STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366342	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary of the Woods	35755 Detroit Road Avon, OH 44011

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 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 record review, observation, facility policy review, and interview, the facility failed to ensure staff followed physician orders when administering Resident #26's and Resident #44's respiratory aerosol treatments. This affected two residents (#26 and #44) out of three residents reviewed for respiratory care. The facility census was 43. Findings include:1. A review of Resident #44's clinical record revealed an admission date of 02/18/26 with diagnoses including chronic obstructive pulmonary disease, emphysema, high blood pressure and cholesterol, atherosclerotic heart disease, esophagitis, peripheral vascular disease, stage IV chronic kidney disease, hyperparathyroidism secondary to renal origin, radiculopathy (spinal nerve compression), cataract, malaise, pupillary abnormality, and dysphagia (trouble swallowing). Resident #44 was discharged from the facility to her private residence on 02/25/26.A review of Resident #44's Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #44 was alert and oriented with mild cognitive impairment, needed assistance with all activities of daily living and experienced shortness of breath at rest, with exertion, and while lying flat.Resident #44's hospital record dated 02/17/26 indicated she was admitted to the hospital with a diagnoses of exacerbation of chronic obstructive pulmonary disease with increased dyspnea on exertion and altered mental status. Symptoms had progressed per Resident #44's daughter since her fall 10 days ago with no traumatic injury noted. Resident #44's used five liters of oxygen continuously per nasal cannula to maintain an appropriate oxygen saturation. Resident #44 would need physical and occupational therapy to increase strength and functionality in acute and long-term care facilities. Resident #44 had experienced increased generalized weakness limiting participation in physical and occupational therapy sessions at home. Resident #44 required two-person assistance with transfers and mobility with increased continuous home oxygen.A review of Resident #44's physician orders dated 02/01/26 to 02/28/26 indicated to administer 3 milliliters of Ipratropium,-albuterol inhalation solution 0.5-2.5 (3) milligram/milliliter (combination of two bronchodilators) via inhalation orally five times a day while awake. Nurse to remain with resident the full 15 minutes during the respiratory treatment to monitor respiratory status. Administer continuous oxygen at five liters per minute.A review of Resident #44's nursing progress note dated 02/22/26 at 9:15 P.M. indicated Resident #44's family talked to the physician and requested to have Resident #44 sent to the hospital for an evaluation and treatment. The physician instructed the nurse on duty to send Resident #44 to the hospital for fluid overload, kidney failure and hypoxia. The Director of Nursing (DON) was notified of the situation and family concerns. A review of Resident #44's nursing progress note dated 02/22/26 at 9:36 P.M. revealed the family reported that they found Resident #44 hooked up to his nebulizer and not the oxygen. The family reported Resident #44 was disconnected from oxygen for a long period of time, was blue with oxygen saturation measured at 47 percent. The nurse on duty at that time implemented several interventions to return Resident #44 to her baseline breathing status. The oxygen saturation level increased to 97 percent. Resident #44 was noncompliant during the night and removed her oxygen per nasal cannula. Resident #44 would be monitored to maintain oxygen saturation above 93 percent throughout the night.An interview with Resident #44's daughter-in-law on 06/01/26 at 8:50 A.M. revealed Resident #44 had gone to the (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital after sustaining a fall at home. The hospital discharged Resident #44 to the facility for rehabilitation due to weakness and planned to return home upon discharge from the facility. Resident #44 daughter-in-law stated she was unable to remember the exact date when the family visited Resident #44 in her room and found her with the aerosol mask applied to her face and no oxygen was being administered with the aerosol treatment. Resident #44 was slumped over with her arm reaching for her oxygen tubing. There were no staff members in the room with Resident #44 during the respiratory aerosol treatment administration. Resident #44's daughter-in-law stated she reported the incident to the nurse (unnamed) and DON.An interview with Licensed Practical Nurse (LPN) #53 on 06/01/26 at 12:27 P.M. revealed she had reported to the DON that Resident #44's family was upset about the administration of Resident #44's respiratory aerosol treatment without her oxygen. LPN #53 stated the family told her Resident #44 had blue color, but when she assessed Resident #44, she was not blue and was alert and oriented. LPN #53 applied oxygen, and Resident #44 gradually returned to her baseline. An interview with LPN #51 on 06/01/26 at 2:09 P.M. revealed Resident #44's family had complained to her