

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Copper Knoll Health & Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Courthouse Parkway Washingtn C H, OH 43160	
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 - Many	Provide and implement an infection prevention and control program. Based on observation, interview and policy review, the facility failed to ensure laundry was stored to prevent the spread of infection. This had the potential to affect all 64 residents who reside in the facility. The facility census was 64. Findings Included: Based on observation, interview and policy review, the facility failed to ensure laundry was stored to prevent the spread of infection. This had the potential to affect all 64 residents who reside in the facility. The facility census was 64. Findings Included: Observation on 12/31/25 at 8:35 A.M. with the Environmental Manager (EM) #39 of the 300 hall central bath with a linen cart with four shelves filled with linens, towels, washcloths, and other miscellaneous items had a front flap that was opened up and on top of the cart, leaving all of the items on the cart exposed. The bathtub was about one foot from the cart. Interview on 12/31/25 at the time of the observation the EM #39 stated the cover was constantly up and the items were exposed when housekeeping goes in multiple times per day in all of the central bath rooms. Continued observation revealed the 200 hall central bath room with a linen cart designed the same as the 300 hall central bath with the linen cart flap open and on top with items on top of the flap. The cart was about two feet from the bathtub. Continued observation of the 100 hall central bath with a linen cart the same design as the 200 and 300 hall central baths with the flap open with items on the top of the flap. The EM #39 verified the flaps were all up and not covering the items on the cart and could be exposed to bacteria from the bathtub. Review of the policy titled, Handling Clean Linen, dated 11/01/23 clean linen shall be delivered to resident care units on covered linen carts with covers down. Nothing shall be kept on top of linen carts. Only rolls of bags used for linen transport may be kept on the carts, in the designated pockets only.		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, review of the safety data sheets, and policy review, the facility failed to ensure the resident environment was free of accident hazards. This affected four (#01, #16, #26 and #54) out of four residents reviewed and had the potential to affect all seven (#01, #16, #26, #33, #51, #54 and #64) independently mobile residents who reside in the memory care unit. The facility census was 64. Findings include-Based on observation, interview, review of the safety data sheets, and policy review, the facility failed to ensure the resident environment was free of accident hazards. This affected four (#01, #16, #26 and #54) out of four residents reviewed and had the potential to affect all seven (#01, #16, #26, #33, #51, #54 and #64) independently mobile residents who reside in the memory care unit. The facility census was 64. Findings Include: 1. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included anxiety disorder, dementia in other diseases classified elsewhere, severe with other behavioral disturbance, major depressive disorder, attention-deficit hyperactivity disorder, hallucinations, and post-traumatic stress disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 had severe cognitive impairment, supervision with eating, substantial assistance with toileting, dependent with bathing, and partial assistance with personal hygiene. 2. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE]. Diagnoses included Alzheimer 's disease with late onset, dementia, anxiety disorder, and adult failure to thrive. Review of the most recent MDS 3.0 assessment revealed Resident #16 had severe cognitive impairment, supervision with eating, dependent with toileting, dependent with bathing, and supervision with personal hygiene. 3. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia, vascular dementia, depression, amnesia, and cerebral infarction. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #26 had moderately impaired cognition, supervision with eating, independent with toileting, supervision with bathing, and independent with personal hygiene. 4. Review of the medical record Resident #54 was admitted to the facility on [DATE]. Diagnosis included Alzheimer 's disease, unspecified dementia, other symptoms and signs involving cognitive functions and awareness, and personal history of other diseases of the nervous system and sense organs. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #54 had severe cognitive impairment, supervision with eating, independent with toileting, dependent with bathing, and supervision with personal hygiene. Observation and interview on 12/31/25 at 10:30 A.M. the State Tested Nurse Aide (STNA) #50 verified the central bathing door was unlocked with one large jug of soap with no lid and five razors sitting on the table directly inside the door. The STNA #50 verified the door was unlocked due to being broken and the medication room unlocked as well. Interview on 12/31/25 at 10:35 A.M. Licensed Practical Nurse (LPN) #36 verified the medication room door was unlocked with items in the cabinets included the following: Five insulin syringes with needles Five razors One tub of Clorox wipes 75 count Acetaminophen (pain reliever) 325 milligrams (mg) two full bottles One bottle of vitamin D3 50 micrograms (mcg) 250 tablets One bottle of cimetidine (acid reducer) 200 mg 60 tab bottle Six bottles of acetic acid irrigation 500 milliliters (ml) in each Two jugs of drug buster Two bottles of hand sanitizer LPN #36 verified the medication room door had been unlocked for about one hour. Review of the safety data sheet (SDS) for drug buster dated 10/10/14 identifies the hazard of eye damage/irritation, skin sensitization, skin corrosion/irritation. Review of the SDS for Clorox commercial solutions dated 06/02/20 states handle in accordance with good industrial hygiene and safety practice. Review of the SDS for germ-x hand sanitizer dated 01/16/15 identifies the hazard of flammable liquid and vapor. Review of the SDS for Lysol dated 07/30/21 identifies the hazard flammable aerosol, causes eye irritation. Review of the SDS for body wash dated 01/07/15 identifies (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	storage as keep out of reach of children, store in a dry, well-ventilated place away from incompatible materials. Review of the SDS for Refresh tears dated 11/07/23 states handle in accordance with good industrial hygiene and safety practice. Review of the SDS for Ear Wax Remover dated 07/28/14 identifies the hazard causes serious eye irritation. Review of the policy titled, Medication Storage, dated 11/01/23 all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Review of the policy titled, Dementia Care, dated 11/01/23 care and services will be person-centered and reflect each resident ' s individual goals while maximizing the resident ' s dignity, autonomy, privacy, socialization, independence, choice, and safety.		

