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	02/10/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and family interview, review of Geriatric Nursing clinical literature and review of the facility policy, the facility failed to develop and implement a comprehensive, individualized and effective fall management program to decrease Resident #32's risk of falls including a fall with injury. The facility also failed to ensure fall prevention interventions were in place for Resident #30, #32, #50, and #59. This affected four residents (#32, #30, #50, and #59) of five residents reviewed for accidents. The facility census was 53. Actual harm occurred on 01/25/26 when Resident #32, who had moderate cognitive impairment, a history of multiple falls and risk for falls and history of urinary tract infection (UTI) sustained an unwitnessed fall resulting in an orbital fracture. Prior to the fall with injury, between 10/20/25 and 01/22/26 Resident #32 sustained seven falls without evidence of effective interventions being in place to decrease her risk of falls. Between 12/23/25 and 01/25/26, the facility failed to identify a change in the resident's condition (symptoms indicative of a urinary tract infection) without intervention which increased the resident's fall risk and likely contributed to the fall with injury. Findings include: 1. Review of the medical record for Resident #32 revealed an original admission date of 09/09/25 with diagnoses including chronic kidney disease, repeat falls, reduced mobility, rheumatoid arthritis, end stage renal disease, hearing loss, anxiety, obstructive sleep apnea, osteoarthritis of the right knee, and intervertebral disc displacement, lumbar region. Review of the admission note dated 09/09/25 at 9:11 P.M. revealed Resident #32 arrived on the unit at 6:55 P.M. on a stretcher from a medical center. Resident #32 had presented to the emergency room (ER) due to a fall with no broken bones or fractures. Resident #32 was alert and oriented to person, place, time and surroundings and was able to make needs known. Review of the fall risk assessment dated [DATE] revealed Resident #32 as at moderate risk of falls. Review of the care plan initiated 09/10/25 revealed Resident #32 was at risk for injury related to falls due to impaired and reduced mobility, impaired cognition, use of medication that contributes to falls, history of repeated falls prior to admission, and an unsteady gait. Interventions to assist in preventing falls included a call before you fall sign, provide items to self-occupy such as fidget toys or busy board, and keep the bed in the low position. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #32 had moderate cognitive impairment and no behaviors. The assessment revealed the resident required (staff) set up or clean-up assistance for eating and brushing her teeth. She required partial to moderate (staff) assistance toileting hygiene, personal hygiene, showers/bathing, upper body dressing, rolling left and right, sitting to lying, lying to sitting, sitting to standing, and bed to chair and chair to bed transfers. The resident required substantial to maximum (staff) assistance with lower body dressing and putting on/taking off footwear. The assessment revealed the resident was occasionally incontinent of bladder and always continent of bowel. The MDS revealed Resident #32 had a history of falls prior to admission.Review (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 0689 Level of Harm - Actual harm Residents Affected - Few	of the physician's progress note dated 09/18/25 included Resident #32 was admitted for skilled nursing and rehab. Resident #32's chief complaint was mobility and activity of daily living (ADL) dysfunction secondary to weakness with decrease in strength, decrease in functional mobility and reduced ability to safely ambulate placing the resident at risk for falls. Review of the nurse's note dated 10/20/25 at 4:40 P.M. revealed the nurse was informed Resident #32 was on the floor. Resident #32 was assisted into the wheelchair, this nurse asked the resident how did you fall? The resident stated I was trying to get out of bed. The call light was explained to Resident #32. No injuries were observed. Record review revealed no evidence this intervention was appropriate or effective based on the resident's cognitive impairment. Review of the post-fall fall risk assessment dated [DATE] revealed Resident #32 was at moderate risk of falls.Review of the Interdisciplinary Team (IDT) note dated 10/21/25 at 3:18 P.M. included a review of the resident's fall from 10/20/25. The new intervention implemented was a call before you fall sign. Review of the nurse's note dated 10/25/25 at 9:55 P.M. included the nurse was notified that Resident #32 was on the floor in the dining room in front of the wheelchair. Resident #32 revealed she wanted to go lay down and when she preceded to stand while chair unlocked it shifted and she slid to floor. Review of the post-fall fall risk assessment dated [DATE] revealed Resident #32 was at moderate risk of falls.Review of the IDT note dated 10/28/25 at 1:41 P.M. revealed the IDT reviewed the incident on 10/25/25. The nursing intervention was that Resident #32 was educated and verbalized understanding. There was no evidence the facility implemented