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

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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 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 (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 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 interview the facility failed to ensure there was a Registered Nurse providing services at least eight hours a day, seven days a week. This had the potential to affect all 80 residents residing in the facility. Facility census was 80. Findings include:Review of the Daily Nurse Staffing Summaries from 04/20/26 through 06/01/26 with the Director of Human Resources (Dir. HR) #133 revealed there was not a RN for at least eight hours a day, seven days a week on 04/24/26, 05/02/26, 05/03/26, 05/16/26, 05/17/26, and 05/28/26. Interview on 06/01/26 at 11:35 A.M. with the Administrator and the Director of Nursing (DON) confirmed there was no an RN in the building for at least eight hours a day, seven days a week. Interview on 06/01/26 at 11:41 A.M. with the Dir. HR #133 confirmed there was not an RN in the building for at least eight hours a day, seven days a week.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure medications were stored in a safe and secure manure and failed to ensure medications were not expired. One medication room and three medications carts were observed. The facility identified there was one medication room and six medication carts. This had the potential to affect all 73 residents residing at the facility.Findings include:Observation on 03/09/26 at 2:00 P.M. revealed the skilled medication cart located in the residential hall was observed unlocked with the computer open. Observation revealed there was no staff within view of the unsecured medication cart. One resident was observed sitting in a chair and additional residents were observed ambulating in the hall. At 2:03 P.M., Unit Manager (UM) #388 entered the hall where the unsecured medication cart was located. UM #388 confirmed the medication cart was left unlocked and unattended. UM #388 revealed the nurse was in a room with a resident. Observation on 03/11/26 at 11:03 A.M. of the medication storage with UM #388 revealed the medication storage room also had a refrigerator used for medications that required refrigeration. On the outside of the refrigerator door, there was a temperature log dated March 2026. The last date the refrigerator temperature was completed on the log was 03/06/26; 03/01/26 was also not completed. UM #388 confirmed the medication refrigerator temperature log was not completed for 03/01/26 and 03/07/26 through 03/11/26 and revealed the refrigerator temperature was to be monitored daily to ensure medications were stored at the correct temperature. Medications located in the refrigerator included one RSV prefusion injection, five boxes of flu vaccine injections 10 per box, two secured starter kits with multiple medications visible inside, and two Shingrix vials. Observation of the over-the-counter stock medications with UM #388 revealed several expired medications which included hemorrhoidal ointment two ounces with an expiration date of 01/2026; naproxen 220 milligrams (mg) 200 capsules with an expiration date of 12/2025; four bottles of guaifenesin 200 mg 100 tablets with an expiration date of 02/2026; naproxen sodium 220 mg 200 capsules expired 01/2026; acidophilus probiotic 100 million 100 tablets expired 02/2026, three containers of guaifenesin 400 mg 100 tablets with an expiration date of 10/2025; two bottles of melatonin 0.5 mg 60 capsules with an expiration of 10/2025; coenzyme Q10 30 soft gels with an expiration of 02/2026; zinc 50 mg 100 tablets with an expiration of 01/2026; and ocular vitamins 60 tablets with an expiration of 11/2025. UM #388 revealed the person who use to monitor the medication storage room for expired medications no longer worked at the facility. Observation on 03/11/26 at 11:33 A.M. with Registered Nurse (RN) #429 of the medications in the skilled medication cart revealed a partially used bottle of zinc 50 mg (100 tablets) expired 11/2025. RN #429 confirmed the bottle of zinc was marked as opened on 03/03/26 (three plus months after it expired).Observation on 03/11/26 at 11:41 A.M. with Licensed Practical Nurse (LPN) #389 of the Verranda medication cart confirmed a bottle of Fexofenadine 180 mg (30 tablets) partially used with an expiration date of 01/2026Observation on 03/11/26 11:52 A.M. with RN #430 of the Long Hall medication cart confirmed a mostly used bottle of milk of magnesium 1,200 mg (16 fluid ounces) expired 10/2025.Interview on 03/11/26 at 12:09 P.M. with the Director of Nursing (DON) revealed her expectations included expired medications were to be disposed of before the expiration date. The DON stated there should be no expired medications on the medication cart for resident use. The DON also revealed medication carts have to be locked or monitored when not in use and temperatures of the refrigerator must be monitored daily to ensure they were kept within required temperature to ensure medications active ingredients don't go bad. Review of the facility's undated policy titled 5.0 Medication Storage undated revealed medications will be stored in a manner that maintains the integrity of the product ensures the safety of the residents and is in accordance with Ohio Department of Health guidelines. With the exception of emergency drug kits, all medications will be stored in a locked cabinet, cart or (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medication room that is accessible only to authorized personnel, as defined by facility policy. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. Medications requiring refrigeration will be stored in a refrigerator that is maintained between two and eight degrees Celsius (36 to 46 degrees Fahrenheit). Temperature will be checked daily to ensure it is within the specified range.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations, resident and staff interviews, and review of the facility policy, the facility failed to provide substantial nutritional evening snacks when meals times were greater than 14 hours. This had the potential to affect all 73 residents who receive meals from the kitchen. The facility census was 73.Findings include:During a resident council meeting on 03/10/26 at 3:00 P.M., twelve residents who attended stated bedtime snacks were only provided upon request or if residents were able to go get the snacks independently. Activity Director #354, whom residents invited to attend the meeting, stated if a resident was not able to take themselves to the snack area, a resident could request a snack be taken to them. Interview on 03/12/26 at 12:21 P.M., Dietary Manager #504 stated there had been a recent change in meal times. Dinner service began at 4:45 P.M. Breakfast service began at 7:45 A.M., resulting in a 15-hour time frame between supper and breakfast. Dietary Manager #504 stated the kitchen did not send a specific snack for bedtime. However, snacks were stocked each day. By the next day, snacks were obliterated. Dietary Manager #504 stated the facility had vending machines that were accessible to residents but verified it required an ability to purchase items in the machine. During an interview on 03/12/26 at 3:15 P.M., Certified Nursing Assistant (CNA) #316 verified staff did not go room to room to offer all residents snacks at bedtime. Those residents who were able could request snacks. Interview on 03/16/26 at 1:36 P.M. with Dietary Manager #504 revealed she was unable to give an exact time the dining room for residents needing mealtime assistance (assisted-dining room). The kitchen needed to wait until the residents on the floor were served before the residents in the assisted-dining room would be served. The kitchen tried to serve breakfast at 9:15 A.M. and she was unsure about the dinner meal. Interview on 03/17/26 at 1:34 P.M. with Certified Nursing Assistant (CNA) #316 revealed the meals were delivered to the assisted-dining room at 9:30 A.M., 12:30 P.M. and 5:30 P.M.; CNA #316 revealed some of the residents in the assisted-dining room were dependent on staff to feed them and some required some assistance, supervision, queing and/or partial assistance. Interview on 03/17/26 at 5:36 P.M. with CNA #319 revealed breakfast was served between 9:30 A.M. and 9:45 A.M. and dinner was usually served in the asssisted-dining room around 5:30 P.M. daily. There were 10 to 13 residents who ate their meals in the assisted-dining room daily. Observation on 03/17/26 at 5:38 P.M. revealed the meal trays were delivered to the assisted-dining room. The residents in the dining room included Residents #4, #11, #20, #22, #30, #31, #34, #42, #49, #68, #73, #75, and #80. Observation on 03/18/26 at 9:35 A.M. revealed breakfast trays arrived in the assisted-dining room. This was 16 hours after the substantial evening meal (dinner) and breakfast the following day. At 9:39 A.M., 11 residents were served their meal in the assisted-dining room. Review of the facility's undated policy titled Meal the community or in Times and Frequency revealed the facility will provide at least three meals daily at regular times comparable to standard mealtimes (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in accordance with residents' needs, preferences, request and plan of care. Meals will be served in a timely manner to maintain food quality, food safe and palatable food temperatures. In nursing facilities, there will be no more than 14 hours between a substantial evening meal (dinner) and breakfast the following day. All residents will be offered a bedtime snack. If a nourishing snack is served at bedtime, then up to 16 hours may elapse between a substantial evening meal and breakfast the next day.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review and staff interviews, the facility failed to timely implement its Quality Assurance Performance Improvement (QAPI) corrective actions for identified regulatory deficiencies. This had the potential to affect all 73 residents residing in the facility.Findings include: During the survey, concerns were identified regarding failure of staff to monitor pressure and non-pressure skin impairment for Resident #32. Concerns were also identified regarding meal times without a substantial bedtime snack being offered to all residents. Interview on 03/16/26 at 10:50 A.M., Corporate Nurse #503 verified the facility had not completed weekly assessments for Resident #32's pressure and non-pressure skin impairment. Corporate Nurse #503 stated the deficient practice had been identified by the Quality Assurance (QA) committee and a plan was developed to address the concerns. Corporate Nurse #503 stated she wanted to submit supportive information and provide their action plan with an implementation date of 02/26/26 regarding an increase in pressure ulcer quality measure numbers. An action plan for wound measurements and weekly skin assessments not being entered into the computerized charting system (dated 02/27/26) was also provided. The plan included entering information into the computerized charting system, reviewing treatment orders to ensure all residents with wounds were seen during wound rounds, and reviewing weekly skin observations to ensure completion. Licensed nurses were to be educated on wound/skin impairment policy and completion of assessments. Interview on 03/19/26 at 8:54 A.M., the Administrator stated one of the areas the QA committee had been addressing was wounds/skin impairment. When asked what, if any part of the plan, had been implemented, the Administrator stated she would have to find out. The Administrator stated the contracted dietary company changed meal times without having an agreement with the facility to do so. The Administrator stated once the problem was identified she met with the company and made it known she expected collaboration with the facility on those decisions. It had been identified and discussed there was too much time between dinner and breakfast and the facility would need notified so that snacks could be provided. This had not occurred as the facility continued to work on adjusting meal times. The Administrator did not provide dates for any action taken. The Administrator stated due to staff turnover of key personnel it had not been possible for staff to implement the QA plans. Development of those programs were still in process. Interview on 03/19/26 at 12:05 P.M., Corporate Nurse #503 verified the plans addressing wounds were developed on 02/26/26 and 02/27/26. However, the new Director of Nursing (DON) began employment on 03/02/26 and was getting her feet wet: then the survey started on 03/09/26 so the plan was put on hold. Corporate Nurse #503 was unable to state if the plan had ever been initiated. During review of staffing, the Administrator stated the previous DON had quit without notice on 02/23/26 and the new DON started on 03/02/26. In the interim the DON duties were being fulfilled by Corporate Nurse #503 and Registered Nurse #434. Interview on 03/19/26 at 12:16 P.M., the DON stated when she started employment on 03/02/26 she found a QA plan to address improving wound care dated 02/19/26. The DON stated when she started on 03/02/26 she started reviewing orders every day to ensure anybody who had a wound was added to the list for the wound Nurse Practitioner (NP) to evaluate. The DON indicated she had no idea how Resident #32's lack of wound assessments were not identified or addressed. The DON stated she had been unable to locate any evidence the previous DON had initiated the implementation of the plans. Review of the facility's QAPI policy (effective 09/23/24) revealed the care and service standards of the facility were continuously tracked, reviewed, analyzed, monitored and improved by the committee. The facility maintained center specific quality clinical and service indicators that were to be monitored and improved by the QA committee if undesirable patterns or trends were established. The administrator was responsible for overseeing the committee's initiatives to sustain and/or improve quality outcomes of problems identified within the facility.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on document review and interview, the facility failed to conduct quality assurance committee meetings a minimum of quarterly. This had the potential to affect all 73 residents.Findings include:Review of sign in sheets for the facility's quality assurance committee meetings were held on12/23/24, 03/25/25, 06/25/25, and 09/25/25. Interview on 03/19/26 at 8:25 A.M., the Administrator verified the facility had not held a quality assurance committee meeting since September of 2025. The Administrator stated the facility continued to identify regulatory concerns and plan corrective actions.Review of the facility's Quality Assurance Performance Improvement (QAPI) policy (effective 09/23/24) revealed the committee was scheduled to meet a minimum of quarterly.

