STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinsburg Post Acute	8551 Darrow Road Twinsburg, OH 44087

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to maintain the most current and accurate advance directive in the resident record. This affected one resident (#71) of three residents reviewed for death. Facility census was 65.Findings include:Review of Resident #71's closed medical record revealed an admission date of [DATE] and diagnoses including muscle wasting and atrophy, depression, dementia with behavioral disturbance, dysphagia, hypertension and diffuse large B-cell lymphoma within the intra-abdominal lymph nodes. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 was cognitively impaired.Review of Resident #71's physician's orders revealed an order dated [DATE] for an advance directive for cardiopulmonary resuscitation (CPR) full code and an order dated [DATE] for admission to hospice for diagnose senile degeneration of the brain with a prognosis of six months or less provided disease follows its expected course. No other advance directive orders were noted in Resident #71's medical record.Review of a plan of care dated [DATE] revealed Resident #71 had an advance directive of full code. Listed interventions included advance directive and code status will be honored and advance directive will be in the medical record at all times.Review of hospice documentation faxed to the facility on [DATE] revealed Resident #71 was admitted to hospice services on [DATE] by Hospice Registered Nurse (HRN) #231. Advance directives were discussed before care was initiated on [DATE] with Resident #71's wife and they did not want CPR or other life-sustaining measures if his heart or lungs stopped working. A Do Not Resuscitate (DNR) order was also completed at this time. Further review of a death visit note dated [DATE] at 12:25 P.M. and authored by HRN #228 revealed Resident #71 expired on [DATE] at 12:30 P.M. and CPR was not initiated. The facility had called to report Resident #71 had expired and upon arrival, HRN #228 confirmed Resident #71 was absent of vitals.Review of a progress note dated [DATE] at 12:57 P.M. and authored by Registered Nurse (RN) #225 revealed Resident #71 expired on [DATE] at 12:30 P.M. and hospice, physician and family were made aware and Resident #71 was cleaned.Telephone interview on [DATE] at 8:25 A.M. with RN #225 revealed she was agency staff and could not recall the last time she worked at the facility. RN #225 recalled working on [DATE] but reported it was a last-minute shift and recalled hospice staff (names not provided) had wheeled Resident #71 in his wheelchair to his room and he looked bad, like he was going to go (pass away). RN #225 reported checking Resident #71's vitals and gave him Morphine medication as directed by hospice staff. RN #225 stated staff told her Resident #71 had passed away within the hour she had been at the facility and she spoke with Unit Manager (UM)/Licensed Practical Nurse (LPN) #105 as she had noticed Resident #71 had an advance directive of full code on his Medication Administration Record (MAR). RN #225 recalled UM/LPN #105 told her to don't worry about [the code status] as they [not specified] would take care of it. RN #225 reported if a resident was full code and were found unresponsive then staff should initiate CPR and shared on [DATE] (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Twinsburg Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8551 Darrow Road Twinsburg, OH 44087	

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no code was called and CPR was not provided to Resident #71.Interview on [DATE] at 9:05 A.M. with CNA #107 revealed on [DATE], night shift had gotten Resident #71 up for the day and therapy staff had assisted him with his breakfast. Hospice staff including Home Health Aide (HHA) #231 was present and took over, placing Resident #71 in bed and making him comfortable. CNA #107 recalled going in Resident #71's room with his lunch tray around 11:30 A.M. and tried to wake him up but he had already passed away so she reported this to the nurse (name not recalled). CNA #107 did not recall Resident #71's advance directive and confirmed no code was called on [DATE]. Interview on [DATE] at 9:17 A.M. with LPN #183 recalled she had picked up a shift on [DATE] but was not responsible for Resident #71 and did not recall a code being called this date. Interview on [DATE] at 10:30 A.M. with HHA #231 revealed she was present with Resident #71 when he passed away and recalled him looking like he was going to take his last breath in his wheelchair so she and HRN #228 had placed him in the bed, cleaned him and he passed away 30 minutes or so later. Interview on [DATE] at 10:38 A.M. with HRN #228 revealed she was present when Resident #71 passed away on [DATE] and recalled he had been actively dying so this was expected. HRN #228 was asked about Resident #71's advance directive and explained the hospice company would admit residents with a full code advance directive, but during care conferences and over time discussions would be had regarding goals of care and the advance directives often changed. HRN #228 pulled up Resident #71's hospice records during the interview including an advance directive for Do Not Resuscitate Comfort Care (DNR-CC) signed by Resident #71's wife on [DATE]. HRN #228 explained as they had this advance directive, CPR was not to be done thus no code was called on [DATE].Telephone interview on [DATE] at 10:58 A.M. with HRN #231 revealed when a resident signed on hospice services, consents were completed including advance directives and the hospice company would then fax the consent and advance directive to the facility. HRN #231 stated during a hospice admission he had no way to print out an advance directive and he was not the staff responsible to fax these documents to the facility.Telephone interview on [DATE] at 11:16 A.M. with Certified Nurse Practitioner (CNP) #226 revealed she had been notified Resident #71 had signed onto hospice services during [DATE] and reviewed the facility record during the interview which indicated Resident #71 had an advance directive of full code. CNP #226 stated she was surprised to read this as usually when residents signed on hospice, hospice staff could come in, educate the resident and family on advance directives and most of the time an advance directive of Do Not Resuscitate would be put in place. CNP #226 stated hospice staff were responsible for completion of the new advance directive form as the hospice medical director signed off on it and usually hospice would fax these documents to the facility. During the interview CNP #226 confirmed she only could find evidence Resident #71 was to be a full code from the facility's