident #34 revealed an admission date of 08/20/16. Diagnosis included cerebral atherosclerosis, atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs and adult failure to thrive. Review of the Significant Change Minimum Data Set (MDS) dated [DATE] revealed Resident #34 was severely cognitively impaired. Resident #34 had a condition or chronic disease that may result in a life expectancy of less than six months. Review of the physician order for Resident #34 revealed an order dated 02/14/26 to admit to Hospice related to cerebral atherosclerosis. Review of the care plan for Resident #34 dated 02/16/26 revealed the resident is receiving hospice services and is not expected to improve in condition for diagnosis of cerebral atherosclerosis. Interventions included: Hospice to provide bath or shower aid; Refer to Hospice provider as needed; and to see Hospice plan of care. Record review and interview on 03/16/2026 at 3:33 P.M. with Licensed Practical Nurse (LPN) Unit Manager (UM) #393 revealed Hospice would normally place their visit notes and care plan in the Hospice binder or the resident's paper chart. LPN UM #393 confirmed there was no care plan from Hospice or visit documentation from the nurse or Hospice Aid available in Resident #34's electronic record, hard chart or Hospice binder. LPN UM #393 revealed he did not know when Hospice visits were or information regarding visits or information regarding the Hospice plan of care. Interview on 03/16/2026 at 4:06 P.M. with the Administrator revealed the facility should collaborate with hospice and should have a copy of the care plan and documentation on file. Phone interview on 03/16/2026 at 4:38 P.M. with Hospice Registered Nurse (RN) #702 confirmed hospice picked up Resident #34 for services on 02/14/26. Hospice RN #702 confirmed Hospice did not provided the facility with a care plan or Hospice Nursing documentation. Review of the facility policy titled, Hospice dated 07/18/25 revealed communication will be maintained between the center and Hospice to ensure quality patient care. 2. Record review for Resident #56 revealed an admission date of 09/24/24. Diagnoses included chronic diastolic congestive heart failure (CHF) and chronic kidney disease, stage three. Review of the Quarterly MDS dated [DATE] revealed Resident #56 was cognitively intact. Resident #56 had applications of ointments/medications other than to feet. Review of the care plan dated 02/22/26 revealed Resident #56 did not have a care plan specific for a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rash. Review of the physician order for Resident #56 dated 12/28/25 revealed an order for clobetasol ointment 0.05% apply to chest, abdomen, arms topically every day and evening shift for rash. Review of Assessment for Resident #56 signed by Certified Nurse Practitioner (CNP) #501 with a visit date of 11/26/25 at 9:45 A.M. revealed nummular (circular or oval lesions) eczema rash present to chest, back, arms and abdomen. Cleanse with normal saline, apply clobetasol 0.05% BID (two times a day). Review of the electronic medical record revealed no further documentation or follow up on Resident #56's nummular eczema since 12/05/25. Record review revealed Resident #56 continued with the clobetasol treatment. Observation on 03/09/2026 at 6:41 A.M. of incontinence care provided by Certified Nursing Assistant (CNA) #307 revealed Resident #56 had multiple red, circular areas on her abdomen, chest and arms. The areas presented in a variety of sizes. Interview on 03/18/2026 at 3:48 P.M. with Licensed Practical Nurse (LPN) Unit Manager (UM) #388 confirmed Resident #56 did not have any documentation in the electric medical record or paper chart that included follow up and continued observation by the nursing staff of Resident #56's nummular eczema. . Interview on 03/18/2026 at 4:30 P.M. with Regional Director of Clinical Services (RDCS) #503 confirmed Resident #56 had no nursing follow up documentation in the medical record including weekly skin assessments on the nummular eczema and confirmed there should have been. RDCS #503 also confirmed Resident #56 did not have a care plan for the nummular eczema condition. 3. Review of Resident #32's medical record revealed diagnoses including pain, muscle wasting and atrophy, abnormalities of gait and mobility, peripheral vascular disease, osteoarthritis, iron deficiency anemia and hypertension. An admission nursing assessment dated [DATE] indicated Resident #32 had a scab to the right elbow (no measurements), scab to the left elbow (no measurements), and bruising to the left buttock (no measurements). Resident #32 was discharged to the hospital 02/02/26 for planned spinal surgery. Resident #32 was readmitted to the facility on [DATE]. An admission nursing assessment dated [DATE] indicated Resident #32 had an abrasion on the left buttock measuring 2 centimeters (cm) x 1.5 cm x 0.1 cm, a scab to the left heel measuring 3 cm x 2 cm x 0 cm and a surgical incision to the back neck (no measurements or description). On 03/11/26 at 4:36 P.M., the Director of Nursing (DON) verified other than what was located on the admission assessments the facility had no comprehensive assessments or documentation of healing of any of Resident #32's skin impairment. Resident #32 was followed by a wound clinic. On 03/16/26 at 10:50 A.M., Corporate Nurse #503 stated the facility only had one policy for wounds/skin impairment. Review of the Wounds/Skin Impairments policy (effective 07/17/24) revealed the skin observation tool should have been completed by a licensed nurse at least every seven days, detailing any wound/skin impairments. Corporate Nurse #503 verified Resident #32's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-pressure related skin impairment was not assessed weekly by the facility or wound clinic. This deficiency represents non-compliance investigated under Complaint Number 2801169.