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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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Bethany Nursing Home, Inc	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	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)

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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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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.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and policy review the facility failed to ensure residents were offered activities to meet their interests and support psychosocial well-being. This affected four residents (Resident #22, #30, #31 and #57) of four residents reviewed for activities. The facility census was 73. Findings include: 1.Review of the medical record for Resident #22 revealed an admission date [DATE]. Diagnoses included dementia, difficulty in walking, chronic kidney disease stage 3, anxiety and solitary pulmonary nodule. Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed the resident had impaired cognition. Resident #22 required substantial/maximal assistance from staff for eating and dependent for all other activities of daily living (ADLs). Incontinence of bowel and had an indwelling catheter. Review of the care plan dated [DATE] revealed self-directed activities as Resident #22 preferred to participate in self-directed activities such as watching TV and listening to music. Interventions included assisting the resident to perform self-directed activities as needed. Provide materials for self-directed activities per resident request if able and review with the resident what their self-directed preferences are as needed. Review of the activates documentation for Resident #22 during February and [DATE] revealed no documentation of activities Resident #22 participated in. Review of the activities calendar for Resident #22 for [DATE] revealed on [DATE] at 7:30 A.M. simple social was to be offered and that was all for the day. On [DATE], [DATE] and the rest of the month the only activity scheduled was at 7:30 A.M. caring corner, no other activity in the mornings. On [DATE] no activities were scheduled. In the afternoon the only activities scheduled were bingo, cards, exercise and church. Observation on [DATE] at 8:45 A.M. of Resident #22 revealed she was seated in a Broda chair, in the common area with her eyes closed. No TV or music were playing. At 9:15 A.M. Resident #22 was taken to the dining room for breakfast. Observation on [DATE] at 11:00 A.M. revealed Resident #22 was seated in the common area with her eyes closed. At 2:00 P.M. Resident #22 was seated in the common area with her eyes closed. Observations on [DATE] revealed at 8:45 A.M. Resident #22 was seated in a Broda chair in the common area with no activities. At 10:30 A.M. Resident #22 was seated in the common area with no activity. At 2:00 P.M. Resident #22 was seated in a Broda chair with no activities provided. Interview on [DATE] at 4:45 P.M. with Resident #22's daughter revealed her mother liked to go to activities, like church, music, but now they just sit her out in the caring corner (common area) and maybe turn the TV on. It used to be a hospitality aid who would be out there doing activities and interacting with the residents but now they have taken the hospitality aides away and staff don't have time to interact with residents. Interview on [DATE] at 11:35 A.M. with Licensed Practical Nurse (LPN) #508 revealed floor staff do not have time to provide activities to the residents. Residents are placed in the common area (caring (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	corner) and do not get any activities all day. Interview on [DATE] at 1:00 P.M. with Nurse Aide (NA) #303 revealed when the new company took over, they had hospitality aides (HA) get state tested/certified. NA #303 stated she finished her class and was waiting to take the test to be state tested/certified. NA #303 shared she did not feel some of the residents that sit in the caring corners got their activity/socialization needs met like they did before the transition. Previously, HA would provide that socialization and activities for residents in the caring corner. The NA shared some of the residents will not ask to do an activity but will participate if offered/encouraged. Interview on [DATE] at 10:12 A.M. with Activity Director #354 verified the activity calendar for Resident #22 showed activities that could be offered but no evidence the resident had participated in the activity for February or [DATE]. Observation on [DATE] at 12:41 P.M. revealed Resident #22 was seated in a Broda chair with her eyes closed. No TV or music was provided. Interview on [DATE] at 7:54 A.M. with the Director of Nursing (DON) verified the residents that sit out in the caring corners should have some type of stimulation and activities to do that would interest them. Interview on [DATE] at 10:26 A.M. with CNA #330 revealed Activities did not do much with residents that are in the caring corners, just the usual residents are asked to join activities and the others just sit in front of the TV all day. 2. Review of the medical record for Resident #30 revealed an admission date of [DATE]. Diagnoses included poor memory, cognitive impairment, muscle weakness and chronic pain. Review of the significant change in status MDS dated [DATE] revealed section F (preferences) was not completed related to activities because the resident was unable to complete and family was not interviewed. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #30 had impaired cognition. Review of the care plan dated [DATE] revealed self-directed activities Resident #30 preferred to participate in such as watching TV programs in her room. Interventions included assisting the resident to perform self-directed activities as needed. Provide materials for self-directed activities per resident request if able and review with the resident what their self-directed preferences are as needed. Review of the activity calendar for [DATE] revealed at 7:30 A.M. simple social sensory stimulation on [DATE], on [DATE], on [DATE] at 7:30 A.M. caring corner-library-common area, on [DATE] at 12:30 P.M. hymns and gospel music, 2:00 P.M. communion and at 6:00 P.M. cards and games club room. There was no documentation of Resident #30 participating in any activities. Observation on [DATE] at 8:45 A.M. of Resident #30 was seated in a wheelchair in the common area with her eyes closed. No music or TV was playing. At 9:15 A.M. Resident #30 was taken to dining room for breakfast. Observation at 11:00 A.M. revealed Resident #30 was seated in the common area with her eyes closed. At 2:00 P.M. Resident #30 was seated in the common area with her eyes closed. (continued on next page)

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	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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on [DATE] revealed at 8:45 A.M. Resident #30 was seated in a wheelchair in common area with no activities noted. At 10:30 A.M. Resident #30 was seated in the common area with no activity noted. At 2:00 P.M. Resident #30 was seated in a wheelchair with no activities provided. Observations on [DATE] at 11:10 A.M. revealed Resident #30 was seated in the common area with the TV off and no activities going on. Interview on [DATE] at 10:12 A.M. with Activity Director (AD) #354 verified the activity calendar for Resident #30 showed activities that could be offered but no evidence of resident participation in the activities. Interview on [DATE] at 11:35 A.M. with Licensed Practical Nurse (LPN) #508 revealed floor staff do not have time to provide activities to the residents. Residents are placed in the common area (caring corner) and do not get any activities all day. Interview on [DATE] at 1:00 P.M. with Nurse Aide (NA) #303 revealed when the new company took over, they had hospitality aides (HA) get state tested/certified. NA #303 stated she finished her class and was waiting to take the test to be state tested/certified. NA #303 shared she did not feel some of the residents that sit in the caring corners got their activity/socialization needs met like they did before the transition. Previously, HA would provide that socialization and activities for residents in the caring corner. The NA shared some of the residents will not ask to do an activity but will participate if offered/encouraged. Interview on [DATE] at 7:54 A.M. with the Director of Nursing (DON) during an observation of Resident #30 seated in the common area with no TV or music playing, verified the residents that sit out in the caring corners should have some type of stimulation and activities to do that would interest them. Interview on [DATE] at 10:26 A.M. with CNA #330 revealed Activities did not do much with residents that are in the caring corners, just the usual residents are asked to join activities and the others just sit in front of the TV all day. 3. Review of the medical record for Resident #31 revealed an admission dated [DATE]. Diagnoses included dementia, glaucoma, macular degeneration and muscle weakness. Review of the quarterly MDS dated [DATE] revealed the resident had impaired cognition. Resident #31 required set up assistance with eating and substantial/maximal assistance with all other ADLs. Review of the care plan dated [DATE] revealed Resident #31 preferred to attend group activities such as bingo, group reminiscing, holiday celebrations and movie watching. Interventions included assist resident to participate with group activities, assist resident to activities and review with resident representative the resident's group activity preferences if the resident was unable