records.During an interview on [DATE] at 12:40 P.M. the Administrator and the Director of Nursing (DON) were made aware of the discrepancies in the facility's documentation regarding Resident #71's advance directive of full code not matching the accurate DNR-CC advance directive documents from the hospice company and did not disagree with these findings.Review of the facility policy, Advance Directives, revised 2021 revealed if the resident representative has executed one or more advance directive(s) copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. The director of nursing services (DNS) or designee notifies the attending physicianof advance directives or changes in advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. The resident wishes are communicated to the resident's direct care staff and physician by placing the documents in a prominent, accessible location in the medical record.the plan of care for each resident is consistent with his or her documented treatment preferences and/or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Twinsburg Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8551 Darrow Road Twinsburg, OH 44087	

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	advance directive.This deficiency represents non-compliance identified during the investigation of Complaint Number 2649661.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366419	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinsburg Post Acute	8551 Darrow Road Twinsburg, OH 44087

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 observation, interview, record review and review of the facility policy, the facility failed to provide timely incontinence care for Resident #16 and #20. This affected two residents (Residents #16 and #20) of three resident reviewed for incontinence care. The facility census was 65.Findings include:1. Record review for Resident #16 revealed an admission date of 08/22/25 with diagnosis including dementia, cervicalgia, and muscle weakness. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was severely cognitively impaired. Resident #16 was always incontinent of urine and occasionally incontinent of bowel. Resident #16 used a wheelchair for mobility, was dependent for chair/bed to chair transfer, wheelchair mobility, toilet transfer and for toileting hygiene. Resident #16 had no wounds or skin problems. Resident #16 was on a turning and repositioning program. Review of the care plan dated 09/02/26 revealed Resident #16 had bladder incontinence. Interventions included to offer toileting rounds upon request and as needed and to provide incontinent care upon request and as needed. Observation on 12/29/25 at 9:24 A.M. revealed Resident #16 was in her room sitting in a Geri chair with her eyes closed. Hospice Registered Nurse (RN) #228 revealed the hospice aide finished Resident #16's shower and placed her in the Geri chair earlier that morning. The hospice aide visited with Resident #16 five days a week for 30 minutes to one hour each visit. Observation on 12/29/25 at 10:00 A.M. revealed Resident #16 was still resting quietly in her Geri chair in her room. Interview on 12/29/25 at 10:01 A.M. with Hospice Aide #230 confirmed she showered Resident #16 this morning, and she visited Resident #230 five days a week and also visited several other residents while at the facility. Hospice Aide #230 revealed sometimes when she visited, Resident #16 would be saturated with urine. Observation on 12/29/25 at 10:30 A.M. revealed Resident #16 was located across from the nurses station in her chair, her eyes were open but she did not respond to conversing. Observation on 12/29/25 at 11:35 A.M. revealed Resident #16 was located across from the nurses station in her chair. Observation and interview on 12/29/25 at 1:52. P.M. with Certified Nursing Assistant (CNA) #199 confirmed she was Resident #16's primary CNA. Observation revealed Resident #16 was still located in her chair across from the nurses station in the same area and position as previously observed. CNA #199 confirmed Resident #16 had been there since that morning and confirmed Resident #16 not been checked or changed since hospice did it around 9:00 A.M. Observation on 12/29/25 at 2:00 P.M. of incontinence care for Resident #16 provided by CNA #199 and Licensed Practical Nurse (LPN) #183 revealed Resident #16's brief was saturated. LPN #183 and CNA #199 confirmed Resident #16 had a dressing intact to the buttocks, the surrounding tissue and buttocks coccyx/sacral area was deep red. CNA #199 revealed no one her told her how often she was supposed to check and change her residents but she tried to do it after lunch and after dinner, and Hospice would do Resident #16 in the morning. Interview on 12/29/25 at 3:00 P.M. with MDS RN #223 revealed residents should be checked, changed, and repositioned every two hours as this was standard of care. 2. Record review for Resident #20 revealed an admission date of 07/28/16 with diagnosis including hemiplegia affecting right dominant side, contracture of right hand, right forearm, right upper arm, left forearm, right elbow, and pressure ulcer of sacral region. Review of the quarterly MDS assessment dated [DATE] revealed Resident #20 was moderately cognitively impaired. Resident #20 was always incontinent of bowel and bladder, had impairment on both sides of the upper extremities, used a wheelchair for mobility, was dependent for toileting hygiene, chair/bed to chair transfer, and wheelchair mobility. Review of the care plan dated 01/31/24 revealed Resident #20 had bladder incontinence. Interventions included to check resident if he is continent, offer to assist with toileting, and if he is incontinent, remove (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinsburg Post Acute	8551 Darrow Road Twinsburg, OH 44087