interventions to ensure the resident was assisted to bed per choice.Review of the nurse's note dated 10/29/25 at 2:47 P.M. revealed the nurse was called to Resident #32's bedroom, observing her lying on her right side on the right side of the bed, nose bleeding. This nurse asked the resident what happened, and the resident was slow to respond stating she slid down from bed, she was wearing in house slippers with no gripper. The resident's top lip was bitten on the fall, and Resident #32 was sent to the ER. Review of the nurse's note dated 11/03/25 at 6:58 P.M. revealed Resident #32 arrived back from the hospital visit after being monitored after a fall.Review of re-admission note dated 11/03/25 at 8:26 P.M. revealed Resident #32 was on and antibiotic for a UTI.Review of the fall risk assessment dated [DATE] revealed Resident #32 was at moderate risk of falls.Review of the IDT note dated 11/04/25 at 11:31 A.M. for Resident #32 revealed the intervention implemented was to encourage Resident #32 to not sit on side of bed without assistance. Record review revealed no evidence this intervention was individualized or effective.Review of the physician orders for Resident #32 revealed an order for a call before you fall sign dated 11/04/26. (This was the intervention implemented on 10/20/25).Review of the quarterly MDS 3.0 assessment dated [DATE] assessment revealed Resident #32 had moderate cognitive impairment, no behaviors, required set up or clean up (staff) assistance for eating, brushing her teeth, and personal hygiene. The resident required partial to moderate (staff) assistance with rolling left to right, sitting to lying, lying to sitting, sitting to standing, and bed to chair and chair to bed transfers. She was occasionally incontinent of bladder and always continent of bowel. The MDS included Resident #32 had no falls, which was inaccurate as Resident #32 had falls on 10/20/25, 10/25/25, and 10/29/25. The fall on 10/29/25 resulted in a six-day hospitalization. Review of the progress note dated 11/11/25 at 5:22 P.M. included the nurse was called to Resident #32's bedroom and observed the resident sitting on her buttocks in front of the wheelchair. No injuries were noted and Resident #32 was put back in her wheelchair to have dinner. Review of the IDT note dated 11/11/25 at 6:11 P.M. included a nursing intervention to offer Resident #32 to go bed after dinner. There was no documented evidence of a root cause analysis for the fall.Review of the nurse's note dated 12/01/25 at 9:22 P.M. revealed Resident #32 was on the floor on the side of her bed upon the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	nurse walking into the room. There was no evidence of fall/safety interventions being initiated following this fall. Review of the post-fall fall risk assessment dated [DATE] revealed Resident #32 was at high risk for falls. Review of Certified Nurse Practitioner (CNP) #350's Acute Visit note dated 12/23/25 (untimed), revealed a chief complaint of lethargy and blood in tissue. Resident #32 had an altered mental status, unspecified, acute, unstable. Resident #32 presented severely lethargic and altered orientation status. Resident #32 was currently alert and oriented to person only, which represented a change from her baseline. Resident #32 also demonstrated delayed responses during clinical assessment and endorses feeling tired. Nursing staff notes significant change in patient's mental status from the baseline. Assessment was completed with the review of recent labs, medications and vital signs. Ordered a urinalysis (UA) with culture and sensitivity (C&S) (collect urine specimen) to evaluate for urinary source of acute delirium/encephalopathy. Notify provider with results when available. Review of the progress note dated 1/20/26 at 10:04 P.M. revealed Resident #32 was observed on the floor next to the bed by staff. Resident was requesting for the heat to be turned down. New intervention was to offer light weight or different material pajamas for comfort. There was no evidence to support how the facility identified these to be adequate and/or effective fall safety interventions. Review of the progress note dated 01/22/26 revealed Resident #32 tried to get up from her wheelchair in her room and slide down to her buttocks at 1:10 P.M. Resident #32 was assisted back to her wheelchair. An x-ray was ordered due to complaints of pain to the resident's lower back. Review of the Laboratory UA with culture and sensitivity report revealed a urine collection date of 01/14/26 (order for specimen testing received on 12/23/25). Received date to lab of 01/14/26 at 6:50 A.M. and a reported date of 01/23/26 at 9:47 A.M. The results were noted to be abnormal and included positive nitrate in the urine. (Nitrite positive urine is a sign of a UTI). Antibiotics to treat UTI's kill the bacteria that cause nitrites in urine). The results met criteria to perform a urine culture. The culture revealed greater than 100, 000 E- Coli, sensitivity was completed and included on the report. There was no documented evidence the physician or CNP were notified. Review of the progress note dated 01/25/26 at 1:02 P.M. revealed Resident #32 was observed on the floor sitting on her buttocks, with a low yell for help. Resident #32's right eye had a very large/hematoma