to communicate. Review of the activity calendar for Resident #31 for [DATE] revealed on [DATE] simple social sensory stimulation at 7:30 A.M. then Caring Corner/library at 7:30 A.M. on all other days and nothing else offered in the mornings. The afternoon activities that were to be offered were bible study, bingo, church, card/games, brain [NAME] and exercise. There was no documentation of these activities being offered or completed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 8:42 A.M. of Resident #31 revealed the resident was seated in the common area watching TV. Interview on [DATE] at 8:46 A.M. with Resident #31 revealed she was sitting in the common area watching TV. When asked if activities were offered to her, she stated she went to Bingo if staff would come to take her but usually, she was sitting with nothing to do. She also shared staff use to do things with her but now they don't have time. Observation on [DATE] at 7:55 A.M. Resident #31 was seated in the common area with no TV or music playing and no activities available for the residents. Interview on [DATE] at 10:12 A.M. with Activity Director #354 verified the activity calendar for Resident #31 showed activities that could be offered but there was no documentation to show which activities the resident participated in. Interview on [DATE] at 11:35 A.M. with Licensed Practical Nurse (LPN) #508 revealed floor staff do not have time to provide activities to the residents. Residents are placed in the common area (caring corner) and do not get any activities all day. Interview on [DATE] at 1:00 P.M. with Nurse Aide (NA) #303 revealed when the new company took over, they had hospitality aides (HA) get state tested/certified. NA #303 stated she finished her class and was waiting to take the test to be state tested/certified. NA #303 shared she did not feel some of the residents that sit in the caring corners got their activity/socialization needs met like they did before the transition. Previously, HA would provide that socialization and activities for residents in the caring corner. The NA shared some of the residents will not ask to do an activity but will participate if offered/encouraged. Interview on [DATE] at 7:54 A.M. with the Director of Nursing (DON) during an observation of Resident #31 seated in the common area with no TV or music playing, verified the residents that sit out in the caring corners should have some type of stimulation and activities to do that would interest them. Interview on [DATE] at 10:26 A.M. with CNA #330 revealed Activities does not do much with residents that are in the caring corners, just the usual residents are asked to join activities and the others just sit in front of the TV all day. 4.Record review for Resident #57 revealed an admission date of [DATE]. Diagnoses included muscle wasting and atrophy and neurocognitive disorder with Lewy bodies. Review of the Annual MDS dated [DATE] for Resident #57 revealed it was very important to keep up with the news and to participate in religious services. Review of the quarterly MDS dated [DATE] revealed Resident #57 was cognitively intact. Resident #57 had no impairment to the upper or lower extremity, used a walker for mobility, required set up or clean up assist from staff for eating, and partial/moderate assist from staff for walking 10 feet. Review of the care plan revealed Resident #57 did not have a care plan for activities. Interview on [DATE] at 1:10 P.M. with Resident #57 revealed his concern was he wished he had more to do. Resident #57 revealed the facility did not offer activities he liked and he wished the facility offered more activities he preferred/liked. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 10:12 A.M. with AD #354 revealed Resident #57 use to participate in activities a lot before his wife passed away last year. His wife encouraged him to go to the facility activities. The Director stated after the resident fell and messed his shoulder up, he stopped attending activities. AD #354 confirmed the facility was to offer one-on-one activities to residents who did not otherwise participate in the facility activities. Record review of the list of residents who received one on one activities with AD #354 for the previous 12 months revealed Resident #57 was not on the list. AD #354 confirmed one-on-one activities were never offered or attempted with Resident #57 and she did not know Resident #57's likes or dislikes for activities and revealed there was never an intervention or care plan for activities put into place after his wife died. AD #354 revealed she was the only activities person and she had to provide all the activities to the residents that resided in the Assisted Living and in the Nursing Home. Interview on [DATE] at 10:55 A.M. with the Administrator revealed activity staff should do an assessment on admission and quarterly to determine the residents' likes and dislikes related to activities and the residents should have their activities care planned. If the resident was not participating in activities, the resident should receive one-on-one activities from the activities department. The Administrator shared Resident #57's wife died on [DATE]. Interview on [DATE] between 2:12 P.M. and 4:03 P.M. with Resident #57 revealed he enjoyed reading sports magazines, and getting manicures. Resident #57 shared no one at the facility asked him what he enjoyed doing and revealed he use to enjoy going to the activity programs but he stopped going after he fell because of the pain he had at the time. Resident #57 confirmed he got bored in his room and wished he had more to do. Interview on [DATE] at 3:22 P.M. with Certified Nursing Assistant (CNA) #316 revealed Resident #57 use to participate in activities and after he broke his shoulder, he stayed in his room and didn't attend the dining room or facility group activities. CNA #316 shared she use to offer to take him to activities for the first few times after the fall but he would say no, so she did not offer after that. Review of the facility policy Activities Programming, dated [DATE] revealed the activities programming must include but not limited to reflect the schedule, preferences, goals, choices, and rights of the patients. Are appropriate for those with cognitive impairments and appropriate for higher functioning patients and give the patients a sense of purpose or belonging.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to ensure the residents received nutritional supplements as physician ordered and failed to ensure the amount of fluid offered/consumed was documented when there was a physician order to encourage fluid intake for a resident. This affected two (Residents #4 and #37) of two residents reviewed for nutrition. This had the potential to affected an additional nine residents the facility identified who had physician orders to receive a nutritional supplement named Ensure. The facility census was 73.Findings include:1. Record review for Resident #4 revealed an admission date of 08/13/21. Diagnosis included Alzheimer's disease, mild protein calorie malnutrition, adult failure to thrive, and abnormal weight loss. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was severely cognitively impaired. Resident #4 had impairment to both sides of the upper extremities, and required partial/moderate assistance with eating. Review of the care plan revealed Resident #4 was at risk for nutritional complications related to dysphagia, vitamin deficiency, adult failure to thrive, diagnosis of malnutrition, and abnormal weight loss. Interventions included to provide therapeutic diet as ordered. Review of the physician orders for Resident #4 revealed an order for Ensure (a high calorie nutritional supplement) two times a day for risk for malnutrition dated 01/16/26. The physician order did not include the amount of Ensure to administer to Resident #4. Record review of the Medication Administration Record (MAR) for January 2026 for Resident #4 revealed the order for Ensure was scheduled to be administered at 12:00 P.M. and 4:00 P.M. The MAR indicated Resident #4 did not receive the ensure twice daily on 01/18/26, , one on 01/20/26 at 12:00 P.M., twice on 01/21/26, twice on 01/22/26, once on 01/23/26 at 12:00 P.M., once on 01/28/26 at 12:00 P.M., once on 01/29/26 at 12:00 P.M., and once on 01/30/26 at 12:00 P.M. Review of the progress notes revealed Ensure two times daily was not available on 01/18/26, 01/20/26, 01/21/26, 01/22/26, and 01/23/26. The progress note dated 01/23/26 at 12:48 P.M. revealed the facility waiting on a delivery of Ensure. Review of the Nutrition assessment dated [DATE] completed by Registered Dietician (RD) #706 revealed Resident #4 had a weight loss of 8.5 pounds noted over the last 30 days which equaled 7.2% significant weight loss. Resident #4 will require more than set up help at times for meals. The diet ordered was a regular with dysphagia mechanically altered texture, thin liquids. Ensure twice daily (BID) for malnutrition risk, appetite varied from zero to 50 percent (%)per meals due to weight loss and variable intake. Resident does get supplement BID. To continue with current plan of care (POC). RD to follow up and monitor as appropriate. The nutrition assessment did not state the amount of Ensure to administer to Resident #4 The MAR for February 2026 revealed Resident #4 did not receive the Ensure once on 02/03/26, 02/04/26, 02/05/26, 02/06/26, 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/13/26, 02/12/26, 02/14/26, and 02/25/26. The progress notes revealed Ensure was unavailable on 02/06/26, and two times on 02/10/26, 02/11/25, and 02/12/26. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MAR for March 2026 revealed Resident #4 did not receive the Ensure on 03/04/26 at 4:00 P.M., 03/07/26 at 4:00 P.M., 03/08/26 at 4:00 P.M., and 03/13/26 at 4:00 P.M. Interview on 03/17/26 at 12:07 P.M. with Administrator revealed the facility used to order the Ensure from a specified company and if they ran out, they could go to the store and use the company credit card and purchase it. With the new company that took over mid December 2025, they don't have a credit card they cannot just get it. Telephone interview on 03/17/26 at 1:03 P.M. with RD #706 revealed after the transition to the new company in December 2025, Ensure was no longer a part of the formulary they provide. RD #706 stated there was a time period the Ensure was not available, and was not made aware until February 2026. RD #706 revealed the note dated 03/02/26 at 11:48 A.M. written by the Corporate RD #707 revealed Resident #4 had an order for Ensure twice daily; she recommended switching to four ounces of Med Pass (a high calorie nutritional supplement) due to supplement availability. The new supplement order will provide similar/equivalent calories. RD will monitor for tolerance/acceptance and adjust nutrition recommendation as appropriate. RD #706 revealed nursing was notified and this should have been done on 03/02/26. They were not able to order the Ensure, it was supposed to be switched over. It was a concern when the residents were not getting the supplements put into place for nutrition. Interview on 03/17/26 at 1:36 P.M. with Licensed Practical Nurse (LPN) #375 stated there was a time the facility had no Ensures, and it was a mess. Nursing would get a few cases in then when they were gone, they had to wait, and this occurred frequently. The facility had nothing to supplement the Ensure with. Telephone interview on 03/17/26 at 1:42 P.M. with Regional Lead Dietitian #707 revealed the Administrator reached out to her for a substitute for Ensure, she sent the information to change the supplement to the Administrator who said once she received it, would get the order from the physician. Interview on 03/18/26 at 10:10 A.M. with the Administrator stated she sent the email to the physician requesting to change the supplements for the residents and Certified Nurse Practitioner (CNP) on 03/05/26 at 8:00 A.M. The CNP responded on 03/05/26 at 8:50 A.M. that it was ok to change to change out the nutritional supplements but the Administrator did have the time to do anything with it yet. The Administrator confirmed they have not changed out the nutritional supplements at the time of the interview (03/18/26). 2. Review of Resident #37's medical record revealed diagnoses included acute kidney failure, muscle wasting and atrophy, dementia, congestive heart failure and anemia. 2a. A plan of care initiated 12/18/26 indicated Resident #37 was at risk for complications secondary to diuretic use due to diagnoses of congestive heart failure and chronic kidney disease. On 01/28/26, an physician order was written to encourage fluids greater than 2,000 milliliters per day (ml/day). Review of the Medication Administration Record (MAR) dated January 2026 revealed the order started the evening of 01/28/26 and went through the afternoon of 01/31/26. The MAR had checkmarks for encouraging fluids but there was no documentation of the amount of fluid offered/consumed. On 03/12/26 at 1:27 P.M., Registered Nurse (RN) #434 verified she was unable to locate any tracking of the fluids that were offered/provided. RN #434 verified without record of the amount of fluid offered each shift it would not be possible to ensure Resident #37 was receiving at least 2,000 ml/day. 2b. On (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/10/26 ,a weight of 193.5 pounds was recorded for Resident #37. On 02/26/26, an order was written for carnation instant breakfast (high calorie nutritional supplement) 240 ml every morning and every bedtime. On 03/09/26, a weight of 181.5 pounds was recorded. A plan of care initiated 03/09/26 revealed Resident #37 was at risk for weight loss or malnutrition related to chronic disease, dyskinesia or the esophagus and dysphagia. One of the goals was for Resident #37 to have optimal nutrition status. One of the interventions was to provide supplements as ordered. On 03/11/26, a weight of 180 pounds was recorded. A quarterly nutrition assessment dated [DATE] indicated Resident #37 had a 5.8 percent (%) weight loss in 30 days. No eating functional issues were noted. Resident #37's appetite was poor to fair. Resident #37 was at risk for malnutrition due to weight loss and decreased intake. Resident #37 had a supplement order with fortified cereal (a higher calorie cereal) in the morning and four ounces of med pass supplement (a high calorie nutritional supplement) at bedtime in place of Carnation Instant Breakfast order as it was not going to be available. The supplement was addressed and the dietitian recommended changes to the fortified cereal and med pass due to the Carnation Instant Breakfast not being on the facilities formulary. Review of Resident #37's meal ticket on 03/17/26 revealed it did not state fortified cereal was supposed to be provided with breakfast. On 03/17/26 at 1:35 P.M., Dietary Manager #504 stated the facility had not yet started the fortified cereal and it was not even available. Dietary Manager #504 stated there was discussion of the facility initiating use of fortified cereal or fortified potatoes for residents but the kitchen had not received a list of those changes as they were supposed to exhaust the supply of Carnation Instant Breakfast before those changes were made. Dietary Manager #504 stated Resident #37 did not have Carnation Instant Breakfast ordered with meals so kitchen did not provide it. A supply of Carnation Instant Breakfast was observed in the dining room in the event nursing staff needed it. On 03/17/26 at 1:40 P.M., Licensed Practical Nurse (LPN) #380 stated if supplements were recorded on MAR, nurses were responsible for providing the supplements. When asked where the Carnation Instant Breakfast was stored, LPN #380 stated she did not recall ever mixing it for administration to Resident #37 but if it was on the MAR she would have given it. Review of the March 2026 MAR indicated an x was recorded on the area for staff to record the percentage of the Carnation Instant Breakfast which was consumed the morning of 03/01/26. NA was recorded under the percentage at bedtime on 03/06/26, the morning of 03/11/26 and 03/12/26, and at bedtime on 03/13/26. The morning of 03/17/26, Licensed Practical Nurse (LPN) #375 recorded Resident #37 consumed 50% of the Carnation Instant Breakfast. On 03/17/26 at 1:47 P.M., LPN #375 stated the Carnation Instant Breakfast was provided with breakfast and aides mixed it. Resident #37 ate in the dining room with the residents who required assistance. LPN #375 identified Certified Nursing Assistant (CNA) #316 as one of the aides who worked in the assist dining room who was familiar with Resident #37 and her need for the Carnation Instant Breakfast. On 03/17/26 at 1:48 P.M., CNA #316 denied Resident #37 required a supplement. If a resident did not have the supplement listed on the dietary ticket and nurses did not inform the CNAs of the order, the CNAs did not know to provide one. CNA #316 stated she was unaware Resident #37 had an order for Carnation Instant Breakfast and she had never been notified by a nurse that it was expected aides would provide it for her during her meal.

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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. 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 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, and interview, the facility failed to permit a resident to choose dining location and times. This affected one (Resident #31) of four residents reviewed for choices. The facility census was 73.Findings include: Observations on 03/11/26 revealed breakfast was served in the dining room for residents who needed assistance or supervision with eating between 9:30 A.M. and 9:48 A.M. Review of Resident #31's medical record revealed diagnoses included Alzheimer's disease, dementia, glaucoma, and macular degeneration. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #31 was usually able to make herself understood, was able to understand, and was severely cognitively impaired. The assessment indicated Resident #31's vision was moderately impaired. On 03/16/26 at 9:42 A.M., Resident #31's niece was observed propelling her in the hall and declaring it was ridiculous that residents did not get to eat breakfast until 10:00 A.M. Observation and interview on 03/16/26 at 10:03 A.M., Resident #31 was in her room with her breakfast tray on the overbed table. Resident #31 was independently drinking fluids from a spouted two handled cup. Resident #31's niece stated there was a period when Resident #31 was more confused and she thought that was the reason Resident #31 was sent to the dining room for residents who needed assistance. Resident #31's niece stated Resident #31 used to be finished eating by 9:00 A.M., but was now 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 so she could eat breakfast earlier. On 03/16/26 at 10:33 A.M., Speech Language Pathologist (SLP) #441 stated Resident #31 was on speech therapy's caseload. Resident #31 was coughing with meals and with the use of straws. SLP #441 stated Resident #31 required supervision for eating due to trouble swallowing, poor vision, and the need for verbal cues. Resident #31 ate better with a tray table because the dining table was too high. Resident #31 could eat in her room per her wishes if there was adequate staff to sit with her and provide one on one supervision. At the time of the survey, there was insufficient staff to provide one on one supervision for Resident #31 to eat in her room so she could receive her tray earlier.