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wet or soiled clothing/brief, and provide incontinent care Observation on 12/29/25 at 9:36 A.M. of wound care to Resident #20's left sacral wound provided by LPN #148 and RN #206 (Wound Care Certified Nurse Practitioner (CNP) #238 was present) revealed Resident #20's brief was wet with urine. The sheets Resident #20 rested on was peppered in crumbs and what appeared to be flaking skin cells verified by LPN #148. Observation revealed RN #206 turned Resident #20 to his side, unfastened the brief and LPN #148 moved the side of the brief covering the wound, removed the wound dressing then CNP #238 measured the wound. After the measurement was completed, CNP #238 stepped back and LPN #148 completed the wound care treatment then refastened the same soiled brief. LPN #148, RN #206 and CNP #238 then exited the room. RN #206 returned to the nurses station while LPN #148 and CNP #238 returned to the treatment cart and moved the cart to the next resident room. Interview with LPN #148 confirmed they completed care with Resident #20 an confirmed Resident #20's brief was saturated with urine. LPN #148 revealed the aides will do rounds after breakfast and change the resident. Observation revealed LPN #148, CNP #238 nor RN #206 notified any staff Resident #20's brief was saturated with urine. Interview on 12/29/25 at 10:05 A.M. with Certified Nursing Assistant (CNA) #199 confirmed she was Resident #20's primary CNA. When asked by the surveyor when she will be providing incontinence care for Resident #20, CNA #199 revealed she planned on starting care at the top of the hall and she was not sure when she would get to him. Observation on 12/29/25 at 11:00 A.M. of incontinence care for Resident #20 provided by CNA #199 and #107 confirmed Resident #20's bed sheets were still peppered with crumbs and dried skin cells. CNA #199 and #107 confirmed Resident #20's brief was saturated with urine. CNA #199 revealed no one told her he was wet and revealed her shift started at 7:00 A.M. and confirmed this was the first time this shift checking for incontinence and changing Resident #20. CNA #199 revealed he required two people to assist him with turning and stated there was not enough people who will help. Interview on 12/29/25 at 11:45 A.M. with LPN #183 revealed residents were not being changed timely and there were a lot of heavy care residents. Interview on 12/29/25 at 2:51 P.M. with DON and Administrator revealed the DON has always expected staff to assess residents for incontinence care every two hours or as needed. Administrator confirmed there had been family concerns expressed to her regarding residents not receiving timely incontinence care. Review of the facility policy titled, Urinary Continence and Incontinence - Assessment and Management revised August 2022 revealed If a resident does not try to toilet, or for those with such severe cognitive impairment that they cannot either point to an object or say their own name, staff will use a check and change strategy. A check and change strategy involves checking the residents continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to help protect the skin.This deficiency represents non-compliance identified during the investigation of Complaint Number 2607407, 2703210, and 2649661.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Twinsburg Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8551 Darrow Road Twinsburg, OH 44087	

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 interview, medical record review, and policy review, the facility failed to ensure Resident #62 was monitored and treated timely for a change in condition after a fall. This affected one resident (Resident #62) of three residents reviewed for falls. The facility census was 65.Findings include:Review of the closed medical record for Resident #62 revealed an admission date of 11/18/25 and a discharge date of 12/22/25. Diagnosis included spinal stenosis cervical region, fusion of spine cervical region, fibromyalgia, muscle weakness, need for assistants with personal care, and lack of coordination.Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was cognitively intact. Resident #62 was always incontinent of urine and occasionally incontinent of bowel. Resident #62 used a walker for mobility, required partial/moderate assistants for bed mobility, substantial/maximal assistants for sit to stand and chair/bed to chair transfers. Resident #62 used a manual wheelchair and required substantial/maximal assistants for wheelchair mobility. Resident #62 did not have a fall anytime in the last month prior to admission/entry or reentry. Resident #62 did have one fall since admission with no injury. Resident #62 had surgery involving fusion of spinal bones requiring active skilled nursing facility (SNF) care.Review of the care plan for Resident #62 dated 11/19/25 revealed Resident #62 had a decline in functional abilities and mobility related to recent hospitalization, status post-surgery with diagnosis spinal stenosis with laminectomy (a spine surgery that removes part or all of the lamina, the bony plate on the back of the vertebra) and fusion of cervical spine C-3 - C9. Interventions included nursing to provide skilled nursing services per the physician's orders to improve or maintain patient function. Resident #62 was also at risk for injury related to limitations imposed by medical condition spinal stenosis s/p C3 - C9 laminectomy and fusion requires assistants with mobility. Interventions included to assist resident with mobility as needed related to recent surgical procedures, mobility limitation and pain. Monitor for changes in condition or declines in ability to participate in activities of daily living, decreased strength, increased weakness or changes in cognition, notify physician if occurs.Review of Resident #62's care plan for pain revealed the resident had potential for altered level of comfort due to recent survey, diagnoses spinal stenosis, laminectomy and fusion of C3-C9, and osteoarthritis revealed interventions including but not limited to to assess for non-verbal indicators of pain, assess pain every shift and as indicated, offer nonpharmacological interventions to relieve discomfort or pain, and to position for comfort. Review of the progress note for Resident #62 dated 12/18/25 at 3:40 P.M. completed by Registered Nurse (RN) #109 revealed, Resident was observed on the floor in her bathroom, while trying to use the bathroom without assistance, she was found lying flat on her back, facing upward with her legs stretched out and was trying to sit up, but was unable to do so, her wheel walker was in front of her, resident stated that she was trying to use the bathroom with out any assistance, she also stated that she hit her head on the wall of the bathroom before falling to the floor, Resident was checked for injury, there was no visible injury noted, but she complained of dizziness, nausea and she vomited twice. She was seen by the NP (Nurse Practitioner) who started her neurological check, then put order in for N/S (normal saline) to be started immediately, resident's daughter was notified, with an immediate intervention for resident to be assisted off the floor to her wheel chair, then to her bed by staff.Review of the progress note for Resident #62 dated 12/18/25 at 4:57 P.M. completed by RN #109 revealed following the fall the resident complained of dizziness as well as nausea and vomiting, and the nurse wanted to have the resident sent out to the ER (emergency room), but the NP saw resident after checking her out, and the NP (#226) stated that resident was being treated in-house (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Twinsburg Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8551 Darrow Road Twinsburg, OH 44087	