with small cut in the corner of the eye. Resident #32 was alert enough to say it hurt, rating her pain an eight on a pain scale of zero to 10. Review of a progress note dated 01/25/26 at 1:12 P.M. revealed Resident #32 was transported to the emergency room (ER). Review of the progress note dated 01/25/26 at 3:42 P.M. revealed the ER nurse called. Resident #32 had an orbital fracture/right orbital floor fracture and Review of the Medication Administration note dated 01/26/26 at 8:33 A.M. revealed Resident #32 received Oxycodone tablet 5-325 milligrams (mg) (opioid pain medication) for pain. Repositioning, relaxation, distraction and comfort measures were provided and ineffective. The resident's right eye was slightly opened and Resident #32 revealed it hurts today. Review of the IDT note for Resident #32 dated 01/26/26 revealed the resident's daughter noted she was noticing a change in her mother with things she did (i.e. play with the remote control and pulling multiple tissues and rubbing them on her chest then stacking them). She noted she believed if she figured out a phone number, she would continuously call it multiple times or that her mother becomes fixated as she did with the remote to the bed and hit the button and not realizing she had to stop.Interview on 01/29/26 at 4:34 A.M. with Resident #32's daughter/Responsible Party, while a second daughter was on the phone, revealed concerns Resident #32 had several falls within a short amount of time and had increased confusion. The Responsible Party revealed Resident #32 was more confused than ever and continued to have falls and had a severe eye injury. The daughter stated she requested a UA which was ordered but not collected until (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	01/14/26. The results were reported on 01/23/26 but no treatment was started for the UTI until the daughter went to the facility on [DATE], upset and requested a copy of the results due to her mother's increased confusion. The daughter was given the results which confirmed a UTI and the nurse notified the CNP and treatment with an antibiotic was then initiated. The Responsible Party revealed she spoke to the Director of Nursing (DON) who reported to her this was an oversight and apologized. On 02/09/26 at 1:15 P.M. an attempted interview with CNP #350 was unsuccessful as the CNP refused to speak to the surveyor.On 02/09/26 at 4:10 P.M. an observation with Certified Nursing Assistant (CNA) #205 revealed Resident #32 was lying in bed. Observation revealed and CNA #205 confirmed Resident #32's bed was not in the low position as per the plan of care and there was no call before you fall sign located in the room. Interview on 02/10/26 at 12:45 P.M. with the DON confirmed fall interventions in the care plan should be in place for every resident. Fall investigations were requested for Resident #32 from the DON; however, no investigations were provided for review during the survey. Medical literature recognizes urinary tract infections as a known contributor to increased fall risk in elderly nursing home residents. UTIs in older adults frequently present with atypical symptoms such as weakness, confusion, or functional decline, which can increase the likelihood of falls. Therefore, accepted standards of practice require assessment for underlying causes, including infection, following a resident fall. Sources include [NAME], J., et al., The Relationship of Urinary Tract Infections and Falls in a Nursing Home, Director Journal; Geriatric Nursing clinical literature on UTIs and fall risk in older adults.Review of the undated facility policy titled, Falls and Fall Risk, Managing revealed based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall risk factors include incorrect bed height or width and conditions that may contribute to the risk of falls including infection. 2. Record review for Resident #30 revealed an admission date of 10/24/25. Diagnoses included intracranial injury, fracture of base of skull, maxillary fracture, displaced fracture of shaft of left tibia, disorders of autonomic nervous system, difficulty walking, muscle weakness, and traumatic brain injury. Review of the care plan initiated 10/27/25 revealed Resident #30 had potential for injury related to falls due to impaired communication, impaired cognition, impaired safety awareness, and restlessness related to head injury. Interventions included Resident #30 was to have his bed kept in low position, a pillow on the right side to assist with positioning, and mat on the floor beside the bed. Review of the Fall Risk Observation assessment dated [DATE] revealed Resident #30 was at moderate risk for fallsReview of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #30 was severely cognitively impaired. Resident #30 required partial/moderate assistance with chair/bed to chair transfer. Resident #30 had falls since admission.Observation on 02/09/26 at 9:09 A.M. revealed Resident #30 was lying in bed. A mat was on the floor to left side bed only. A second mat was leaning against the wall. The bed was raised and not in a low position. Observation on 02/09/26 at 9:16 A.M. with LPN #236 confirmed Resident #30 was at risk for falls. Observation revealed Resident #30 was lying in bed. There was one mat on the floor to the left side of the bed, and the second mat was leaning against the wall. LPN #236 confirmed the mat leaning against the wall should be on the floor next to the bed on the right side. LPN #236 also confirmed Resident #30's bed was not in a low position, and Resident #30 did not have a pillow to his right side while in bed as per the plan of care. Review of the undated facility policy titled, Falls and Fall Risk, Managing revealed based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Fall risk factors include incorrect bed height or width and conditions that may contribute to the risk of falls including infection. 