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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 interview and record review, the facility failed to ensure all resident funds were disbursed within 30 days of death. This affected one of one resident (#100) of one resident reviewed for disbursement of funds upon death. The facility identified nine residents with personal fund accounts residing in the facility. The facility census was 73.Findings include: Review of the closed medical record for Resident #100 revealed an admission date of [DATE]. Resident #100 expired in the facility on [DATE].Review of the resident funds account for Resident #100 revealed as of [DATE], Resident #100 had $4403.88 in her personal fund account that had not been disturbed after her passing on [DATE]. Interview on [DATE] at 11:03 A.M. with [NAME] Business Office Manager (BOM) #506 and the Administrator verified there had not been any BOM working at the facility since [DATE]. Regional BOM #506 verified funds are to be returned within 30 days upon death and this had not happened with Resident #100's funds.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interview, the facility failed to ensure residents' personal information was maintained in a manner to respect privacy related to personal and medical information. This affected two residents (#32 and #61) of 28 residents reviewed for privacy. The facility census was 73.Findings include: 1. Review of Resident #61's medical record revealed diagnoses including traumatic subdural hemorrhage and zoster ocular disease (shingles in the eye). Review of documentation confirmed Resident #61 had an appointment with the eye surgeon on 03/09/26. 2. Review of Resident #32's medical record revealed diagnoses including peripheral vascular disease, polyneuropathy, iron deficiency anemia, and generalized muscle weakness. 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). No further assessments were located. However, Resident #32 did have a confirmed appointment at a wound center on 03/09/26 and orders for treatments to the left buttock and surgical wounds. On 03/09/26 at 6:40 A.M., a posting was observed on the wall on the skilled hall indicating Resident #61 had an ophthalmologist appointment at an eye surgery center at 3:15 P.M. with pick up at 2:45 P.M. The posting also indicated Resident #32 had a wound center appointment at 8:45 A.M. with pick up time at 8:15 A.M. On 03/09/26 at 6:43 A.M., an interview with Licensed Practical Nurse (LPN) #374 verified the appointment information posted included information which would inform others that Resident #32 had a wound and that was not information the general population should have access to and that Resident #61 had vision issues. Review of the facility's admission packet revealed residents were provided a copy of the Resident Rights and Facility Responsibilities. The rights included the right to secure and confidential personal and medical records.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and review of drug information from Medscape, the facility failed to ensure a resident had indications for use of an antipsychotic medication. This affected one (Resident #13) of three residents reviewed for psychotropic medication use. Findings include:Review of Resident #13's medical record revealed diagnoses including psychotic disorder with delusions and vascular dementia with anxiety. Orders included seroquel (antipsychotic) 12.5 milligrams every night at bedtime. Review of a nurse practitioner note dated 05/14/26 indicated Resident #13's daughter reported seroquel was started for insomnia. Due to concerns for QT prolongation (QT interval represents the time from the start of ventricular depolarization to the end of repolarization, reflecting the total duration of ventricular electrical activity) the Resident's daughter was informed to avoid seroquel upon discharge. Review of a discharge planning assessment dated [DATE] indicated Resident #13 was expected to stay in the facility long term. Review of drug information in Medscape revealed seroquel was not approved for dementia-related psychosis. Elderly residents with dementia-related psychosis were treated with antipsychotic drugs were at increased risk of death. On 05/27/26 at 5:00 P.M., the Director of Nursing (DON) was interviewed regarding the use of seroquel in a resident with a diagnosis of dementia and for any information regarding how the benefits outweighed the associated risks. On 05/28/26 at 10:51 A.M., the DON stated Resident #13 used to be in the residential care facility and was admitted with the orders for seroquel. The DON was unable to provide any additional information related to why the seroquel use in a resident with dementia outweighed the associated risk and verified Resident #13 was not a short term stay.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure required notifications were provided to residents and/or representatives upon transfer to the hospital for two (Residents #37 and #88) of two residents reviewed for hospitalization, and failed to provide a discharge summary for one (Resident #90) of two residents reviewed for discharge. The facility census was 73. Findings include: 1. Review of Resident #88's medical record revealed diagnoses including muscle wasting of multiple sites, difficulty walking, cellulitis, chronic venous hypertension with ulcer of bilateral lower extremities, and congestive heart failure. A progress note by Nurse Practitioner (NP) #502 dated 01/02/26 revealed Resident #88 was noted to have increased agitation, severe paranoia and delusions, and was refusing all medications and care. Attempts had been made to initiate oral antipsychotic medication but none had been received due to refusal. Resident #88 received two doses of Haldol (antipsychotic) on 01/01/26 and one dose the morning of 01/02/26 which was mildly effective. Resident #88 continued to refuse medications and care. Resident #88 was refusing food and liquids and exhibited combativeness with staff with attempts to provide care. NP #502 documented she spoke with the family and believed the facility was unable to provide any additional interventions in the nursing facility but she would benefit from transfer to a geriatric psychiatric facility. No transfer or bed-hold notices were able to be located. On 03/18/26 at 12:36 P.M., Corporate Nurse #503 verified she was unable to locate a written transfer or bed-hold notice, stating Resident #88's son was present at the time of the transfer. 2. Review of Resident #37's medical record revealed diagnoses including acute kidney failure, intermittent asthma, cognitive communication deficit, dementia, and congestive heart failure. A progress note dated 02/03/26 at 11:31 A.M. indicated Resident #37 was out for a hematology/oncology appointment and was sent to the emergency room for a blood clot. Resident #37 was going to be admitted to the hospital. No written bed-hold notification was located. On 03/16/26 at 1:05 P.M., the Administrator verified Resident #37 was not provided a written bed-hold notification.3. Review of Resident #90's medical record revealed diagnoses including benign neoplasm of the heart, hypertension, congestive heart failure, depression, generalized muscle weakness, dementia and irritable bowel syndrome. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #90 was able to make herself understood, was able to understand others, and was cognitively intact with a goal to discharge to the community. The assessment indicated active discharge planning was already occurring. A nursing note dated 12/31/25 at 3:41 P.M. indicated home-going medications were reviewed with Resident #90's daughter with verbalization of understanding. Resident #90 was discharged with 24 Lidocaine patches, 24 Prevacid tablets (medication used to reduce the production of stomach acid), and eight Oxycodone (pain medication) tablets. Resident #90 and her daughter offered no complaints upon discharge. Resident #90's daughter was providing transportation home.On 03/18/26 at 9:35 A.M., Licensed Practical Nurse (LPN) #388 verified she discharged Resident #90. At the time of discharge, a list of medications, diet orders, supplement orders, and future laboratory tests were provided. LPN #388 stated a discharge summary/recapitulation of stay was not completed.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on closed medical record review and interview, the facility failed to ensure timeliness of completion and submission of Minimum Data Set (MDS) assessments. This affected one (Resident #18) of two residents reviewed for submission of MDS assessments. The census was 73.Findings include: Review of Resident #18's closed medical record revealed an admission date of 09/23/25 with diagnoses of osteoarthritis, osteoporosis, chronic obstructive pulmonary disease, depression, and generalized anxiety disorder. Resident #18 discharged from the facility on 10/15/25.Review of Resident #18's MDS assessments revealed an admission MDS assessment with an assessment reference date (ARD) of 09/30/25 was completed with a completion date of 10/08/25. A discharge MDS with an ARD of 10/15/25 was not completed.On 03/18/26 at 4:45 P.M., interview with Registered Nurse (RN) #434 verified Resident #18's discharge MDS with an ARD of 10/15/25 was not completed and was not submitted as required.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure accuracy of Minimum Data Set (MDS) assessments. This affected two (Residents #10 and #32) of 27 residents whose assessments were reviewed for accuracy. The census was 73.Findings include: 1. Review of Resident #10's medical record revealed diagnoses including stage two chronic kidney disease, congestive heart failure, Alzheimer's disease, depression, anxiety disorder and restless leg syndrome. Review of a quarterly MDS assessment with an assessment reference date of 11/21/25 indicated Resident #10 received insulin injections seven of the last seven days.Review of Resident #10's November 2025 physician orders and the Medication Administration Record (MAR) from 11/14/25 to 11/21/25 revealed no evidence of insulin administrations.On 03/18/26 at 4:45 P.M., interview with Registered Nurse (RN) #434 verified the MDS dated [DATE] was inaccurate in regard to insulin administration.2. Review of Resident #32's medical record revealed diagnoses including pain, chronic obstructive pulmonary disease, cirrhosis of the liver, and peripheral vascular disease. Review of hospital records dated 02/03/26 revealed Resident #32 had left plantar and right medial foot ulcers. Review of a nursing admission 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. Review of an admission MDS assessment dated [DATE] revealed no unhealed pressure ulcers, no venous and arterial ulcers, no diabetic foot ulcer or other open lesions on the foot were noted.Review of a wound clinic note dated 03/02/26 indicated Resident #32 had a stage three pressure injury (a full-thickness skin injury extending through the dermis into the subcutaneous fat tissue) acquired on 02/05/26 and a chronic non-pressure left foot ulcer acquired on 02/10/26.On 03/17/26 at 11:35 A.M., an interview with RN #434 verified she had no documentation from the wound clinics when she coded the MDS. RN #434 stated she only had the information available on the admission nursing assessment as no further assessments were documented.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to ensure comprehensive care plans were developed for two (Residents #32, and #56) of 27 residents reviewed for comprehensive care planning. The census was 73.Findings include: 1. Review of Resident #32's medical record revealed diagnoses including pain, muscle wasting, chronic obstructive pulmonary disease, cirrhosis of the liver, peripheral vascular disease, iron deficiency anemia, and generalized muscle weakness. A nursing admission assessment dated [DATE] indicated Resident #32 had an abrasion on the left buttock, a scab on the left heel and a surgical incision on the back neck. On 02/09/26, orders were received to cleanse the abrasion to the left buttock with normal saline, pat dry, and cover with a foam dressing every day and as needed and to cleanse the surgical wound with normal saline, pat dry and cover with a dry dressing every day and as needed. A plan of care initiated 02/14/26 indicated Resident #32 was at risk for pressure ulcer related to advanced age, chronic health conditions and immobility. A plan of care initiated 03/03/26 revealed Resident #32 had skin impairment with interventions to provide treatments as ordered (initiated 02/14/26). No further skin assessments were able to be located in the medical record. Upon request, the facility obtained wound assessments from the wound clinic. On 03/09/26 at 6:40 A.M., a posting on the wall of the skilled unit revealed Resident #32 had an appointment that day with the wound center at 8:45 A.M. Review of wound clinic notes dated 03/09/26 revealed Resident #32 had a stage three sacral pressure ulcer (involving the top two layers of skin and fatty tissue) which was acquired on 02/05/26, a partial thickness chronic non-pressure ulcer acquired on 02/10/26, and a stage three pressure ulcer to the right plantar foot acquired on 02/02/26. On 03/17/26 at 11:35 A.M., Registered Nurse (RN) #434 verified she had never created a care plan referring to the actual pressure ulcers or the non-pressure ulcer of the left foot as she did not have access to the wound clinic notes and had not been informed of the skin impairment. The care plan related to impaired skin was due to the surgical incision and would require different interventions. 