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	and she gave the above orders. The resident's family member was notified of the order.Review of the progress note dated 12/18/25 at 6:40 P.M. completed by RN #109 revealed the spinal surgeon office was contacted and stated if there was anything new about the resident the resident should be sent to ER, but they were not here to see what is going on with her at this time, as it should be determined by the facility.Review of Resident #62's medical record, including the Medication Administration Record and Treatment Administration Record revealed no evidence the resident was monitored for pain every shift per her plan of care. The medical record contained no evidence of non-pharmacological interventions used to manage the resident's pain post fall.Review of the progress note dated 12/22/25 at 11:00 A.M. completed by Licensed Practical Nurse (LPN) #113 revealed the resident was transported to the ER for status post fall on 12/18/25, and daughter at bedside notified.Review of the Computed Tomography (CT) scan of Resident #62's cervical spine without IV contrast results, ordered by Physician #240 for Resident #62, dated 12/22/25, with the exam time of 1:05 P.M., revealed the reason for exam was fell hit head, neck dizziness, recent surgical fusion revealed postoperative changes of CT of C6 laminectomies with bilateral posterior screw and rod fixation. Findings concerning for a nonspecific fracture of the left CT facet adjacent to the left C3 screw. There was also possible backing out of hardware at the C3 level. Surgical evaluation suggested. Notification of the findings were made to Physician #240 via phone call on 12/22/25 at 1:41 P.M.Interview on 12/30/25 at 11:37 A.M. with Resident #62's daughter revealed Resident #62 was admitted to the facility after neck surgery. When she was admitted , she wore a neck brace. Resident 62 visited the surgeon after admission who said she was healing well and she could remove the neck brace. Resident #62 then had a fall hitting her head; one of the nurses told her there was back and forth about her going to the hospital, the nurses wanted her to go because she was acting different, but the CNP said no. Resident #62's daughter revealed on 12/22/25 she went in to visit her mom who was complaining of dizziness and neck pain so she (the daughter) over road the CNP and had Resident #62 sent to the hospital ER. Resident #62 had a scan at the hospital, and the doctor came in to speak with her, livid, with a neck brace she applied to Resident #62 neck and stated she had multiple neck fractures. The surgeon did not want to do the surgery, he said she was too fragile but she was lucky she was not paralyzed. Resident #62 revealed to the physician she took herself to the bathroom because she had been calling for assistance, but no one came then she fell hitting her head.Interview on 12/30/25 at 1:24 P.M. with CNP #226 verified she was in the facility on 12/18/25 when Resident #62 fell and hit her head. CNP #226 confirmed she was aware Resident #62 vomited shortly after hitting her head and confirmed this was the first time Resident #62 had vomited since being admitted to the facility, but she had vertigo (dizziness) in the past. CNP #226 revealed she completed a neuro exam which appeared normal, she witnessed Resident #62 vomiting, then she ordered neuro checks to be continued by the nurses per the protocol and ordered Zofran for the nausea and vomiting. CNP #226 revealed she asked Resident #62 if she wanted to go to the hospital and stated, I recommended she stay, but it was up to her and she said no. CNP #226 revealed she had the nurse call the surgeon and they deferred to back to the CNP and revealed when she went to the hospital, it was because the daughter wanted her sent. CNP #226 confirmed she never spoke to the daughter after the fall to discuss the fall or potential risks. CNP #226 revealed after the fall, the staff never reported any changes in Resident #62's condition or she would have sent her out. Interview on 12/30/25 at 1:45 P.M. with RN #109 regarding the fall on 12/18/25 revealed her first instinct was to have Resident #62 sent out, but the NP assessed her and decided not to send her. The NP saw her twice that day. RN #109 revealed the time frames in the progress notes for how the day went was inaccurate because she did not document at the times she completed tasks for Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366419	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinsburg Post Acute	8551 Darrow Road Twinsburg, OH 44087

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	#62. RN #109 confirmed she called Resident #62's surgeon two times that day. The first call was before the fall to discuss swelling in Resident #62's hand which the surgeon stated that, the hand swelling, would not be related to the laminectomy. The second call was after the fall, and the surgeon office said if there were any new changes after the fall to send her to the ER. RN #109 confirmed Resident #62 had new changes after the fall and hitting her head. RN #109 confirmed Resident #62 vomited twice directly after the fall and confirmed she never vomited before the fall. RN #109 revealed the CNP assessed Resident #62 and did not want her sent to the hospital she said she saw her and started IV's and ordered labs. No x-rays or scans were ordered. RN #109 revealed there was one additional difference after Resident #109 fell on [DATE] she noticed and stated, after the fall I noticed when she would sit up she complained of pain in the neck but after she layed down she was fine, she did not want pain medications because she did not have pain when lying down. RN #109 confirmed Resident #62 had pain in the neck prior to the fall but reiterated this pain was different because it was only when going from a laying position to a sitting position which she never complained of before the fall and revealed the pain resolved when laying down. Phone interview on 12/30/25 at 2:01 P.M. with LPN #134 revealed Resident #62 had been her patient in the past and revealed she was at the facility when Resident #62 fell (on 12/18/25). LPN #135 revealed Resident #62 fell in the bathroom. After the fall the staff went and got her, (LPN #134) and revealed they (her and two Certified Nursing Assistants (CNA's), tried to help Resident #62 up off the floor. LPN #134 revealed Resident #62 kept complaining of dizziness and she threw up, she threw up quite a few times. LPN #134 revealed she the Unit Manager wanted to send her out and (CNP #226) was going to do what she wanted. LPN #134 revealed RN #109 was Resident #62's primary