3. Record review for Resident #50 revealed an admission date 06/10/24. Diagnoses included displaced posterior arch fracture of first cervical vertebrae, fracture of neck, and Parkinsonism. Review of the fall risk observation /assessment dated [DATE] revealed Resident #50 was high risk for falls.Review of the modification of the quarterly and Medicare five-day MDS 3.0 assessment dated [DATE] revealed Resident #50 was severely cognitively impaired. Resident #50 used a manual wheelchair for mobility and required substantial/maximal assistance for chair/bed to chair transfer. Resident #50 had no fall since admission (inaccurate, fall with major injury 12/31/25). Review of the care plan initiated 01/19/25 revealed Resident #50 was at risk for falls related to impaired cognition, impaired safety awareness, diagnoses of dementia, Menier's, and osteoarthritis, use of medications that contribute to falls, and recent and remote history of falls. On 12/31/25 Resident #50 had a fracture of the cervical spine and returned from the hospital with a c-collar. Fall interventions included to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance. Assure the bed is in low position when in bed and place the fall mat to the right side of the bed. Observation on 02/09/26 at 9:42 A.M. revealed Resident #50 was lying in bed. The bed was raised and not in a low position. The fall mat was on the left side of the bed, and the call light was on the floor behind the head of the bed not within reach for the resident. Observation and interview on 02/09/26 at 9:49 A.M. with LPN #263 confirmed Resident #50 was at risk for falls. LPN #263 confirmed Resident #50 was lying in bed. The bed was raised and not in a low position. The fall mat was on the left side of the bed, and the call light was on the floor behind the head of the bed not within reach for the resident. Review of the undated facility policy titled, Falls and Fall Risk, Managing revealed based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall risk factors include incorrect bed height or width and conditions that may contribute to the risk of falls including infection. 4. Review of the medical record revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, COVID-19, dementia with behavioral disturbance, major depressive disorder, gastroesophageal reflux disease (GERD), and hyperlipidemia.Review of the admission MDS 3.0 assessment revealed it was still in progress.Review of the Brief Interview for Mental Status (BIMS) score dated 02/06/26 revealed a score off 00, indicating Resident #59 had severe cognitive impairment.Review of the fall risk assessment dated [DATE] revealed a score of 22 indicating Resident #59 was at high risk for falls.Review of the care plan initiated 02/06/26 revealed Resident #59 was at risk for falls with or without injury related to altered mental status, antipsychotic medication, history of falls, dementia, psychosis, hallucinations, noncompliance with transfers, and attempts to get up on his own. Interventions included bed pillows for positioning when occupied, educate to keep call light within reach when in bed or sitting next to the bed.Observation on 02/10/26 at 9:02 A.M. with CNA #205 confirmed Resident #59 was lying in bed. Resident #59 did not have bed pillows for positioning, and his call light was in his top nightstand drawer with the drawer closed. CNA #205 confirmed the call light was not within Resident #59's reach. Review of the undated facility policy titled, Falls and Fall Risk, Managing revealed based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall risk factors include incorrect bed height or width and conditions that may contribute to the risk of falls including infection. This (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	deficiency represents non-compliance for Master Complaint Number 2733495.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain a timely urine sample for a physician ordered urinalysis for a resident exhibiting signs and symptoms of a urinary tract infection (UTI). The facility also failed to ensure timely physician notification of the diagnostic results indicating positive findings consistent with a UTI. The failure to promptly initiate diagnostic testing and follow acceptable standards of nursing practice resulted in a delay in identifying and treating the resident's potential infection placing the resident at risk for worsening infection and avoidable decline. This affected one (Resident #32) of three residents reviewed for timely obtaining and reporting physician ordered labs. The facility census was 53.Findings include:Review of the medical record for Resident #32 revealed an original admission date of 09/09/25 with