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 Assessment for Resident #56 signed 12/05/25 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 Quarterly MDS dated [DATE] revealed Resident #56 was cognitively intact. Resident #56 had applications of ointments/medications other than to feet. 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 the care plan dated 02/22/26 revealed Resident #56 did not have a care plan specific for a rash or eczema. Observation on 03/09/2026 at 6:41 A.M. of incontinence care provided by Certified Nursing Assistant (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CNA) #307 revealed Resident #56 had multiple red, circular areas on her abdomen, chest and arms. The areas varied in sizes. Interview on 03/18/2026 at 4:30 P.M. with Regional Director of Clinical Services (RDCS) #503 confirmed Resident #56 did not have a care plan for the nummular eczema condition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three residents (Resident #57, #64 and #84) of 30 residents reviewed were offered to participate in care plan meetings. The facility census was 73. Findings include: 1.Record review for Resident #57 revealed an admission date of 06/10/25. Diagnosis included muscle wasting and atrophy and neurocognitive disorder with Lewy bodies. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was cognitively intact. Resident #57 had no impairment to the upper or lower extremity, used a walker for mobility, required set up or clean up assist for eating, and partial/moderate assist for walking 10 feet. Review of Resident #57's medical record revealed Resident #57 did not have a care plan for activities and there was no evidence Resident #57 ever was offered or participated in a care conference to determine his plan of care. Interview on 03/09/2026 at 1:14 P.M. with Resident #57 revealed he never had a care plan meeting while at the facility (confirming he was never offered one) and revealed he never participated in developing his plan of care. Interview on 03/12/2026 at 10:12 A.M. with Director of Recreation #354 revealed Resident #57 had not been participating in activities, was not receiving, and was not offered one-on-one activities. Director of Recreation #354 confirmed Resident #57 did not have a care plan related to activities programming. Interview on 03/16/2026 at 1:52 P.M. with Administrator revealed the only note she was able to find regarding a care plan meeting for Resident #57 was on 07/10/25 at 1:48 P.M.; Administrator revealed the note was typed and unsigned and revealed Resident #57 should have had a care plan meeting on admission and quarterly to determine his plan of care. 2.Review of Resident #64's medical record revealed diagnoses including multiple sclerosis, paraplegia, depression, heart disease and constipation. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #64 was sometimes able to make herself understood, was usually able to understand others and was cognitively intact. During an interview on 03/10/26 at 11:12 A.M., Resident #64 stated she was not invited to participate in care plan meetings. On 03/17/26 at 12:45 P.M., Registered Nurse (RN) #434 stated she was unable to locate documentation of care conferences. The nurse who had sent out care plan conference notifications was no longer employed at the facility. RN #434 stated Resident #64's daughter never responded to invitations to care conferences. RN #434 did not know if Resident #64 was ever invited to care conferences so she had the opportunity to participate in the development or revision of the plan of care. 3. Review of the medical record for Resident #84 revealed an admission date 04/25/24. Diagnoses included dysphagia, kidney disease and chronic pain. Review of the annual MDS dated [DATE] revealed under the area of preferences revealed it was very important for her and family be involved in discussion about her care. (continued on next page)

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	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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #84 had intact cognition. Review of Resident #84's medical record revealed Resident #84 did not have a care plan for activities and there was no evidence Resident #84 ever was offered or participated in a care conference to determine his plan of care. Review of the last care conference notes dated 03/05/25 revealed Resident #84 attended the plan of care meeting. Interview on 03/10/26 at 8:40 A.M. with Resident #84 revealed she has not been asked to attend a care conference and would like to attend and have input on her plan of care. Interview on 03/16/2026 at 1:52 P.M. with Administrator revealed the only note she was able to find regarding a care plan meeting for Resident #84 was on 03/05/25. Administrator verified Resident #84 should have had a care plan meeting on admission and quarterly to determine her plan of care needs. Residents/family should be offered to participate in their plan of care. Review of the facility's admission packet revealed care plan meetings were held at least once every three months or when there was a significant change in a resident's physical or mental health. All staff involved with the care of the residents were involved and present at the conference, as well as the resident and whomever else the resident designated: responsible party, family members etc. The resident care conference was the time to talk about what was going on with the resident. All aspects of care and the living environment were up for discussion and residents/responsible parties must feel free to ask questions about the care and daily routine. Any concerns may be discussed. A resident and his/her family had the right to make choices about care services, daily schedule and life in the home and be involved in the care plan meeting. Notification of the date was to be provided via telephone.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to implement a restorative nursing program as recommended for Resident #3 following the resident's discharge from therapy to assist the resident to maintain her functional ability. This affected one resident (#3) of eight residents reviewed for activities of daily living. Findings include: Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including dementia, muscle weakness, and difficulty walking.Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had severe cognitive impairment. The assessment revealed Resident #3 required (staff) supervision or touching assistance with eating and personal hygiene, partial/moderate (staff) assistance with oral hygiene, toileting hygiene, upper and lower body dressing, bathing, and transfers. Resident #3 used a walker and a wheelchair for mobility and required supervision or touch assistance for walking 150 feet.Review of the Modification of quarterly MDS assessment dated [DATE] revealed Resident #3 had severe cognitive impairment. The assessment revealed Resident #3 required (staff) set up or clean up assistance with eating, substantial/maximal (staff) assistance with oral hygiene, and was dependent on staff for personal hygiene, toileting hygiene, upper and lower body dressing, bathing, and transfers. Review of the care plan for Resident #3 dated 01/31/26 revealed the resident required assistance with activities of daily living (ADLs) related to advanced age, chronic health conditions, cognitive impairment and a history of deficits from a cardiovascular accident and weakness. Interventions included one person transfer, one person assist bed mobility, provide set up only for meals, and remind resident to use a walker for ambulation and transfer. Observation on 03/10/26 at 10:07 A.M. revealed Resident #3 was sitting up in her chair. Resident #3 was awake, looked directly at the surveyor but did not respond verbally to questions.Interview on 03/16/2026 at 11:51 A.M. with Director of Rehab #358 revealed Resident #3 had been on caseload with Physical Therapy (PT) from 10/24/25 to 01/14/26 for a decline in transfer status. At the end of therapy the distance Resident #3 could walk varied, she started out as moderate assistance of two with a front wheeled walker (FWW) to a sit to stand and a FWW with assistance of one. During the interview, Director of Rehab #358 revealed a restorative referral was made for the resident at the time of discharge from PT and would have been left on the Restorative Nurse/Wound Care Nurse's desk. Director of Rehab #358 revealed there had been a change in positions and now there was a new nurse taking the position of the previous Restorative/Wound Care Nurse. The current Certified Nursing Assistant (CNA)/Restorative Aid now worked the floor as a CNA quite a bit. Record review revealed the restorative program/services specified by therapy on 01/15/26 were not placed in Resident #3's plan of care for staff to implement. On 03/16/2026 at 12:10 P.M. the surveyor and Director of Rehab #358 observed Registered Nurse (RN) #432 sitting at the Restorative Nurse/Wound Care Nurse's desk. RN #432 revealed she was the current Wound Care Nurse but not responsible for restorative nursing as that position had not been replaced when the previous restorative nurse left. At the time of the observation, review of a form titled, Restorative Services Transfer Form dated 01/15/26 and signed by Physical Therapy Assistant (PTA) #421 as the signature/title of the person making the transfer and dated 01/15/26 by Former Wound Care/Restorative Care Licensed Practical Nurse (LPN) #701 as the signature/title of the person accepting the transfer for Resident #3 revealed the following: The goal of the program was for Resident #3 to maintain current level. The form included a restorative referral with recommendations for program delivery to provided six times per week. Specific equipment included a 1.5-pound cuff weight (ankle weight), ball, t-band (thera-band) and a forward wheeled walker. The form included the resident would be assisted by one staff (to walk) 65 feet. Strategies included Resident #3 would demonstrate slight retro (leaning backwards) lean which first standby needs time to correct. Cues for directional changes. Continued interview with RN #432 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed since she started, there were no restorative nursing programs being provided for any residents including Resident #3. On 03/16/2026 at 12:45 P.M. review of Resident #3's MDS assessments (10/20/25 and 01/16/26) with MDS Coordinator RN #434 noted the MDS on 01/16/26 demonstrated the resident had some level of decline in functional ability when compared to the assessment from 10/20/25. MDS Coordinator RN #434 stated, Typically if I notice a decline when I do an MDS assessment, I bring it to the stand-up meeting which includes the entire disciplinary team, Administrator, DON, Therapy, Social Worker, Maintenance, Dietary, Activities, two Unit Managers (UM), and Admissions for discussion. MDS Coordinator RN #434 was unable to provide evidence Resident #3 had been discussed. Interview on 03/16/26 at 1:15 P.M. with Regional Director of Clinical Services (RDCS) #503 revealed the facility no longer had a Restorative Nurse or Restorative CNA, the floor CNAs were responsible to provide restorative programs. RDCS #503 revealed this change occurred following a change in ownership the middle of December 2025. Interview on 03/16/2026 at 2:37 P.M. with CNA #310 revealed she was assigned to care for Resident #3; however, she had never provided any type of restorative nursing services and she stated she had never been trained and never used bands or balls with the resident. Interview 03/16/2026 2:38 P.M. with CNA #346 revealed she never provided restorative programs for residents including Resident #3. At the time of the interview, observation of Resident #3's room revealed there were no therapy bands, no balls or any therapy equipment in the room. CNA #346 walked Resident #3 to her bathroom located in her room with a walker and stated, we never walked her 65 feet daily, we don't do restorative. CNA #346 revealed they used to have a restorative aide. Interview on 03/16/2026 at 2:46 P.M. with CNA #321 revealed, We do not do restorative exercises with our residents; we use to have restorative aides, now no one. Interview on 03/16/2026 at 2:51 P.M. with RDCS #503 revealed once a care plan for restorative goes in the electronic system for the resident, that flags the point of care (POC) tasks. RDCS #503 revealed she had not seen any completed yet for residents, including for Resident #3.