nurse that day and revealed several times they tried to get Resident #62 off the floor, they had to lay her back down because when they sat her up, she would throw up. The staff went to get the CNP who did neuro checks then they helped and got Resident #62 up off the floor and she (LPN #135) left and went back to her assignment. Record review with Director of Nursing (DON) on 12/30/25 at 2:37 P.M. of the 72 hour Neuro Assessment Flow Sheet initiated 12/18/25 at 11:15 A.M. for Resident #62 revealed neuro checks (which included level of consciousness, extremities - motor and sensory, pupils, and vital signs) were to be completed on day one - every 15 minutes times (x) four, then every thirty minutes x six, then every one hour x four, then every four hours x 4. On day two and three they were to be completed every shift. DON confirmed the neuro assessment was not completed on 12/18/25 at 4:00 P.M., 5:00 P.M. or 6:00 P.M. as ordered. The assessment was done at 3:00 P.M. then not again until 7:00 P.M. (It was supposed to be done every hour). The next assessment was done at 2:00 A.M. DON confirmed the neuro assessments were not completed as ordered. DON confirmed there was no documentation in the medical record of any changes in condition (with exception of vomiting) after the fall. DON confirmed confirmed she was unable to locate any documentation in Resident #62's medical record confirming Resident #62 was monitored for pain every shift while residing at the facility. Phone interview on 12/30/25 at 4:21 P.M. with CNA #133 revealed he frequently worked with Resident #62 before and after the fall on 12/18/25. CNA #133 revealed the only thing really different after the resident fell was when she sat up she would have pain, and when she laid down she was ok. CNA #133 confirmed she never done that before the fall. Review of the facility policy titled, Change in Resident's Condition or Status dated February 2021 revealed our facility promptly notifies the resident, his or her attending physician, and the resident's representative of changes in the resident's medical/mental condition and or status. The deficiency represents non-compliance investigated under Complaint Number 2703210 and 2649661.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinsburg Post Acute	8551 Darrow Road Twinsburg, OH 44087

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 0686 Level of Harm - 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, observation, interview, and policy review, the facility failed to implement a comprehensive, resident centered plan for the prevention and treatment of pressure ulcers for Resident #26 and Resident #48. This affected two residents (Resident #26 and #48) of three residents reviewed for pressure ulcers.Actual harm occurred beginning on 12/08/25 when Resident #26 who was dependent on staff for activities of daily living, had current pressure ulcers and was at risk of developing additional pressure ulcers was found to have a new open wound area to the gluteal/upper thigh. The facility failed to complete a comprehensive wound assessment of the area, failed to provide appropriate/adequate interventions, and failed to ensure the facility wound physician and wound nurse were timely notified of to prevent the deterioration of the of the wound. On 12/15/25 the wound was first assessed to be an unstageable (a full-thickness wound where the actual depth is hidden by dead tissue (slough or eschar) pressure ulcer to the gluteal area which deteriorated and required antibiotics for a wound infection. Findings include:1. Record review revealed Resident #26 was admitted to the facility on [DATE] with diagnosis including hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, contracture unspecified joint, pressure ulcer sacral region Stage III (full-thickness skin loss, where fat is visible but bone, tendon, or muscle isn't exposed, creating a deep crater that can have rolled edges (epibole) and slough) and bed confinement status. Additional diagnosis added and dated 12/30/25 to included pressure ulcer left elbow unstageable, pressure ulcer left buttocks unstageable, pressure ulcer left heel unstageable, and pressure ulcer of the right heel unstageable.Review of the admission Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 was rarely or never understood. Resident #26 had an indwelling catheter, was always incontinent of bowel and bladder, was dependent (on staff) for eating, toileting hygiene, personal hygiene, bed mobility, chair/bed to chair transfer. The assessment revealed Resident #26 was at risk for pressure ulcers, had unhealed pressure ulcers, one Stage III present upon admission and no other pressure ulcers were present. Resident #26 had a pressure reducing device for the bed and received pressure ulcer injury care.Review of the care plan dated 09/22/25 revealed Resident #26 was at risk for skin breakdown/pressure ulcers related to osteomyelitis, left hemiparesis and diabetes mellitus. Interventions included to administer medication and treatments as ordered, keep skin clean and dry to the extent possible, and enhanced barrier precautions. Review of the care plan and physician orders revealed no documentation of turning or repositioning restrictions. Review of the progress note for Resident #26 dated 12/08/25 at 4:05 P.M. completed by Registered Nurse (RN) #224 revealed during the wound treatment round this nurse observed a new open area on left back of upper thigh and its skin bruise and tear so this nurse put dressing on it so this nurse clean with ns (normal saline) pat it dry and cover it with foam dressing and notified all responsible party.Review of the physician orders, Treatment Administration Records (TAR) and progress notes for Resident #26 revealed no physician order was obtained for care or treatment to Resident #26's new wound documented in the progress note on 12/08/25 to the left back of upper thigh and no further treatment was applied to the wound until 12/11/25.Review of a Skin Issues Note/Form for Resident #26 dated 12/11/25 at 11:08 A.M. completed by Wound Care Licensed Practical Nurse (LPN) #148 revealed Resident #26 had a new wound to the left gluteus. The wound was a pressure ulcer that assessed to be an unstageable pressure ulcer due to slough and or eschar injury present. The wound was acquired in house, identifying an exact date of 12/11/25. The measurements included three centimeters (cm) length by two cm width by (undetermined depth). Slough was 10% with a moderate amount of exudate. The surrounding tissue was excoriated.Review of the physician (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Twinsburg Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8551 Darrow Road Twinsburg, OH 44087	