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of wound consultant notes, policy review, and interview, the facility failed to ensure routine skin assessments were completed for a resident with pressure ulcers. This affected one (Resident #32) of three residents reviewed for pressure ulcers The facility identified three residents with pressure ulcers. Findings include:Review of Resident #32's medical record revealed diagnoses including pain, muscle wasting and atrophy, abnormalities of gait and mobility, peripheral vascular disease, osteoarthritis, iron deficiency anemia and hypertension. An admission nursing assessment dated [DATE] indicated Resident #32 had pressure ulcers to the bottom of the left foot and right outer heel. There were no measurements or other descriptions of the pressure ulcers. Resident #32 was discharged to the hospital 02/02/26 for planned spinal surgery. Resident #32 was readmitted to the facility on [DATE]. An admission nursing assessment dated [DATE] indicated Resident #32 had an abrasion on the left buttock measuring 2 centimeters (cm) x 1.5 cm x 0.1 cm, a scab to the left heel measuring 3 cm x 2 cm x 0 cm and a surgical incision to the back neck (no measurements or description). There was no assessment of a pressure ulcer. No subsequent assessments were located although a posting on the wall on 03/09/26 at 6:40 A.M. revealed Resident #32 had an appointment with a wound clinic that day. On 03/11/26 at 4:36 P.M., the Director of Nursing (DON) verified other than what was located on the admission assessments the facility had no comprehensive assessments or documentation of healing of any of Resident #32's skin impairment. Resident #32 was followed by a wound clinic. Upon request, the facility obtained wound clinic notes. Review of the wound clinic notes dated 03/09/26 revealed Resident #32 had a stage three pressure ulcer (involving the top two layers of skin and fatty tissue) on the sacrum and a stage three pressure ulcer on the right plantar foot. On 03/16/26 at 10:50 A.M., Corporate Nurse #503 stated the facility only had one policy for wounds/skin impairment. Review of the Wounds/Skin Impairments policy (effective 07/17/24) revealed the skin observation tool should have been completed by a licensed nurse at least every seven days, detailing any wound/skin impairments. Corporate Nurse #503 verified Resident #32's non-pressure related skin impairment was not assessed weekly by the facility or wound clinic. This deficiency represents non-compliance investigated under Complaint Number 2801169.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview and policy review the facility failed to ensure Resident #30's urinary tract infection (UTI) was addressed timely and Resident #45 received timely incontinence care. This affected two residents (Resident #30 and #45) of two residents reviewed for bladder incontinence/urinary tract infection (UTI). The facility census was 73.Findings Include: 1. Review of the medical record for Resident #30 revealed an admission date of 08/09/17. Diagnoses included cognitive impairment, muscle weakness, chronic pain and anxiety.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had impaired cognition. Resident #30 was dependent on all activities of daily living (ADL's) and was incontinent of bowel and bladder.Review of the care plan dated 03/06/26 for incontinent of bladder and/or bowel related to severe cognitive impairment and severe physical impairment. Interventions included[SP1.1][TH1.2] keeping skin as clean and dry as possible.Review of the physician orders revealed on 12/16/25 an order was received to obtain a urine specimen for dip (use a urine strip to assess the resident's urine for a UTI) and notify the physician in the morning due to agitation on night shift. On 12/19/25 obtain a urine dip and notify completed on 12/19/25 at 3:15 P.M. On 12/20/25 an order for cefdinir (antibiotic) 300 milligrams (mg) by mouth two times a day for UTI. On 12/23/25 Nitrofurantoin Monohydrate capsule (antibiotic) 100 mg one capsule by mouth twice a day for UTI for three days, take with food.Review of the Medication Administration Record (MAR) for December 2025 revealed on 12/16/25 the urine dip was not obtained. On 12/20/25 urine dip obtained and Cefdinir 300mg was started on 12/20/25 at 12:00 P.M.Review of the progress note dated 12/15/25 at 3:50 P.M. revealed Resident #30 was having behaviors, trying to remove her top saying so hot get it off it is burning me. Noted to be talking with eyes closed and screaming no and hitting the wall. She refused by mouth medication. Lights off and soft music was being played and Resident #30 was repositioned in bed was all ineffective. When asked if she was having pain, she said yes when I pee it hurts, encouraged water and informed the unit manager. On 12/20/25 at 8:00 A.M. Resident #30 was straight cath as ordered for urinalysis (UA) dip. Was incontinent of urine a moderate amount, straight catheter with 50 cc of concentrated urine. The dip completed as ordered found nitrate positive, leukocytes and blood. At 12:50 P.M. physician notified of positive UA dip. It was ordered due to dysuria (pain when urinating) complaints about burning and unable to urinate. Order for UA and C&S and check with family Rocephin (antibiotic) allergies. At 12:54 P.M. daughter was informed she was going to start an antibiotic pending UA and culture and sensitivity (C&S).Interview on 03/09/26 at 2:15 P.M. with daughter of Resident #30 revealed in December 2025 Resident #30 had signs and symptoms of a UTI and they did not put her on an antibiotic for six days. Staff would say Resident #30 was at her baseline and did not have a UTI.Interview 