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	04/21/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of the medical record and interview with staff and residents, the facility failed to ensure showers for Resident #1, who was dependent for activities of daily living, were completed as scheduled. This affected one resident (Resident #1) of three reviewed for bathing. The facility census was 82. Findings include:Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included stenosis of cardiac prosthetic, diabetes, right sides hemiplegia, cerebral infarction, edema, hypertension, insomnia, non-rheumatic aortic stenosis, irritable bowel syndrome, congestive heart failure, benign prostatic hyperplasia, anxiety disorder, depression, prosthetic heart valve, cardiac pacemaker, degenerative disc disease, and gout.Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #1 had intact cognition, had upper body one side impairment, had lower body one side impairment, required maximal assist for toilet hygiene, bathing, and personal hygiene, turning in bed, and was frequently incontinent of bladder and bowel. Review of the plan of care dated 03/18/26 with a revision date of 04/02/26 revealed Resident #1 required assistance with activities of daily living (ADLs) due to advanced age, chronic health conditions and recent hospitalization. Interventions included assist with transfers via butterfly (a long, wide, and stable transfer board with a smooth top and special cutouts, used by people with limited mobility to transfer between a wheelchair and other surfaces) and therapy services as needed. Review of the progress notes from 03/17/26 to 04/15/26 revealed no documentation Resident #1 refused to take a shower. Review of the Documentation Survey Report from 03/17/26 to 04/13/26 revealed Resident #1 was scheduled to have a shower on day shift on Tuesdays and Saturdays, however, he only had one shower during that time on 04/01/26. There were no refusals documented.On 04/13/26 at 9:50 A.M., an interview with Resident #1 revealed he had only received one bath/shower since he has been at the facility, and the rest of the time staff just wiped him down with wet wipes.On 04/21/26 at 10:45 A.M., an interview with the Director of Nursing (DON) verified there was no documentation of Resident #1 received his scheduled showers. The facility did not have a bathing/showering policy per the Administrator. This deficiency represents non-compliance investigated under Complaint Number 2979712 and is a recite to the survey completed 03/24/26.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of the medical record, review of the Self-Reported Incident, review of pharmacy delivery slips, and interview with the staff, the facility failed to reconcile narcotic medications delivered from the pharmacy with the pharmacy delivery slip upon delivery to the facility to ensure the facility received all the listed narcotic medications. This affected one resident (Resident #69) of three residents reviewed for delivery of medication. The facility census was 82. Findings include: Review of the medical record revealed Resident #69 was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis, hypertension, Barrett's esophagus, malignant neoplasm of the lymphoid, insomnia, hypothyroidism, spinal stenosis, obstructive sleep apnea, irritable bowel syndrome, chronic pain, pain in the knees, polyneuropathy and anemia. Review of the physician's orders revealed Resident #69 had an order dated 12/09/25 for Fentanyl (an opioid analgesic) 25 microgram (mcg) patches, apply one patch every three days. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #69 had intact cognition.Review of the March 2026 Medication Administration Record (MAR) revealed Resident #69 was not administered Fentanyl 25 mcg as scheduled on 03/27/26. No other information was documented as to why it was not administered. There was no documentation of her pain level on the MAR. Review of the pain assessment dated [DATE] revealed Resident #69 had pain or was hurting in the last five days, her pain frequency was occasionally, it rarely affected sleep, therapy, or day-to-day activities. The numeric scale was zero out of 10. Resident #69 had no complaints of pain at this time and was sitting up in wheelchair eating dinner with call light in reach.Review of the Self-Reported Incident dated 03/27/26 revealed Resident #69 was ordered Fentanyl patch 25 mcg an hour. On 03/27/26, it was noted that no patches were available. When the pharmacy was contacted, they reported that four patches were sent to the facility on [DATE] and signed for by a facility nurse. The patches were never logged into the narcotic drawer and the nurse working did not remember seeing the patches on that date. An investigation was initiated; The patches were believed to be inadvertently thrown out in the pharmacy bag. A search was conducted of the medication cart. A sweep of the trash cans was conducted and validated the dumpster trash was already picked up for the day. Audit of all narcotics in the house and found no discrepancies. The facility reviewed the involved nurse's file, checked licenses, the nurse was notified and interviewed, the resident's pain was assessed, and no negative implications were identified. The facility interviewed like resident to ensure all medications were given as ordered. Pain scores reviewed of like residents. A whole house narcotic audit was conducted to ensure accurate counts. All narcotic medication log sheets were reviewed for accuracy. Education of all nurses was completed on misappropriation of property and on the inventory of controlled drug policy to include validating pharmacy manifests when signing for medications.Review of the handwritten, signed witness statement written by Licensed Practical Nurse (LPN) #306 dated 03/27/26 revealed she had received medication from the pharmacy, and she specifically remembered only getting one narcotic card in the skilled pharmacy bag. She did not remember receiving Fentanyl patches in the bag. The only patch she received was a Pyxis (a computerized, automated medication dispensing system used to securely store and manage patient medication replacements). She indicated she believed the patches were stuck inside the bag and got thrown away. She stated she did sign the order receipt but indicated she had not verified the slip matched the narcotic received.Review of the controlled substance delivery sheet dated 03/24/26 revealed four Fentanyl 25 mcg/hour patches were delivered for Resident #69 and were signed for by LPN #306 on 03/24/26 at 6:38 A.M.Review of the Pharmacy Transaction report revealed on 03/27/26, 03/30/26, 04/02/26, and 04/11/26, Fentanyl 25 mcg patches were pulled from the facility's stock medications. The resident was not charged for those medications.On 04/21/26 at 11:00 A.M. an interview with Regional Nurse #110 verified the nurse (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have checked the narcotic in when she received them and checked them against the pharmacy delivery slip. She stated the resident was not in any pain, did not miss any doses because the pulled the medication from the starter kit, and the resident was not charged for the lost medications. The facility did not have a narcotic delivery policy or procedure per the Administrator.