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 0686 Level of Harm - Actual harm Residents Affected - Few	orders dated 12/11/25 for Resident #26 revealed an order for treatment to the left rear thigh which included to cleanse with normal saline, pat dry, apply calcium alginate with silver to the wound bed only, cover with dry dressing daily and as needed.Review of a Skin issues Note/Form for Resident #26 dated 12/29/25 completed by Wound Care Nurse LPN #148 revealed the left gluteus unstageable pressure injury was deteriorating. The wound bed had 100% slough present, the wound was in-house acquired, had heavy exudate with a faint odor, the surrounding tissue was dark reddish brown, and the dressing had heavy dressing saturation. The wound measured five cm in length by 13 cm in width by 1.7 cm depth.Review of the physician order dated 12/29/25 for Resident #26 revealed new orders for wound treatment to the left gluteus, cleanse with 0.25% Dakins, pat dry, pack wound with Mesalt ribbon, cover with foam dressing daily and as needed. An additional order dated 12/29/25 included Doxycycline Hyclate (antibiotic) oral tablet 100 milligrams (mg) give one tablet by mouth two times a day, prophylactically, for wound infection for 14 days.Interview on 12/29/25 at 11:15 A.M. with Certified Nursing Assistant (CNA) #199 revealed resident rounds which included turning and repositioning, would be done after breakfast, then after lunch and before dinner. CNA #199 revealed rounds including turning and repositioning should be done three times in a 12-hour shift.Interview on 12/29/25 at 11:45 A.M. with Licensed Practical Nurse (LPN) #183 revealed residents should be checked and changed every two hours. However, the LPN revealed residents were not checked, changed, turned and repositioned timely. Observation on 12/29/25 at 1:32 P.M. revealed Resident #26 was lying in bed. Resident #26 was lying on his backside. Resident #26 was difficult to understand. Resident #26 was not observed to have an indwelling catheter.Record review and interview on 12/29/25 at 1:36 P.M. with Wound Care Nurse LPN #148 revealed Resident #26 was admitted to the facility with a Stage III sacral wound. Since admission, Resident #26 developed five additional in-house pressure ulcers, a left elbow in-house unstageable pressure ulcer (found on 12/18/25), a left heel and right heel unstageable in -house pressure ulcers (found on 10/09/25), and a right planter foot unstageable in-house pressure ulcer (with 100% eschar when found on 12/11/25). The LPN indicated the sacral wound had since been improving and all other wounds were stable. On 12/08/25 a pressure ulcer was found on Resident #26's gluteus area. The nurse who identified the area documented the pressure ulcer as a bruise and skin tear but never notified Wound Care Certified Nurse Practitioner (CNP) #238 or the facility wound care nurse, and an order was not obtained to treat or care for the wound until Wound Care Nurse LPN #148 was notified on 12/11/25 (three days later) of the area. Wound Care Nurse LPN #148 revealed at first she thought the wound was due to the resident being wet because he was a heavy wetter and the wound also had excoriation around it, but when Wound Care CNP #238 assessed the wound on 12/11/25, it was determined by Wound Care CNP #238 it was an unstageable pressure ulcer. Wound Care Nurse LPN #148 revealed Resident #26 does not refuse care to the wound team and was never told of him refusing any care. Wound Care Nurse LPN #148 revealed she believed the wound was caused from Resident #26 not getting up out of bed often, being a heavy wetter, and he had been staying in bed to help heal his wounds. Wound Care Nurse LPN #148 revealed Resident #26 was transferred from the second floor (on 12/22/25) where the long term care residents resided down to the first floor where he could be monitored more closely. Resident #26 was ordered an indwelling catheter to be placed 12/29/25. Wound Care Nurse LPN #148 confirmed the date on the Skin Issue Form/Note indicated the date the wound on the left gluteus was found was 12/11/25, Wound Care Nurse LPN #148 confirmed that was an incorrect date because the wound was actually found on 12/08/25. Interview on 12/29/25 at 3:05 P.M. with Certified Nursing Assistant (CNA) #107 revealed she provided care for Resident #26. CNA #107 revealed Resident #26 needed turned by staff, as his mobility was limited; he could not be turned to the left side due to a stroke so he (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Twinsburg Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8551 Darrow Road Twinsburg, OH 44087	

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 0686 Level of Harm - Actual harm Residents Affected - Few	could only be turned on his back or to the right. Resident #26 never refused to be turned but stated staff were limited with positions to turn him.Interview on 12/30/25 at 9:22 A.M. with LPN #191 revealed Resident #26 could turn on either the right or left side, and there were no restrictions. Interview on 12/30/25 at 9:38 A.M. with CNA #161 revealed Resident #26 never refused turning and revealed but only goes toward the left side, he never turns on the right side. Interview on 12/30/25 at 1:24 P.M. with CNP #226 revealed the nurse called her on 12/08/25 to notify her of a new wound on Resident #26. CNP #226 revealed she told the nurse to notify the Wound Care CNP for orders because she was the one who takes care of the residents' wounds. Interview on 12/31/25 between 10:00 A.M. and 3:30 P.M. with Wound Care CNP #238 revealed she had concerns with Resident #26's wound to the left gluteus, the wound worsened and required surgical debridement and due to an infection in the wound, Resident #26 required an oral antibiotic. Wound Care CNP #238 revealed she should be notified of new wounds when they occur and confirmed she was not notified of Resident #26's wound to the left gluteus until 12/11/25.Observation on 12/31/25 at 4:10 P.M. of wound care to Resident #26's left gluteus wound completed by Wound Care Nurse LPN #148 revealed the left gluteus wound had a strong foul odor with drainage visible covering the outside of the dressing. The wound bed was 100% a dark gray color with sloughing. Wound Care Nurse LPN #148 confirmed the wound was tunneling. Resident #26 moaned and yelled out loud intermittently throughout the wound care. A request was made for a wound care prevention policy. The facility provided a policy on wound care but it did not include skin management or prevention. Review of the facility policy titled, Repositioning revised May 2013 revealed repositioning was a common, effective intervention for preventing skin breakdown, promoting circulation and providing pressure relief. If an existing ulcer was present, positioning the resident on an existing ulcer should be avoided. Evaluation included does the resident need scheduled position changes? Does the resident need positioning changes more frequently than hourly? Interventions included a turning/repositioning program includes a continuous consistent program for changing the residents position and realigning the body. A program is defined as a resident's approach documented, monitored, and evaluated. Residents who were in bed should be on at least an every-two-hour repositioning schedule. If ineffective, the turning and repositioning frequency would be increased. 