03/11/2026 3:31 P.M. regarding Resident #30 with Unit Manager Registered Nurse (RN) #393 stated typically when a resident complains of any dysuria or has mental status change, they will usually check the resident's urine within one to two days depending on symptoms, will straight cath the resident for the specimen and check to see if anything shows up on the UA dip. If anything shows up on the UA dip it will be sent out for a UA with culture and sensitivity (C&S). The results take two or three days to get back from the lab. A broad-spectrum antibiotic may be ordered in the meantime. Resident #30 was lethargic, had hallucinations and had altered mental status. RN #393 verified Resident #30 was having signs and symptoms of a UTI on 12/15/25 and a urine sample was not sent out until 12/21/25, six days later. The urine sample should have been collected and sent out immediately. 2. Review of the open medical record for Resident #45 revealed an admission date 02/27/23. Diagnosis included colostomy, spinal stenosis, increased weakness and inability to control bowel or bladder.Review of the quarterly MDS dated [DATE] revealed Resident #45 had intact cognition. Resident #45 required staff to assist with toileting. Review of the care plan dated 01/26/26 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bethany Nursing Home, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 626 34th Street, NW Canton, OH 44709	

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for incontinent of bladder due to inability to control bowel and bladder and Benign Prostatic Hyperplasia (BPH). Interventions included one person assisting with toileting, check and changing briefs frequently as needed and providing toileting hygiene with brief changes.Observation on 03/11/26 at 11:00 A.M. of Resident #45's call light was on.Interview on 03/11/26 at 11:24 A.M. with Resident #45 revealed he put his call light on at 11:00 A.M. because he was wet and needed changed. Resident #45 stated staff don't always get to him timely when he puts his call light on. Observation on 03/11/26 at 11:41 A.M. revealed CNA #314 entered Resident #45's room to provide incontinence care and care was provided at this time. Resident #45's disposable incontinence brief was full on urine. CNA #314 assisted Resident #45 with the urinal and putting on a new disposable incontinence brief. Interview on 03/11/26 at 11: 50 A.M. with CNA #314 revealed she just came back from break, and she usually made sure all call lights were answered prior to her going on break for ten minutes. CNA #314 stated there was another aide on the floor, but she was busy with another resident, so she was unable to get his call light. CNA #314 verified 41 minutes was too long for a call light to be on.Interview on 03/11/26 at 12:30 P.M. with the Director of Nursing (DON) verified 41 minutes was too long for a call light to be on for a resident who needed staff assistance. This deficiency demonstrates noncompliance investigated under Complaint Numbers 2801169, 2794252, and 2744565.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, review of the staffing policy, and residents, family, and staff interviews, the facility failed to ensure there was sufficient staff to meet residents' needs in a timely manner. This affected six residents observed during the survey (#22, #31 #34, #45, #52, and #75). This had the potential to affect all 73 residents residing in the facility.Findings include:1. During confidential interviews of 25 residents, nine residents revealed they did not believe there was sufficient staff to provide timely assistance. One additional resident had family present at the time of the interview and stated there was not sufficient staff to timely meet her loved ones needs. Concerns ranged from delayed response to call lights, turning call lights off and not returning, not providing assistance with requests for ambulation, failure to meet toileting and incontinence needs in a timely manner, and being concerned for safety if there was an emergency. 2. There were concerns identified with meal service and having sufficient staff to serve meals to residents timely and to meet their preference of where they want to eat their meals. Observation on 03/10/26 at 8:53 A.M. revealed Resident #22 was waiting for breakfast to be served in the dining room. At 9:15 A.M., meal trays were brought to the dining room on open cart. At 9:32 A.M., Resident #22's breakfast tray was uncovered and set in front of her at 9:32 A.M. but staff did not sit down to assist her until 9:58 A.M. Certified Nursing Assistant (CNA) #326 offered Resident #22 drinks and food. Resident #22 consumed about 10-20 percent (%) of her meal. CNA # 326 did not offer to warm up her meal. WAS THIS CONFIRMED? Observation on 03/10/26 at 8:55 A.M. revealed Resident #75 was brought into the dining room. At 9:30 A.M., a meal placed in front of Resident #75, with no cover over the food. At 9:53 A.M., CNA #326 sat down to assist Resident #75. CNA #326 did not offer to warm up the food. Resident #75 picked up her toast and was eating it with encouragement but after the first bite of eggs. Observation on 03/10/26 at 9:35 A.M. revealed Resident #34's breakfast tray was placed in front of him and was not covered. At 9:53 A.M., CNA #326 sat down to start assisting Resident #34 with his meal. Resident #34 took one bite of his breakfast and then he did not want to eat anymore. CNA #326 did not offer to warm up his food or get his anything else to eat. There were five residents at the table needing to be assisted or encouraged and two residents had to be assisted with eating (Residentd #34 and #75). Interview on 03/10/26 at 10:10 A.M. with CNA # 326 stated residents who required assistance from staff with eating, will come to the dining room and residents