STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366341	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne County Care Center	876 S Geyers Chapel Road Wooster, OH 44691

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEYBased on record review, Facility Reported Incident review, interview, and facility policy review the facility failed to ensure residents were free from staff to resident physical abuse. This deficient practice affected one resident (Resident #16) of three residents reviewed for physical abuse. The facility census was 44.|Findings Include: Review of Resident #16's medical record revealed admission date 04/09/26 with diagnoses including but not limited to traumatic hemorrhage of cerebrum, leukemia, depression, high blood pressure and anxiety.Review of Resident #16's admission Minimum Data Set (MDS) dated [DATE] revealed Resident #16 had severely impaired cognition with a Brief Interview of Mental Status (BIMS) score of five out of possible 15 and was dependent on staff for Activities of Daily Living (ADL) tasks.Review of the Facility Reporting Incident (FRI) Tracking Number 273607 dated 04/21/26 revealed Resident #16 reported Certified Nursing Assistant (CNA) #400 had slapped her hands when she was holding onto the siderail and stated, when we say no we mean no when CNA #400 was performing personal care during the night shift on 04/20/26. Resident #16 was able to identify CNA #16 from several pictures presented for her to identify the CNA she reported. The facility placed CNA #16 on administrative leave pending investigation results. Further review revealed CNA #400 received a disciplinary written warning dated 06/24/25 for violation of resident care related to resident complaints of leaving them on wet bed pads and unfriendly attitude towards residents when answering call lights.Interview on 05/13/25 at 2:35 P.M. with Resident #16 confirmed someone did slap her hands during care.Interview on 05/14/26 at 9:15 A.M. with the Director of Nursing (DON) revealed Resident #16's account of what had occurred during night shift personal care on 04/20/26 did not change during several interviews by other staff members. The DON stated during CNA #400's interview for the facility investigation, CNA #400 did not confirm or deny the allegation of physical abuse reported by Resident #16. The DON verified the CNA was terminated as a result of the investigation of physical abuse. Review of the facility's policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 02/2005 revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This includes, but not limited to, freedom of corporal punishment, involuntary seclusion and any physical or chemical restraint that is not required to treat the resident's medical symptoms.The deficient practice was corrected on 04/22/26 when the facility implemented the following corrective actions: On 04/20/26 Resident #16 was assessed for any bruises or skin tears related to having her hands slapped during care - negative findings were documented.On 04/21/26 CNA #400 was placed on administrative leave pending outcome of the investigation. CNA #400 was terminated.On 04/21/26 residents were interviewed for any further abuse allegations - no further allegations were reported - weekly audits for eight weeks to be implemented.On 04/22/26 all staff were in-serviced on the facility's abuse policy and procedures.On 04/30/26 and 05/07/26 weekly audits completed with no negative findings This deficiency represents non-compliance investigated under Complaint Number 3004666.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366341	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne County Care Center	876 S Geyers Chapel Road Wooster, OH 44691

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review, Facility Reporting Incident review, interview and facility policy review the facility failed to prevent misappropriation of residents' medication. This deficient practice affected one resident (Resident #14) out of one resident reviewed for misappropriation. The facility census was 44.Findings Include:Review of Resident #14's medical record revealed admission date 12/27/22 with diagnoses including but not limited to unspecified dementia, cognitive communication deficit, anxiety, and depression.Review of Resident #14's physician orders revealed an order dated 07/21/25 for antianxiety medication Clonazepam oral tablet 0.5 milligram (MG) give 0.5 MG by mouth at bedtime.Review of Resident #14's Medication Administration Record (MAR) dated 08/01/25 to 08/30/25 revealed Clonazepam was marked as administered per order on 08/19/25.Review of Resident #14's narcotic count sheet for Clonazepam dated 07/22/25 revealed on 08/19/25 at 8:20 P.M. one tablet of Clonazepam was administered with eight tablets left in the medication card. Further review revealed on 08/20/25 at 6:00 A.M. the count sheet was adjusted to match the blister pack with one tablet being marked as removed and the count sheet reflecting seven tablets left, the entry was signed by Licensed Practical Nurse (LPN) #397 and LPN #401.Review of the Facility Reporting Incident (FRI) #264336 dated 08/20/25 revealed during narcotic count at morning shift change on 08/20/26 at 6:00 A.M. it was noted Resident #14's Clonazepam should have had eight tablets in the blister pack and there were only seven observed. At the time LPN #397 and LPN #401 made the decision to document one tablet being deducted from the count sheet to reflect the number of tablets left in the blister pack. Both LPN #397 and LPN #401 signed the entry on the narcotic count sheet for Resident #14's Clonazepam, without notifying the Director of Nursing about the discrepancy with Resident #14's Clonazepam. Neither LPN #397 nor LPN #401 had knowledge of the missing Clonazepam tablet. At 2:30 P.M. on 08/20/25 the DON was notified of the discrepancy with Resident #14's Clonazepam. The DON placed LPN #397 and LPN #401 on administrative leave and requested a urine drug test to be completed for LPN #397 and LPN #401. On 08/22/25 the county sheriff was notified of the narcotic discrepancy, and a report of loss was filed. On 08/25/25 at 8:00 A.M. urine drug results were received by the facility for LPN #397 with negative results reported for Clonazepam, LPN #401's urine drug results were still pending.Interview on 05/14/26 at 9:30 A.M. confirmed Resident #14's Clonazepam count was adjusted by LPN #397 and LPN #401 during the morning narcotic count on 08/20/25. The DON stated neither LPN #397 or LPN #401 knew what had happened with the missing Clonazepam tablet. LPN #397 and stated LPN #401 made the decision to deduct the tablet from the count sheet and had LPN #397 sign the count sheet. Review of the facility's policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 02/2005 revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This includes, but not limited to, freedom of corporal punishment, involuntary seclusion and any physical or chemical restraint that is not required to treat the resident's medical symptoms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366341	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne County Care Center	876 S Geyers Chapel Road Wooster, OH 44691