2. Record review for Resident #48 revealed an admission date of 10/23/23 with diagnoses including multiple sclerosis, muscle weakness, and paraplegia with lower extremity contractures.Review of the care plan initiated 01/15/24 revealed Resident #48 had increased risk for skin breakdown and pressure ulcer formation due to impaired and reduced mobility. Interventions included to administer treatments as ordered by the physician, offload heals, positioning pillows to lower extremities, and prafo boots to keep heels elevated off the bed per physician orders.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 was rarely or never understood. Resident #48 had a pressure ulcer over a bony prominence, was at risk for developing pressure ulcers, had one Stage II (partial thickness loss of skin that exposes the dermis, which is the middle layer of skin. The wound may also appear as a blister or abrasion and is typically tender and painful.) present on admission, entry or reentry, two Stage III ulcers with one of those present on admission/entry or reentry. The assessment revealed Resident #48 had a pressure reducing device to the bed.Observation on 12/29/25 at 11:30 A.M. with Hospice Registered Nurse (RN) #228 revealed Resident #48 was lying in bed. Resident #48's bilateral lower legs were severely contracted, one pressing tightly against the other. Observation revealed nothing was in place to separate the bone on bone contact. Hospice RN #228 confirmed Resident #48 had a wound to the left outer knee that was chronic and being treated. Hospice RN #228 revealed during her assessment, a foam dressing to Resident #48's left inner knee was found that she was unaware of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366419	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinsburg Post Acute	8551 Darrow Road Twinsburg, OH 44087

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 0686 Level of Harm - Actual harm Residents Affected - Few	and confirmed the foam dressing to the left inner knee was dated 12/25/25 (four days earlier). Observation with Hospice RN #228 revealed under the foam dressing to the left inner knee was a piece of calcium alginate covering an open wound. Licensed Practical Nurse (LPN) #183 entered and observed the wound. LPN #183 confirmed with Hospice RN #228 the area to the left inner knee was not documented, neither nurse were aware of the wound and the wound had no physician orders for any treatment. Observation with both LPN #183 and Hospice RN #228 revealed under the border dressing was a piece of calcium alginate covering an open wound. RN #228 measured the open wound open area at three centimeters (cm) in length by two cm in width by 0.1 cm in depth with a small amount of serosanguinous drainage. The surrounding tissue was red. Hospice RN #228 revealed the area was red last week but it was not open, they were putting zinc on it, and they told the Wound Care Nurse (LPN #148). Hospice RN #28 confirmed she never obtained an order to treat the area at the time she was putting zinc on it.Review of the medical record for Resident #48 on 12/29/25 at 11:50 P.M. with LPN #183 confirmed there was no assessment, documentation, or physician order for care and treatment for the wound on Resident #48's left inner knee including no order for zinc. Interview and record review on 12/29/25 at 12:00 P.M. with Wound Care Nurse LPN #148 confirmed there was no assessment, documentation, or physician order for care and treatment for the wound on Resident #48's left inner knee. Wound Care Nurse LPN #148 revealed when a resident received hospice services, she did not monitor their wounds, care or treatments and revealed that was up to hospice to do. Wound Care Nurse LPN #148 revealed Hospice RN #228 never told her about the area or zinc being applied. Wound Care Nurse LPN #148 revealed normally if a resident had a wound, she, or the floor nurse did the measurements, the physician or certified nurse practitioner (CNP) would be notified along with the residents responsible party and a risk management form would be completed. Wound Care Nurse LPN #148 revealed they do find sometimes wounds being treated with no documentation or notification.Observation on 12/31/25 at 4:10 P.M. with LPN #239 present revealed Resident #48 did not have pillows to lower extremities or prafo bots on. Resident #48's contracted lower legs were lying directly one on top the other. LPN #239 confirmed the observation at the time.Review of the facility policy titled, Repositioning revised May 2013 revealed repositioning was a common, effective intervention for preventing skin breakdown, promoting circulation and providing pressure relief. If an existing ulcer was present, positioning the resident on an existing ulcer should be avoided. Evaluation included does the resident need scheduled position changes? Does the resident need positioning changes more frequently than hourly? Interventions included a turning/repositioning program includes a continuous consistent program for changing the resident's position and realigning the body. A program was defined as a specific approach documented, monitored, and evaluated. Residents who were in bed should be on at least an every-two-hour repositioning schedule. If ineffective, the turning and repositioning frequency would be increased. The deficiency represents non-compliance investigated under Complaint Number 2607407 and 2701189.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Twinsburg Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8551 Darrow Road Twinsburg, OH 44087	