were served their meals after nursing can get everyone into the dining room. This cannot be done until CNAs were done with serving residents on the unit, so there was no set time for breakfast other than around 9:30 A.M. before CNAs can get in to the dining room to help residents eat. By the time the CNAs serve all the meal trays in the dining room, it was 10:00 A.M. when CNAs can sit down to assist residents who require assistance with their meals. CNA #326 stated she did not feel there was enough staff to meet residents needs timely during mealtimes. Interview on 03/10/26 at 10:13 A.M. with CNA #323 verified residents have to wait to be assisted until CNAs can get all the meals out and at times, the food was cold by the time CNA #323 can sit down to assist a resident with eating. CNA #323 stated there was usually only two staff in the dining room to assist 13 residents for all meals. There were not enough staff at all for the meals served in (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the dining room who required assistance to eat. Additional staff in the dining room would all residents to not wait as long to be assisted with their meal. Interview on 03/10/26 at 10:15 A.M. with Dietary Manager #504 stated the meal cart has to be held until residents were brought into the dining room. The residents should be brought to the dining room at 9:15 A.M. but there were times that residents and staff were not ready to eat until 9:45-10:00 A.M. The residents requiring assistance have to wait until the CNAs had everyone on the floor done so they can assist in the dining room. Interview on 03/12/26 at 12:21 P.M. with Dietary Manager #504 stated part of the reason breakfast trays were provided to the dining room for residents who needed fed/supervision/assistance so late was because dietary staff had to wait for nursing staff to get all the residents into the dining room before they delivered trays. Observation and interview on 03/16/26 at 9:42 A.M. revealed Resident #31's niece was propelling Resident #31 through the hall and stated it was ridiculous that residents did not eat until 10 A.M. Resident #31's niece stated the resident went through a period where she was more confused and she thought that was why Resident #37 was sent to the dining room for residents who needed assistance. Resident #31 used to be done eating by 9:00 A.M. but with the new company, Resident #31 was getting her breakfast much later. Resident #31 stated she would like to receive her breakfast no later than 9:00 A.M. If it meant eating in her room, she would like her breakfast earlier. Interview on 03/16/26 at 10:33 A.M. with Speech Language Pathologist (SLP) #441 stated in order for Resident #31 to safely eat in her room, she would require one-on-one supervision throughout the meal. SLP #441 stated there was insufficient staff to provide one-on-one supervision for Resident #31 to eat meals in her room. 3. There were concerns identified with call lights being answered timely and providing assistance with toileting timely. Observation on 03/11/26 at 11:00 A.M. revealed Resident #45's call light was on. Interview on 03/11/26 at 11:24 A.M. with Resident #45 revealed he put his call light on at 11:00 A.M. because he was wet and needs changed. Resident #45 stated staff don't always get to him timely when he puts his call light on. Observation on 03/11/26 at 11:41 A.M. revealed Certified Nursing Assistant (CNA) #314 entered Resident #45's room to provide incontinence care. Incontinence care was provided at this time. Resident #45's adult brief was full on urine. CNA #314 assisted Resident #45 with the urinal and putting on clean adult briefs. Interview on 03/11/26 at 11:50 A.M. with CNA #314 stated she just came back from break, and she usually makes sure all call lights were answered prior to her going on break for ten minutes. CNA #314 stated there was another CNA on the floor, but she was busy with another resident, so she was unable to get his call light. CNA #314 verified 41 minutes was too long for a call light to be on. Interview on 03/11/26 at 12:30 P.M. with the Director of Nursing (DON) verified 41 minutes was too long for a call light to be on. Observation on 03/12/26 at 9:34 A.M. revealed a call light was observed on in Resident #52's room when the surveyor entered the hallway. The call light remained on at 9:45 A.M. when Resident #52 ambulated toward the nursing station proclaiming loudly she had her call light on for 25 minutes so (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	she could get assistance getting out of the bathroom. Interview on 03/12/26 at 9:53 A.M., Certified Nursing Assistant (CNA) #314 stated all but one CNA had to go to assist in the dining room for those who required more assistance during meals leaving one CNA to monitor other residents on the hall, monitor and respond to call lights and feed one resident. Call lights were not always able to be responded to while the one staff member available was feeding another resident. Review of the facility's Staffing policy (not dated) revealed the policy was for the facility to maintain adequate staffing on each shift to ensure residents' needs and services were met. This deficiency represents noncompliance investigated under Master Complaint Number 2805282 and Complaint Numbers 2801169, 2794252, and 2744565.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the manufacturer instructions, the facility failed to ensure a medication error rate of less than five percent (%). Two errors were observed in 25 opportunities resulting in an 8.0% error rate. This affected one (Resident #83) of four residents observed for medication administration. The facility census was 73.Findings include: Record review for Resident #83 revealed an admission date of 11/03/25. Diagnosis included type two diabetes mellitus (DM). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 was moderately cognitively impaired and received insulin injections daily. Review of the physician orders revealed on 12/13/25, Resident #83 had an order for insulin lispro 100 units per milliliter (ml) inject subcutaneously (SQ) as per sliding scale. The order included if the blood sugar was 301 to 350 inject eight units. Medications also included insulin lispro 26 units SQ one time a day for DM, give half dose if resident eats less than 50%, hold if patient does not eat dated 12/09/25 and Lantus 50 units SQ in the morning for DM dated 01/20/26.Review of the care plan dated 01/15/26 revealed Resident #83 was at risk for complications and blood glucose fluctuations related to the diagnosis of DM with insulin use. Interventions included to administer insulin as ordered.Observation on 03/09/26 at 9:48 A.M. revealed Licensed Practical Nurse (LPN) #383 assessed Resident #83's blood sugar and Resident #83's blood sugar was 332. LPN #383 confirmed Resident #83 ate 100% of breakfast. LPN #383 removed the lispro insulin pen for Resident #83 from the medication cart and dialed the pen to 34 units. LPN #83 then removed the Lantus insulin pen from the medication cart and dialed the pen to 50 units. LPN #383 never primed either insulin pen (lispro and Lantus) before dialing in the units to be administered. LPN #383 then entered Resident #83's room and administered both insulin injections to Resident #83.Interview on 03/09/26 at 10:06 A.M. with LPN #383 confirmed she did not prime the two insulin pens (lispro and Lantus) prior to dialing in the units and administering the insulin to Resident #83.Review of the manufacturers instructions for use for KwikPen insulin administration, undated revealed under priming your pen: prime before each injection, priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. To prime the pen, turn the dose knob to select two units. Hold the pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding the pen with needle pointing up. Push the dose knob in until it stops and zero is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. If you don't see insulin, repeat the priming steps. Next turn the dose knob to the correct number of units you need to inject.The deficiency represents noncompliance investigated under Complaint Numbers 2801169 and 2744565.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the manufacturer instructions, the facility failed to prime an insulin pen per manufacturer instructions prior to administration, resulting in a significant medication error. This affected one (Resident #83) of one resident observed for insulin administration. The facility identified there were six residents who receive insulin. The facility census was 73.Findings include:Record review for Resident #83 revealed an admission date of 11/03/25. Diagnosis included type two diabetes mellitus (DM). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 was moderately cognitively impaired and received insulin injections daily. Review of the physician orders revealed on 12/13/25, Resident #83 had an order for insulin lispro 100 units per milliliter (ml) inject subcutaneously (SQ) as per sliding scale. The order included if the blood sugar was 301 to 350 inject eight units. Medications also included insulin lispro 26 units SQ one time a day for DM, give half dose if resident eats less than 50%, hold if patient does not eat dated 12/09/25 and Lantus 50 units SQ in the morning for DM dated 01/20/26.Review of the care plan dated 01/15/26 revealed Resident #83 was at risk for complications and blood glucose fluctuations related to the diagnosis of DM with insulin use. Interventions included to administer insulin as ordered.Observation on 03/09/26 at 9:48 A.M. revealed Licensed Practical Nurse (LPN) #383 assessed Resident #83's blood sugar and Resident #83's blood sugar was 332. LPN #383 confirmed Resident #83 ate 100% of breakfast. LPN #383 removed the lispro insulin pen for Resident #83 from the medication cart and dialed the pen to 34 units. LPN #83 then removed the Lantus insulin pen from the medication cart and dialed the pen to 50 units. LPN #383 never primed either insulin pen (lispro and Lantus) before dialing in the units to be administered. LPN #383 then entered Resident #83's room and administered both insulin injections to Resident #83.Interview on 03/09/26 at 10:06 A.M. with LPN #383 confirmed she did not prime the two insulin pens (lispro and Lantus) prior to dialing in the units and administering the insulin to Resident #83.Review of the manufacturers instructions for use for KwikPen insulin administration, undated revealed under priming your pen: prime before each injection, priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. To prime the pen, turn the dose knob to select two units. Hold the pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding the pen with needle pointing up. Push the dose knob in until it stops and zero is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. If you don't see insulin, repeat the priming steps. Next turn the dose knob to the correct number of units you need to inject.The deficiency represents noncompliance investigated under Complaint Numbers 2801169 and 2744565.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, record review, review of the facility policies and Manufacturer guidelines, the facility failed to ensure infection control practices were maintained for three residents (Resident #60, #83 and #86) observed during medication administration, two residents (Resident #2 and #83) observed during blood sugar assessments, one resident (Resident #22) observed for Enhanced Barrier Precautions, one resident (Resident #85) observed with soiled linen on the floor. Additionally, the facility failed to ensure water testing was routinely completed for Legionella. This affected six residents (#2, #22, #60, #83, #85, and #86) and had the potential to affect all residents residing in the facility. The facility census was 73.Findings include:1. Review of the medical record for Resident #85 revealed an admission date 01/06/26. Diagnoses included pneumonia and muscle weakness. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #85 had impaired cognition and was dependent on staff for toileting. Observation and interview on 03/12/26 at 5:34 A.M. of dirty linens on the floor in Resident #85's room. Certified Nurse Assistant (CNA) #332 was in the room assisting Resident #85 with the door open. CNA #332 stated she was cleaning Resident #85 up and she would be picking up the dirty linen and dirty adult briefs off the floor once she was done. CNA #332 verified she did have dirty linens and a dirty brief on the floor in Resident #85's room. Interview on 03/12/26 at 10:30 A.M. with Director of Nursing (DON) verified dirty linens were not to be put on the floor and dirty items should be put in a bag. 2. Record review for Resident #2 revealed an admission date of 07/24/25. Diagnoses included type two diabetes mellitus and acute kidney failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact. Review of the care plan dated 02/02/16 revealed Resident #2 was at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus. Interventions included administering medication as ordered. Review of the physician orders dated 01/8/26 revealed Resident #2 had an order to check blood sugars twice a day in the morning and night (HS), notify if less than 80 or greater than 300. Observation on 03/09/26 at 6:29 A.M. revealed Licensed Practical Nurse (LPN) #387 assessed Resident #2's blood sugar via fingerstick and a glucometer. LPN #387 removed the glucometer from the medication cart drawer with supplies for the fingerstick. LPN #387 entered Resident #2's room, assessed Resident #2's blood sugar via fingerstick and glucometer, (did not clean the glucometer before use) then wiped the glucometer off briefly with an alcohol wipe. LPN #387 then exited the room (without washing her hands or using hand sanitizer) returned to the medication cart and placed the glucometer back in the medication cart drawer without washing her hands or using hand sanitizer. LPN #387 confirmed the task was completed. LPN #387 revealed the glucometer was used for several different residents daily and verified she did not clean the glucometer before use then cleaned the glucometer briefly with an alcohol wipe after use. LPN #387 verified she did not wash her hands before or after checking Resident #2's blood sugar via fingerstick. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Handwashing Requirements with an effective date 02/06/20 revealed employees will wash their hands at appropriate times to reduce the risk of transmission and acquisition of infections. The following is a list of some situations that require hand hygiene and included: When coming on duty, before and after performing any invasive procedure (e.g. fingerstick blood sampling), before and after entering transmission based precaution settings, before and after assisting a patient with personal care, before and after handling peripheral vascular catheters and other invasive devices, and upon and after coming in contact with a patient's intact skin (lifting a patient). Review of the facility's undated policy titled Cleaning and Disinfecting revealed cleaning and disinfecting the meter and lancing device is very important in the prevention of infectious disease. Wipe all external areas of the meter including both front and back surfaces until visibly clean. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipes direction for use. 3. Record review for Resident #83 revealed an admission date of 11/03/25. Diagnoses included type two diabetes mellitus and chronic kidney disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 was moderately cognitively impaired and received insulin injections daily. Review of the physician orders dated 12/13/25 revealed Resident #83 had an order for insulin lispro 100 units per milliliter (ml) inject subcutaneously (SQ) as per sliding scale. Medications included insulin lispro 26 units one time a day SQ dated 12/09/25 and Lantus 50 units SQ every morning dated 01/20/26 for diabetes mellitus. Observation on 03/09/26 at 9:48 A.M. revealed Licensed Practical Nurse (LPN) #383 was going to complete a fingerstick blood sugar assessment and insulin administration for Resident #83. LPN #383 entered Resident #83's room and assessed Resident #83's fingerstick blood sugar via glucometer. LPN #383 never washed her hands nor used hand sanitizer prior to or after assessing the blood sugar. LPN #383 then exited the room, returned to the medication cart, placed the glucometer on top of the cart and removed two insulin pens, Lantus and lispro from the drawer of the medication cart. LPN #383 adjusted the insulin dosage on each pen. LPN #383 returned to Resident #83's room (never washed her hands or used hand sanitizer at any point during the observation), administered the insulin, exited the room, returned to the medication cart and placed the insulin pens back inside the drawer (with additional residents' insulin pens) of the medication cart. LPN #383 never washed her hands or used hand sanitizer. LPN #383 then removed a sani-wipe from the container, wiped the glucometer for approximately 12 seconds, disposed of the wipe and placed the glucometer back in the medication cart. LPN #383 revealed the glucometer was used daily on multiple residents to assess blood sugars. LPN #383 then began documenting in the computer. LPN #383 confirmed she never