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on Facility Reporting Incident review, interview, and facility policy review the facility failed to report misappropriation of residents' pain medication Oxycodone. This deficient practice affected seven residents (Residents #6, #13, #14, #18, #24, #45, and #47) out of seven reviewed for use of pain medication Oxycodone. The facility's census was 44.Findings Include:Review of the Facility Reporting Incident (FRI) #264336 dated 08/20/25 and closed 08/25/25 revealed during the investigation Licensed Practical Nurse (LPN) #401 was required to complete a urine drug test for Clonazepam on 08/20/25. The facility received LPN #401's drug test results on 09/04/25 revealing LPN #401 tested positive for Oxycodone without an active prescription. LPN #401 resigned from employment at the facility on 09/19/25. The facility's investigation led to the Ohio Nursing Board being notified with action taken to suspend LPN #401's LPN license, local law enforcement investigated, Ohio Attorney General's office investigated, and the facility's pharmacy conducted an investigation and whole house audit of resident's ordered Oxycodone. The facility did not report this separate misappropriation incident, only continued to investigate under the original FRI #264336 for the misappropriation of Clonazepam.Interview on 05/14/26 at 10:00 A.M. with the Director of Nursing (DON) confirmed the facility did not initiate a new FRI once the drug results were received for LPN #401 showing the use of Oxycodone. The DON confirmed Residents #6, #13, #14, #18, #24, #45, and #47 had orders for Oxycodone and were identified affected.Review of the facility's policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 12/2005 revealed facility staff should immediately report all such allegations to the Administrator and to the Ohio Department of Health in accordance with the procedures in this policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366341	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne County Care Center	876 S Geyers Chapel Road Wooster, OH 44691

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review the facility failed to ensure Enhanced Barrier Precautions were followed during indwelling urinary catheter care. This deficient practice affected one resident (Resident #11) of one resident reviewed for indwelling urinary catheter. The facility census was 44.Findings Include:Review of Resident #11's medical record revealed admission date 01/16/26 with diagnoses including but not limited to rectum cancer, high blood pressure, obstructive and reflux uropathy, and epilepsy.Review of Resident #11's discharge return anticipated [NAME] Data Set (MDS) dated [DATE] revealed Resident #11 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of eight out of a possible 15 and had an indwelling urinary catheter.Review of Resident #11's physician orders revealed an order dated 03/26/26 for catheter size 18 French (FR) balloon size 10 cubic centimeter (CC) to continuous drainage due to wound healing every shift, and order dated 03/25/26 for catheter care every shift and as needed (PRN), and an order dated 04/07/26 for Enhanced Barrier Precautions to be maintained for high contact care related chronic wound every shift.Review of Resident #11's elimination care plan dated 04/14/26 revealed indwelling urinary catheter with catheter care per physician orders.Observation on 05/13/26 from 11:07 A.M. to 11:15 A.M. during Resident #11's indwelling urinary catheter care completed by Certified Nursing Assistants (CNAs) #254 and #373. There was a small rectangular magnet noted on the upper left-hand doorframe of Resident #11's room with EBP-2 in black print. Upon entering Resident #11's room, CNA #254 and #373 did not don a gown as part of their personal protective equipment (ppe) prior to initiating and completing Resident #11's indwelling urinary catheter care.Interview on 05/13/26 at 11:25 A.M. with CNA #254 confirmed neither CNA placed a gown on as part of their PPE prior to completing indwelling urinary catheter care for Resident #11. CNA #254 stated they should have put on gowns before they started her catheter care.Review of the facility's policy titled, Enhanced Barrier Precautions dated 12/2024 revealed enhanced barrier precautions are utilized to prevent the spread of multi-drug-resistant organisms to residents. Enhanced barrier precautions employ targeted gown and glove use in addition to standard precautions during high contact resident care activities for residents with indwelling medical devices or wounds.This deficiency represents non-compliance investigated under Complaint Number 2683752.