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 observation, interview, record review, and review of the facility policy, the facility failed to maintain enhanced barrier precautions (EBP) and handwashing during resident care. This affected three residents (Resident #20, #48 and #26) of three observed for enhanced barrier precautions.Findings include:1.Record review for Resident #20 revealed an admission date of 07/28/16. Diagnosis included hemiplegia affecting right dominant side, contracture of right hand, right forearm, right upper arm, left forearm, right elbow, and pressure ulcer of sacral region. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was moderately cognitively impaired. Resident #20 was always incontinent of bowel and bladder, had impairment on both sides of the upper extremities, used a wheelchair for mobility, was dependent for toileting hygiene, chair/bed to chair transfer, and wheelchair mobility. Review of the care plan dated 09/11/25 included Resident #20 required enhanced barrier precautions (EBP) during high contact resident care activities due to the presence of open wounds. Observation on 12/29/25 at 11:00 A.M. of incontinence care for Resident #20 provided by Certified Nursing Assistant (CNA) #199 and #107 confirmed Resident #20's brief was saturated with urine. Observation revealed neither CNA #199 nor #107 wore an isolation gown during the incontinence care provided to Resident #20 and observation revealed both CNA's shirts touched Resident #20 and his linen items while providing the care. Both CNA #199 and #107 confirmed they did not put an isolation gown while providing incontinence care for Resident #107 or while changing the soiled linens. Observation on the entrance door for Resident #20's room revealed a sign which stated EBP, everyone must clean their hands including before entering and when leaving, providers and staff must also wear gloves and a gown for the following high contact resident care activities which included changing linens, providing hygiene, and changing briefs. Interview on 12/29/25 at 2:51 P.M. with DON and Administrator confirmed staff should apply an isolation gown and gloves when providing incontinent care for Resident #20. DON confirmed all the nursing staff floated and assisted with all residents. 2. Record review for Resident #48 revealed an admission date of 10/23/23. Diagnosis included multiple sclerosis, muscle weakness, and paraplegia. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #48 was rarely or never understood. Resident #48 had a pressure ulcer over a bony prominence, was at risk for developing pressure ulcers, had one stage two present on admission, entry or reentry, two stage three ulcers with one of those present on admission/entry or reentry. Review of the care plan dated 12/09/25 revealed Resident #48 required EBP due to indwelling medical device, feeding tube, ostomy and open wounds. Interventions included utilize gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Examples of high contact interactions include dressing, bathing, showering, transferring, providing hygiene, shaving, changing linens, changing briefs/toileting, device care or use (central lines, urinary catheters, feeding tube, trach, vent, wound care, etc.) Observation on 12/29/25 at 11:30 A.M. of wound care to Resident #48's left knee provided by Hospice Registered Nurse (RN) #228 and Hospice Aide #230 confirmed Resident #48 had an open area to the left knee. LPN #183 entered the room and was present during care. Both Hospice RN #228 and Hospice Aide #230 confirmed neither wore an isolation gown during wound care and confirmed both care for multiple residents residing at the facility. Interview on 12/30/25 at 10:23 A.M. with DON confirmed Hospice staff were expected to follow the facility infection control practiced including donning and doffing PPE. DON revealed Hospice RN #228 and Hospice Aide #230 visited Resident #10, #15, #16, #18, #48 and #55 on 12/29/25. 3. Record review for Resident #26 revealed an admission date of 09/21/25. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Twinsburg Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8551 Darrow Road Twinsburg, OH 44087	

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	left dominant side, contracture unspecified joint, protein calorie malnutrition, pressure ulcer sacral region stage three, bed confinement status, pressure ulcer left elbow unstageable, pressure ulcer left buttocks unstageable, pressure ulcer left heel unstageable and pressure ulcer of the right heel unstageable. Review of the admission Medicare five-day MDS assessment dated [DATE] revealed Resident #26 was rarely or never understood. Resident #26 had an indwelling catheter, was always incontinent of bowel and bladder, was dependent for eating, toileting hygiene, personal hygiene, bed mobility, chair/bed to chair transfer. Resident #26 was at risk for pressure ulcers, had unhealed pressure ulcers, one stage three present upon admission and no other pressure ulcers were present. Review of the care plan dated 09/28/25 revealed Resident #26 required EBP during high contact resident care activities due to the presence of open wounds and osteomyelitis. Interventions included to utilize PPE (gown and gloves; face-shield as indicated) during high-contact resident care activities (e.g., dressing, bathing/showering, transferring, hygiene, linen changes, brief changes, toileting assistance, device care, wound care). Observation on 12/30/25 at 9:22 A.M. of LPN #191 turning and repositioning Resident #26 in bed revealed LPN #191 repositioned Resident #26's four pillows used to position his body and extremities and his linen and blankets without donning an isolation gown. Observation revealed Resident #26 and his linens frequently touched LPN #191's shirt. LPN #191 did not wash her hands prior to providing care or after completing the care and prior to leaving the room. LPN #191 confirmed Resident #26 had an EBP sign on his door entering his room. The sign included everyone must clean their hands including before entering and when leaving the room; wear gloves and gown when transferring. LPN #191 confirmed she did not wash her hands before entering the room or providing care to Resident #26 or after providing care and before exiting the room. LPN #26 also confirmed she never placed an isolation gown on prior to turning and repositioning Resident #26 in bed. Review of the facility policy titled, Handwashing/Hand Hygiene dated October 2023 revealed the facility considers hand hygiene the primary means to prevent the spread of health-care associated infections. Hand hygiene is indicated immediately before touching a resident, and after touching a resident and or the resident's environment. Review of the facility policy titled Enhanced Barrier Precautions dated December 2024 revealed EBP's refer to an infection prevention and control interventions designated to reduce the transmission of multi-drug-resistant organisms (MDRO's) during high contact resident care activities. EBP apply when a resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical device. Examples of high contact resident care activities requiring the use of gown and gloves for EBP included dressing, bathing, hygiene, changing briefs or toileting, transferring, providing bed mobility, changing linens, device care or wound care.