washed her hands nor used hand sanitizer at any time during the observation of the fingerstick blood sugar assessment or insulin administration and revealed she was always taught to clean the glucometer that way. Review of the facility policy titled Handwashing Requirements with an effective date 02/06/20 revealed employees will wash their hands at appropriate times to reduce the risk of transmission and acquisition of infections. The following is a list of some situations that require hand hygiene and included: When coming on duty, before and after performing any invasive procedure (e.g. fingerstick blood sampling), before and after entering transmission based precaution settings, before and after assisting a patient with personal care, before and after handling peripheral vascular catheters and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366334	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Nursing Home, Inc	626 34th Street, NW Canton, OH 44709

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	other invasive devices, and upon and after coming in contact with a patient's intact skin (lifting a patient). Review of the facility's undated policy titled Cleaning and Disinfecting revealed cleaning and disinfecting the meter and lancing device is very important in the prevention of infectious disease. Wipe all external areas of the meter including both front and back surfaces until visibly clean. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipes direction for use. Review of the Sani Wipe cleaning instructions for glucometers included using the disposable wipe to wipe down the glucometer then allow two minutes wet time. This will be performed after each use of the glucometer. 4. Record review for Resident #60 revealed an admission date of 11/04/22. Diagnoses included radiculopathy, lumbar region, diabetes mellitus and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was severely cognitively impaired. Review of the care plan dated 01/19/26 revealed Resident #60 required assistance with activities of daily living related to weakness and decreased mobility. Observation and interview on 03/10/26 at 8:26 A.M. revealed LPN #375 prepared and administered medications to Resident #60. LPN #375 did not wash her hands or use hand sanitizer before preparing Resident #60's medication. LPN #375 removed 12 medications from the medication cart, prepared the medications in a medication cup and entered Resident #60's room and administered the by mouth medications to Resident #60. LPN #375 then administered the fluticasone propionate nasal spray to each nostril, left the room without washing her hands or using hand sanitizer, returned to the medication cart, opened the drawer of the cart and placed the nose spray back in cart with additional medications without washing her hands or using hand sanitizer. LPN #375 confirmed she never washed her hands or used hand sanitizer before preparing Resident #60's medication or after administering the medication or before reentering the medication cart. Review of the facility policy titled Handwashing Requirements with an effective date 02/06/20 revealed employees will wash their hands at appropriate times to reduce the risk of transmission and acquisition of infections. The following is a list of some situations that require hand hygiene and included: When coming on duty, before and after performing any invasive procedure (e.g. fingerstick blood sampling), before and after entering transmission based precaution settings, before and after assisting a patient with personal care, before and after handling peripheral vascular catheters and other invasive devices, and upon and after coming in contact with a patient's intact skin (lifting a patient). 5. Record review for Resident #86 revealed an admission date of 05/06/25. Diagnoses included Parkinson's disease and chronic kidney disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #86 was cognitively intact. Review of the care plan dated 12/22/25 revealed Resident #86 required assistance with activities of daily living related to Parkinson's disease. Observation and interview on 03/10/26 at 8:52 A.M. revealed LPN #389 prepared and administered medications to Resident #86. LPN #389 did not wash her hands or use hand sanitizer before preparing (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bethany Nursing Home, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 626 34th Street, NW Canton, OH 44709	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #86's medication. LPN #389 removed 10 medications from the medication cart. LPN #389 then placed the medications in a medication cup prepared with applesauce. LPN #389 entered Resident #86's room and administered the medications to Resident #86. LPN #389 then left the room without washing her hands or using hand sanitizer, returned to the medication cart, opened the drawer of the cart and pulled additional medications out of the cart. LPN #389 revealed she was beginning to prepare for the next resident's medication. LPN #389 confirmed she never washed her hands or used hand sanitizer before preparing Resident #86's medication or after administering the medication or before reentering the medication cart. Review of the facility policy titled Handwashing Requirements with an effective date 02/06/20 revealed employees will wash their hands at appropriate times to reduce the risk of transmission and acquisition of infections. The following is a list of some situations that require hand hygiene and included: When coming on duty, before and after performing any invasive procedure (e.g. fingerstick blood sampling), before and after entering transmission based precaution settings, before and after assisting a patient with personal care, before and after handling peripheral vascular catheters and other invasive devices, and upon and after coming in contact with a patient's intact skin (lifting a patient). 