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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 non-pressure related skin impairment was not assessed weekly by the facility or wound clinic. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on observation, interview, record review and review of the facility policy, the facility failed to ensure a comprehensive, resident centered fall prevention program was implemented to prevent resident falls and to ensure staff have access to resident information. This affected one resident, Resident #57 of one resident reviewed for falls with serious injury. The facility census was 73. Findings include: Record review for Resident #57 revealed an admission date of 06/10/25. Diagnoses included muscle wasting and atrophy multiple sites, muscle weakness, neurocognitive disorder with Lewy bodies, and difficulty in walking. Review of the fall history form provided by Minimum Data Set (MDS) Coordinator #434 revealed Resident #57 had a fall on 06/11/25 and 06/12/25. Neither fall documentation was timed and both occurred while getting up unassisted. The documentation included Resident #57 had a skin tear from the fall on 06/11/25.Record review of the Fall Risk Assessment for Resident #57 dated 12/08/25 revealed no score or risk level was provided to determine the resident's fall risk score. Review of the quarterly MDS dated [DATE] revealed Resident #57 was cognitively intact. Resident #57 had no impairment to the upper or lower extremities, used a walker, required supervision or touch assistance for bed mobility, sit to stand, and transfers. Resident #57 had no falls since admission/entry or reentry or the prior assessment, whichever was more recent. Resident #57 had impaired vision and did not wear glasses.Review of the care plan for Resident #57 dated 12/31/25 revealed Resident #57 was at risk for falls. Interventions dated 12/31/25 included place bed in lowest position while resident is in bed and place common items within reach of the resident. One additional intervention was added on 02/13/26 to provide reacher (extended bar to reach or grab items out of the resident's reach).Review of the Eye Care Chart Note for Resident #57 dated 01/07/26 at 2:31 P.M. signed by Optometrist #705 revealed the patient presented for an evaluation of decreased vision in the left (eye) greater than right. It affected both near and far vision. The symptom was constant. The condition was significant.Review of the Post Fall Investigation dated 02/13/26 at 7:15 P.M. completed by Licensed Practical Nurse (LPN) #375 revealed on 02/13/26 at 6:00 P.M. Resident #57 had a fall in his room. Resident #57 was alert and oriented and wandering in his room. Resident #57 was not wearing proper footwear, was using his walker and the environment was not free of clutter. This was an unwitnessed fall. Review of the progress notes for Resident #57 revealed no information about the incident on 02/13/26 at 6:00 P.M. was documented.Review of the fall risk scoring tool dated 02/13/26 at 7:12 P.M. completed by LPN #375 revealed Resident #57 was at low risk for falls. The resident had no falls. Interview on 03/09/2026 between 11:47 A.M. and 1:16 P.M. with Resident #57 revealed he had poor eyesight and confirmed he did not wear glasses. Resident #57 revealed he had a fall recently. Resident #57 revealed he was going to his entrance doorway to his room, he was using his walker when the wheel got caught up in something and he fell. Interview on 03/17/2026 at 9:09 A.M. with Certified Nursing Assistant (CNA) #346 revealed she was working the day Resident #57 fell. Resident #57 fell near the entrance of his room, he said he was reaching for his remote, and his remote was on his stand next to the recliner.Interview on 03/17/26 at 10:25 A.M. with Registered Nurse (RN) MDS Coordinator #434 confirmed the Risk Assessment for Resident #57 dated 12/08/25 revealed no score or no risk level. RN MDS Coordinator #434 revealed she did not know if Resident #434 was high or low risk for falls based on the assessment. Observation on 03/17/2026 at 10:30 A.M. with RN MDS Coordinator #434 of Resident #57's room confirmed Resident #57 did not have a bed in his room. Resident #57 was sitting in his recliner where he confirmed he also slept. Observation revealed Resident #57's reacher (used as an intervention due to his previous fall) was in the corner of his room, on the floor, under a chair. MDS Coordinator #434 confirmed Resident #57 would not be able to obtain the reacher if needed. After retrieving the reacher for Resident #57, Resident #57 expressed he was grateful for his reacher and revealed he did not know where it went (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to.Observation and interview on 03/17/26 at 10:38 A.M. with CNA #321 of the electronical system used for documentation for CNA's Point of Care revealed when she wanted to find resident information, she looked under the tasks bar to determine resident needs. CNA #321 reviewed the task bar and confirmed there was no information under that tab revealing Resident #57 was to have a reacher and verified she was unaware the resident was to have a reacher as a fall prevention intervention.Interview on 03/17/2026 at 10:48 A.M. with Regional Director of Clinical Services (RDCS) #503 revealed the CNA's have access in Point Click Care (PCC) (the facility electronic medical record system used) to pull up the care plan and see the whole care plan which included the resident was to have a reacher. RDCS #503 confirmed the Post Fall Investigation dated 02/13/26 revealed Resident #57 was not wearing proper footwear when he fell and the environment was not free of clutter. RDCS confirmed neither concern was addressed in the care plan as fall prevention interventions. Interview on 03/17/2026 at 10:58 A.M. with CNA #346 revealed she was Resident #57's assigned CNA frequently. CNA #346 revealed she did not know how to access a resident's care plan. The CNA stated the CNAs look at the Kardex, that is what we were taught. CNA #346 verified she never knew Resident #57 was to have a reacher for fall interventions. Interview on 03/19/2026 at 10:50 A.M. with MDS Coordinator #434 confirmed Resident #57 had a history of falls including a fall on 06/11/25 and 06/12/25. MDS Coordinator #434 confirmed the fall information was not in the current electronic medical record due to the company changing systems for documentation. MDS Coordinator #434 confirmed Resident #57 had three interventions in his care plan to assist with fall prevention. The first was to place the bed in the lowest position, place common items within reach and the third was provide the reacher which MDS Coordinator #434 confirmed Resident #57 was unable to reach.Review of the facility policy titled, Falls Management Program dated 01/29/24 revealed the center utilizes a systemic approach to a falls management program that facilitates an interdisciplinary approach with evidence based interventions to develop individual care strategies. Fall Occurrence included to initiate appropriate intervention to aid in prevention of another fall. Complete the Post Fall Investigation to determine, to the extent possible, the cause of the patient fall. Using the Post Fall Investigation, a licensed nurse will review, revise and implement interventions to the care plan based on post fall investigation findings, review of device assessment, and review of the fall risk scoring tool.

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	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

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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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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and physician and staff interviews, the facility failed to ensure medication was not received in an excessive dose for a resident. This affected one (Resident #88) of six residents reviewed for unnecessary medications. The facility census was 73.Findings include:Review of Resident #88's medical record revealed diagnoses included cellulitis (bacterial skin infection) and chronic venous hypertension (increased blood pressure in the veins) with ulcer of bilateral lower extremities. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 was moderately cognitively impaired. Review of the December 2025 Medication Administration Record (MAR) revealed Resident #88 had an order with a start date of 12/09/25 for acetaminophen 500 milligrams (mg) two tablets before meals for pain. Administration was scheduled for 7:30 A.M., 11:00 A.M., and 4:00 P.M. Another order dated 12/09/25 indicated acetaminophen 500 mg two tablets three times a day with medication administration times listed as 9:00 A.M., 2:00 P.M. and 9:00 P.M. Based on nurse signatures on the MAR revealed the following: a total of 6,000 mg was administered on 12/16/25; 5,000 mg was administered on 12/17/25 with the nurse documenting coverage was not required for the 7:30 A.M. dose; 6,000 mg was administered pm 12/18/25; a total of 4,000 mg was documented as provided on 12/19/25 with documentation of the acetaminophen not being administered at 4:00 P.M. or 9:00 P.M. related to nausea/vomiting; and 6,000 mg was administered on 12/20/25. On 12/21/25 staff documented one of the orders was a duplicative order. After the 7:30 A.M. was administered, the order for two tablets before meals was discontinued. Interview on 03/18/26 at 2:03 P.M., Physician #500 stated the upper limits of acetaminophen that would be ordered was 3,000 mg/day. Physician #500 looked through notes himself and the nurse practitioners and was unable to find where the medication was ordered that way. Physician #500 stated laboratory tests were being done during that time frame and did not reveal any liver dysfunction. Physician #500 stated the time frame was when the facility ownership changed and there was a change in the electronic health records the facility used and nurses were still learning the system. Physician #500 questioned whether the acetaminophen was actually administered as indicated on the MAR, stating the nurses who were familiar with the medication ordering patterns would have known no greater than 3,000 mg of acetaminophen should be administered. Interview on 03/18/26 at 3:55 P.M., Corporate Nurse #503 stated she reviewed the December 2025 MAR. Corporate Nurse #503 indicated one of the nurses she spoke to denied she had administered acetaminophen from both orders. Otherwise, nurses did document administration of each ordered dose with the exception of those listed above. Review of Tylenol's label (acetaminophen is the generic form of Tylenol) revealed a warning that severe liver damage might occur if someone took more than 4,000 mg of acetaminophen in 24 hours.