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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 medical record review, observation, staff interview, and policy review, the facility failed to ensure privacy of the electronic medical record. This affected two (#53 and #62) of six residents reviewed for privacy. The facility census was 64. Findings include- Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure privacy of the electronic medical record. This affected two (#53 and #62) of six residents reviewed for privacy. The facility census was 64. Findings Include: 1. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE]. Diagnoses included type two diabetes mellitus, end stage renal disease, major depressive disorder, and hypertension. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #62 had moderately impaired cognition, required supervision with eating, supervision with toileting, and partial assistance with personal hygiene. Observation and interview on 12/29/2025 at 9:59 AM the Licensed Practical Nurse (LPN) #49 verified the medication cart laptop sat on top of the cart open to Resident #62's medication list in the Electronic Medical Record (EMR) on the screen while LPN #49 was away. 2. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE]. Diagnoses included depression, Parkinson's disease without dyskinesia, cervical disc disorder, and chronic kidney disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #53 had moderately impaired cognition, required supervision with eating, dependent for bathing and toileting. Observation and interview on 12/30/25 at 10:29 A.M. the EMR was open to Resident #53's medications and no staff were around at the time. The Medication Aide (MA) #02 verified the laptop was open to Resident #53 where the medications were listed on the screen. The MA #2 verified she was away and obtaining supplies for a resident and left the EMR open. Review of the policy titled, Resident admission Agreement, dated 05/25 documented the facility will maintain residents' records in a confidential manner.		

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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 medical record review, interview, and policy review, the facility failed to adequately monitor the administration of warfarin. This affected one (#56) of five residents reviewed for unnecessary medications. The facility census was 64. Findings include: Based on medical record review, interview, and policy review, the facility failed to adequately monitor the administration of warfarin. This affected one (#56) of five residents reviewed for unnecessary medications. The facility census was 64. Findings Include: Review of the medical record revealed Resident #56 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease late onset, epilepsy, major depressive disorder, peripheral vascular disease, chronic embolism and thrombosis of unspecified vein, and essential hypertension. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #56 had severely impaired cognition, required supervision with eating, dependent with toileting, and dependent with bathing. Review of Resident #56 provider order dated 04/14/25 revealed warfarin (a blood thinning medication) sodium oral tablet five milligrams (mg) give one tablet by mouth in the evening related to chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity. Collect a prothrombin time/international normalized ratio (PT/INR) weekly on Monday. Review of Resident #56's laboratory results for PT/INR were 11/17/25 PT 24.4 and INR 2.3 with progress note Nurse Practitioner (NP) aware, orders for this visit, please continue coumadin five mg daily and repeat INR in one week. Review of Resident #56 lab results for PT/INR were 12/03/25 PT 24.2 and INR 2.3. Review of Resident #56 lab results for PT/INR were 12/19/25 PT 36.8 and INR 3.5 with progress note, orders for this visit, hold coumadin dose tonight times one and repeat PT/INR tomorrow and notify of results. Review of Resident #56 lab results for PT/INR were 12/23/25 PT 14.7 and INR 1.4. Review of Resident #56 lab results for PT/INR were 12/29/25 PT 23.2 and INR 2.2. Review of Resident #56 medical record revealed no PT/INR for 11/24/25, 12/01/25, 12/08/25, 12/15/25, 12/20/25 and 12/22/25. Review of Resident #56 progress note dated 12/26/25 revealed the patient was seen for an acute care visit for decreased INR. The patient was on long-term Coumadin therapy for chronic embolism and thrombosis. The most recent INR was 1.4, which was below the target range. INR recheck was planned, but no new results were available yet. Please keep Coumadin at five mg daily and check if the INR lab was actually done. Weekly Monday INR checks were needed for safe monitoring. Review of Resident #56 care plan dated 07/22/24 revealed currently prescribed an anticoagulation medication therapy with the intervention of will monitor PT/INR. Interview on 12/30/25 at 7:55 A.M. with the Director of Nursing (DON) verified no PT/INR for Resident #56 was completed on the following dates: 11/24/25, 12/01/25, 12/08/25, 12/15/25, 12/20/25 and 12/22/25 and was unsure as to why the labs were missed, the nurses should not administer the dose of warfarin with no PT/INR lab results. Interview on 12/30/25 at 8:26 A.M. with the Nurse Practitioner (NP) #80 verified the PT/INR for Resident #56 was missed a few times in the last month and she was currently working with the DON to come up with a resolution as the PT/INR was important to have drawn to monitor for a therapeutic level of warfarin. The NP #80 additionally verified she stressed to the DON that Resident #56 needed the PT/INR drawn every Monday. Review of the policy titled, High Risk Medications Anticoagulants, dated 02/05/25 reads routine labs, including baseline and subsequent labs, shall be ordered for each resident requiring anticoagulant medication. Results shall be communicated to the physician in a timely manner. Review of the policy titled, Coumadin Monitoring, dated 06/22 it reads Coumadin will be administered in the evening to ensure lab results are received and reported prior to administering the dose on the date of the lab draws. Review of the policy titled, Laboratory Services and Reporting, dated 11/29/23, reads the facility must provide or obtain laboratory services to meet the needs of its residents.		