6. Record review for Resident #22 revealed an admission date of 07/01/21. Diagnoses included chronic kidney disease, stage three and frequency of micturition. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was severely cognitively impaired and had an indwelling catheter. Review of the care plan dated 01/30/26 revealed Resident #22 has a chronic wound or pressure ulcer to the sacrum. The resident had a risk for worsening wounds or the development of additional wounds related to: advanced age, chronic health conditions, cognitive impairment , dry fragile skin , frequent incontinence, history of pressure ulcer development, and inability to turn and reposition independently. Interventions included Enhanced Barrier Precautions (EBP). An additional care plan dated 01/30/26 revealed the resident required an indwelling catheter related to the pressure ulcer. Interventions included EBP. Observation on 03/11/26 at 4:12 P.M. revealed Certified Nursing Assistants (CNA) #300 and #505 provided direct care to Resident #22 and neither CNA placed an isolation gown on. CNAs #300 and #505 completed a brief change, emptied the catheter bag, and transferred Resident #22. CNA #300 partially removed Resident #22's brief to ensure it was clean. After checking the brief, CNA #300 exited the room without washing her hands. CNA #300 returned minutes later with a chair and a leg bag for the indwelling catheter. CNA #300 again never washed her hands or donned an isolation gown. CNA #505 disconnected the urine drainage bag hanging from the side of the bed that was connected to Resident #22's indwelling catheter. CNA #505 never washed her hands before disconnecting the tubing. CNA #300 took the old catheter tubing and bag to the bathroom and drained 200 cubic centimeters (cc) of urine from the bag. CNA #505 then connected the new leg bag tubing to the indwelling catheter then realized she did not have the supplies to secure the tubing to Resident #22's leg. CNA #300 again left the room, never washed her hands or used hand sanitizer and returned moments later with leg secure device for the catheter. Both CNA's completed dressing Resident #22, transferred her to the chair via mechanical lift then exited the room without washing their hands or using hand sanitizer. Interview on 03/11/26 at 4:37 P.M. with CNA #505 confirmed Resident #22 had a sign near the entrance door stating EBP. The sign included to wear gloves and a gown for the following (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	high-contact resident care activities: transferring, and device care and use which included indwelling catheters. CNA #505 confirmed she nor CNA #300 donned an isolation gown when providing direct care to Resident #22 care. CNA #505 confirmed she never washed her hands nor used hand sanitizer before, during or after the care. Interview on 03/11/2026 at 4:38 P.M. with CNA #300 confirmed she never donned an isolation gown when providing direct care to Resident #22 and confirmed she never washed her hands nor used hand sanitizer before, during or after the care. Review of the facility policy titled Handwashing Requirements with an effective date 02/06/20 revealed employees will wash their hands at appropriate times to reduce the risk of transmission and acquisition of infections. The following is a list of some situations that require hand hygiene and included: When coming on duty, before and after performing any invasive procedure (e.g. fingerstick blood sampling), before and after entering transmission based precaution settings, before and after assisting a patient with personal care, before and after handling peripheral vascular catheters and other invasive devices, and upon and after coming in contact with a patient's intact skin (lifting a patient). Review of the facility policy titled Enhanced Barrier Precautions (EBP) effective date 03/26/24 revealed employees providing high-contact patient care activities will follow EBP for patients who meet the criteria. May be indicated for patients with chronic wounds, (pressure ulcers, diabetic ulcers, etc.), and with indwelling medical devices (central lines, urinary catheters, etc.). 7. Interview with the Administrator and record review of the Legionella Monitoring – Ice Machine for 2025 and 2026 on 03/18/26 at 1:27 P.M. revealed the Administrator confirmed the facility was not testing for Legionella as required. The Administrator confirmed in 2025, the facility only tested their ice machines and in 2026 there was no testing completed at the facility for Legionella. The Administrator confirmed the testing was not done correctly. Subsequent interview with the Administrator on 03/19/26 at 4:47 P.M. revealed the facility had city water. The Administrator revealed she called the water company, but they never tested the water for Legionella. The Administrator confirmed at any given time, the facility had empty resident rooms with a private bathroom/sink that had stagnant water and was not tested in 2025 or 2026. Review of the facility policy titled Legionella Water Management Program revised September 2022 revealed the facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. The purpose of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risks of Legionnaire's disease. The identification of areas in the water system that could encourage the growth and spread of Legionella or other water borne bacteria include: Storage tanks, water heaters, filters, aerators, showerheads and hoses, misters, humidifiers, and fountains. The water management program is reviewed at least once a year or sooner. This deficiency demonstrates noncompliance investigated under Complaint Number 2801169.