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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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, observation and record review, the facility failed to ensure a resident was offered to see a dentist. This affected one (Resident #1) of three residents reviewed for dental services. The facility census was 73. Findings include:Findings include:Record review for Resident #1 revealed an admission date 01/14/25. Diagnoses included spinal stenosis, thoracolumbar region and muscle weakness. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively impaired and was dependent on staff for oral hygiene. Resident #1 had no dental care plan. There was no evidence Resident #1 was offered and/or seen by a dentist since admission to the facility in the resident's medical record.Interview on 03/09/26 at 9:28 A.M. with Resident #1 revealed she was concerned because she had not seen a dentist since admission to the facility.Observation and interview on 03/11/26 at 3:54 P.M. revealed Resident #1 was sitting up in her chair and stated she was concerned about not seeing a dentist since admission to the facility. Resident #1 wanted to make sure she did not have any new cavities. Resident #1 revealed she had asked staff about seeing the dentist but could not recall which staff members she asked. Resident #1 had all her own natural teeth and her upper and lower teeth had dark discoloration. Interviews on 03/16/26 at 9:14 A.M. and 1:10 P.M. with the Administrator confirmed Resident #1 was not seen by a dentist since admission to the facility. The Administrator confirmed Resident #1 resided at the facility long term and should have been offered ancillary services including dental. The Administrator confirmed there was no evidence Resident #1 was ever offered or received dental services.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review and policy review, the facility failed to honor food preferences of the residents. This affected one (Resident #84) of three residents reviewed for meal preferences. The facility census was 73.Findings include:Review of the medical record for Resident #84 revealed an admission date 01/15/26. Diagnoses includes dysphagia (difficulty swallowing), kidney disease and chronic pain.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #84 had intact cognition and was on mechanically altered diet.Interview on 03/10/26 at 8:37 A.M. with Resident #84 stated the facility used to send a staff member around and ask the residents what they wanted to eat for their next meal, but the facility quit doing that. Resident #84 stated she does not like green beans and since staff don't come around and ask, she gets green beans even though she does not like them. After you receive the meal, she can ask for something else, but then you have to wait for the substitute to come. The kitchen has an anytime menu, but no one comes around and asks her about it. Resident #84 stated yesterday (03/09/26) they served her green beans even though she does not like them.Interview on 03/12/26 at 1:06 P.M. with [NAME] #507 stated residents get whatever was on the menu, and there were no alternatives for vegetables.Observation on 03/16/26 at 1:22 P.M. of Resident #84's meal tray for lunch revealed Resident #84 was given mixed vegetables with green beans, baked beans, ground kielbasa sausage, roll, and a brownie.Review of the lunch meal ticket dated 03/16/26 for Resident #84 revealed green beans were not listed as a dislike for the resident.Interview on 03/16/26 at 1:36 P.M. with Dietary Manager #504 verified Resident #84 should have received the sliced carrots and not the mixed vegetables because it had green beans in it. Dietary Manager #504 stated the cook did not realize that she was to receive carrots. It was on the production sheet but not on the meal ticket under dislikes. Dietary Manager #504 stated all residents get what was on the menu even if they don't like it and if they want something different, they can tell the staff when the meal was delivered. Staff do not have enough time to check with all residents to see if they would like something different for the meal.Review of the facility's undated policy titled Meal Identification and Preference Cards/Tickets revealed the Director of Dining services or designee will visit a newly admitted individual to obtain food and beverage preferences, dislikes and food allergies/intolerances before a permanent meal ID car/ticket is written. Meal ID cards/tickets will be used during meal service to ensure the correct diet is being served and food preferences are honored.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to ensure medical records were accurate. This affected one (Resident #45) of 30 residents reviewed for accurate medical records. The facility census was 73.Findings include: Review of the medical record for Resident #45 revealed an admission date 02/27/23. Diagnoses included colostomy and inability to control bowel or bladder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 had intact cognition and had an ostomy. Review of the physician orders dated 12/14/25 revealed an order to change ostomy bag every three days, cleanse surrounding skin with normal saline, ensure dry and apply nystatin powder prior to applying new ostomy bag/wafer and as needed. Review of the Treatment Administration Record (TAR) for March 2026 revealed on 03/03/26, 03/09/26 and 03/12/26, the treatment for changing ostomy bag was signed off by Licensed Practical Nurse (LPN) #508. On 03/06/26, the treatment was marked refused by LPN #508. On 03/15/26, LPN #383 signed off that the treatment had been completed. Interview on 03/10/26 at 1:24 P.M. with Resident #45 revealed his ostomy bag is to be changed every three days and it only was getting changed once a week. Interview on 03/16/26 at 2:33 P.M. with LPN #508 stated Resident #45 only wants the unit manager (Registered Nurse (RN) #393) to change his ostomy bag. LPN #410 verified she was not the nurse that completed the treatments but did sign off it was completed by her. Interview on 03/16/26 at 2:44 P.M. with the Director of Nursing (DON) stated Resident #45 only wants RN #393 to change his ostomy bag. The DON verified nurses were to only mark a treatment completed if they completed it and if a resident refuses or an as needed treatment is completed it should be signed off by the nurse that completed the treatment. Interview on 03/16/26 at 2:59 P.M., RN #393 verified he changed Resident #45's ostomy bag on 03/08/26 and 03/13/26 but did not document that he had changed it. RN #393 verified he did not complete Resident #45's ostomy bag treatments on 03/03/26, 03/09/26 and 03/12/26.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on staff interviews, personnel file review and policy review, the facility failed to ensure annual performance evaluations were completed for all certified nursing assistants (CNAs). This affected four of four personnel files reviewed for annual performance evaluations. This has the potential to affect all 73 residents residing in the facility. Findings include:Review of the personnel file for CNA #331 revealed a hire date of 02/27/20. There was no annual evaluation completed for the year 2025.The personnel file for CNA #330 revealed a hire date of 07/12/23. There was no annual evaluation completed for the year 2025.The personnel file for CNA #308 revealed a hire date of 06/13/14. There was no annual evaluation completed for the year 2025.The personnel file for CNA #317 revealed a hire date of 07/19/23. There was no annual evaluation completed for the year 2025.Interview on 03/19/26 at 8:44 A.M. with Human Resources (HR) Director #356 verified there were no annual evaluations completed for CNA #331, CNA #330, CNA #308, and CNA #317 in the last year and should have been completed annually on the staff's anniversary date.Interview on 03/19/26 at 10:26 A.M. with CNA #330 revealed they did not receive an annual evaluation completed in 2025.Interview on 03/19/26 at 10:31 A.M. with CNA #308 revealed they did not receive an annual evaluation completed in 2025.Review of the facility policy titled Performance Appraisal dated 10/01/23 revealed generally all employees will receive a performance appraisal around 90 days and annually thereafter. This includes full-time, part-time and as needed (PRN).

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

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure nursing staff information was posted in a prominent readily accessible location for residents, visitors, and staff. This had the potential to affect all 73 residents residing in the facility.Findings include:Observations on 03/09/26 at 5:45 A.M. revealed there was no nurse staffing information was posted in the facility.Interview on 03/09/26 at 6:37 A.M. with Licensed Practical Nurse (LPN) #387 stated staff assignments were available at the long term care hall nursing desk but she was unsure of where information regarding staffing for the day was posted.Interview on 03/09/26 at 6:43 A.M. with LPN #374 indicated she was unsure where staffing information was posted. LPN #374 assisted in searching for the required posting without success. Observation and interview on 03/09/26 at 7:28 A.M. with the Director of Nursing (DON) revealed the DON stated the nurse staff posting was usually on a clipboard outside of the Administrator's office. The DON verified the information was not posted. The DON spoke with Unit Clerk #443 who stated she had removed the posting the evening of 03/08/26 and provided a pristine sheet of paper from a notebook stating it was what she had removed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of the Facility Assessment and interview, the facility failed to update the facility assessment upon change in ownership to ensure it accurately reflected changes which were incorporated or in the process of being incorporated. This had the potential to affect all 73 residents. Findings include:Review of the Facility Assessment, last updated on 07/15/25, revealed persons involved in completing the assessment included five individuals, four of whom were no longer employed by the facility. The medical director, who was involved, still saw residents but no longer held the position of medical director. Staffing needs were determined utilizing a formula based on overall acuity. The Facility Assessment indicated a process for ongoing review of policies and procedures and who was responsible for the review. Those listed as having the responsibility were the same five individuals who completed the assessment. It indicated the facility had an exclusive partnership with a Medical Center to provide physician services to all residents of the facility. Physical resources listed as available included a transportation van and pickup truck. Providers for dental services, pharmacy services, therapy services, health information technology resources and radiology services were listed. On 03/10/26 at 5:48 P.M., the Administrator stated ownership changed 12/15/25. It was determined the facility had a disproportionate amount of non-licensed staff (hospitality aides) so they put those staff members into a nurse aide training course and the class finished 03/06/26. The facility's on-boarding process had changed. The facility added a skin nurse position and planned to add an afternoon shift supervisor, a staff development coordinator, and an extra nurse on the skilled unit. The Facility Assessment was reviewed with the Administrator on 03/18/26 at 8:54 A.M. The Administrator verified it had not been updated after new ownership started. The Administrator verified the staff given responsibility to review policies no longer worked at the facility with the exception of the medical director who no longer held that position. The Administrator verified changes had been made related to dietary staffing needs as the facility now contracted dietary services. The Administrator verified the assessment had not been updated when new ownership had assessed there needed to be changes in staffing (extra nurse on skilled, staff development coordinator, or afternoon shift supervisor). The new ownership had also begun using agency staff. This was not indicated in the Facility Assessment. The Administrator could not state, with certainty, if the same formula was going to be used for staffing. The transport van and the pickup truck referred to were not operational and the facility was using outside sources. The pharmacy listed as providing services was no longer accurate as the facility started using a different pharmacy. There had also been changes in the dental provider. Therapy was no longer under contract as listed in the facility assessment The Health Information Technology company had also changed and was not reflected in the facility assessment. The Administrator verified the facility assessment needed updated to be accurate.