that they had entered Resident #44's room and found Resident #44 without her oxygen per nasal cannula and had the aerosol treatment mask still in place. Resident #44's family had reported Resident #44's oxygen saturation was low. LPN #51 stated residents with continuous oxygen were supposed to receive their prescribed oxygen during aerosol inhalation respiratory treatments.An interview with LPN #50 on 06/01/26 at 3:02 P.M. stated she was the nurse assigned to provide care for Resident #44 on 02/21/26 during the day shift from 6:30 A.M. to 7:00 P.M. LPN #50 verified the above findings and stated she had administered Resident #44's respiratory aerosol inhalation treatment at around 4:00 P.M. on 02/21/26 and verified she did not remain with Resident #44 during the treatment. LPN #50 stated Resident #44 was noncompliant with keeping her oxygen infusion during the respiratory aerosol treatment earlier in the day and generally didn't like to have her oxygen infusing at the time she received her respiratory aerosol treatments. LPN #50 could not remember if she encouraged Resident #44 to wear her oxygen during her aerosol respiratory treatment. LPN #50 could not remember how low Resident #44's oxygen saturation dropped, but it was less than 93 percent. Oxygen was administered to Resident #44, and her oxygen saturation normalized. Resident #44 was alert and talking during the incident and her lips had not turned a blue color. LPN #50 verified she should have remained with Resident #44 during the respiratory aerosol treatment. LPN #50 stated Resident #44 returned to her baseline mentation and respiratory status after the incident.An interview with the DON on 06/01/26 at 2:29 P.M. revealed she was notified by LPN #53 of the above incident and had conducted an investigation of the incident. The DON agreed LPN #50 should have stayed with Resident #44 during the respiratory aerosol treatment and agreed LPN #50 failed to follow the physician order and facility policy for administration of a respiratory aerosol treatment.2. A review of Resident #26's clinical record revealed an admission date of 05/29/26 with diagnoses including left kidney cancer with acute kidney failure and stage IV chronic kidney failure, high blood pressure, cholesterol and calcium level, cardiac pacemaker, gastroesophageal reflux disease, anxiety, depression, malnutrition with dehydration, hyperparathyroidism secondary to renal origin, and enlarged prostate with obstructive and reflux uropathy.A review of Resident #26's physician orders dated 05/01/26 to 06/01/26 indicated to administer ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml inhaled orally four times a day for shortness of breath and wheezing. Nurse to observe the resident during the full 15 minutes during the respiratory aerosol treatment for any change in condition.An interview with Resident #26 on 06/01/26 at 10:01 A.M. revealed the nurses did not stay with him to observe for changes in his condition during his respiratory aerosol treatments that he remembered. Resident #26 stated the respiratory aerosol treatments helped him breathe easier.An observation of LPN #52 administering Resident #26's respiratory aerosol treatment (ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml) on 06/01/26 at 11:48 A.M. revealed LPN #52 failed to perform a respiratory assessment prior to the administration of the respiratory aerosol treatment and failed to observe Resident #26 during (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the administration of the respiratory aerosol treatment for any changes in condition. An interview with LPN #52 on 06/01/26 at 11:56 A.M. verified she should have performed a respiratory assessment pre and post treatment and observed Resident #26 during the administration of the respiratory aerosol treatment. LPN #52 verified she failed to follow the physician's orders and did not perform an assessment of Resident #26's lungs before administering the respiratory aerosol treatment or observe Resident #26 during the administration of the respiratory aerosol treatment.A review of the facility policy titled Nebulizer Therapy dated 04/01/2022 indicated the policy was for nebulizer treatments to be administered by nursing staff as ordered by the physician using proper technique and standard infection control precautions. The policy explanation and compliance guidelines included to verify the practitioner's order and gather appropriate equipment and medication. Maintain infection control practices and obtain the resident's vital signs and perform a respiratory assessment to establish a baseline. Assemble tubing, nebulizer cup, and mouthpiece per manufacturer's specifications and ensure all connections were secured tightly. Place premeasured medication in the nebulizer cup and connect the nebulizer machine to the power source and turn the machine in the on position. Observe the resident for any change in condition during the treatment. Document the date, time and duration of the therapy, type of medication, oxygen flow, vital signs and respiratory treatment along with teaching provided to the resident. Clean and sanitize equipment after administration and perform a respiratory assessment post-treatment.This deficiency represents non-compliance investigated under Complaint Number 3027973.