diagnoses including chronic kidney disease and end stage renal disease. Review of the quarterly Minimum Data Set (MDS) 3.0 dated 11/08/25 revealed Resident #32 had moderate cognitive impairment, no behaviors, required set up or clean up assistance for eating, brushing her teeth, and personal hygiene. She required partial to moderate assistance with bed to chair and chair to bed transfers. She was occasionally incontinent of bladder and always continent of bowel. Review of Certified Nurse Practitioner (CNP) #350's Acute Visit Note for Resident #32 dated 12/23/25, untimed, revealed the chief complaint was lethargy and blood in tissue. Resident #32 had an altered mental status, unspecified, acute, unstable. Resident #32 presented severely lethargic and altered orientation status. Resident #32 was currently alert and oriented to person only, which represented a change from her baseline. Resident #32 also demonstrated delayed responses during clinical assessment and endorsed feeling tired. Nursing staff notes a significant change in patient's mental status from the baseline. An assessment was completed with the review of recent labs, medications and vital signs. Ordered a urinalysis with culture and sensitivity (UA C&S) to evaluate for urinary source of acute delirium/encephalopathy. Notify the provider with results when available.Review of the physician order for Resident #32 revealed an order dated 12/23/25 to collect urine for a UA C&S, discontinue once collected. The order revealed it was discontinued on 01/22/26 due to the urine being obtained on 01/14/26.Review of the Medication Administration Note dated 12/24/25 at 6:28 P.M. for Resident #32 revealed no urine was obtained for the UA; the resident was hydrating. There was no documented evidence that the physician or CNP was notified.Review of the Medication Administration Note dated 12/26/25 at 12:14 A.M. for Resident #32 revealed for the UA, the resident did not want a man to straight cath her. There was no documented evidence that the physician or CNP was notified.Review of the Medication Administration Note dated 12/29/25 at 12:44 P.M. and 2:57 P.M. for Resident #32 revealed for the UA, the resident was incontinent. There was no documented evidence that the physician or CNP was notified.Review of the Medication Administration Note dated 01/02/26 at 3:23 P.M. for Resident #32 revealed for the UA, the lab will not pick up until Monday.There was no documented evidence that the physician or CNP was notified.Review of the Medication Administration Note dated 01/03/26 at 5:26 P.M. for Resident #32 revealed for the UA, urine was collected into brief. There was no documented evidence that the physician or CNP was notified.Review of the Medication Administration Note dated 01/04/25 at 8:18 P.M. for Resident #32 revealed for the UA, this has been completed. There was no documented evidence that the lab picked up the urine sample or that the physician or CNP was notified.Review of the Medication Administration Note dated 01/10/25 at 8:40 P.M. for Resident #32 revealed for the UA, collect urine for UA C&S; unable to collect.There was no documented evidence that the physician or CNP was notified.Review of the physician orders revealed an order dated 01/12/26 for (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32 to obtain urine via straight catheter for UA C&S.Review of the Medication Administration Note dated 01/12/25 at 5:23 P.M. for Resident #32 included the CNP was in house today, the nurse placed a new order per CNP for the UA; obtain urine for UA C&S.Review of the Laboratory UA C&S results for Resident #32 revealed a collection date of 01/14/26, a received date (to the lab) of 01/14/26 at 6:50 A.M. and a reported date of 01/23/26 at 9:47 A.M. The report indicated abnormal results including positive nitrate (Nitrite positive urine is a sign of a UTI. Antibiotics to treat UTI's kill the bacteria that cause nitrites in urine). The results met criteria to perform a urine culture. The culture revealed greater than 100,000 E- Coli, sensitivity (an indication of what antibiotic will kill the bacteria growth) was completed and included on the report. Review of the interdisciplinary team (IDT) note for Resident #32 dated 01/26/26 revealed the resident's daughter noted that she was noticing a change in her mother with things she does, example: playing with the remote control and pulling multiple tissues and rubbing them on her chest then stacking them. She noted that she believed that if she figures out a phone number, she will continuously call it multiple times or that her mother becomes fixated as she did with the remote to the bed and hit the button and not realizing she had to stop.Review of the nurse's note for Resident #32 dated 01/28/26 at 4:18 P.M. included Resident #32's daughter requested a copy of the urinalysis results and paperwork. Resident #32's daughter received copies of the following: face sheet, medication list, and UA results.Review of the physician orders for Resident #32 revealed an order dated 01/28/26 for nitrofurantoin monohyd macro capsule (antibiotic) 100 milligrams (mg) by mouth two times a day for a UTI for five days.Interview on 01/29/26 at 4:34 A.M. with Resident #32's daughter/responsible party, while a second daughter was on the phone, revealed Resident #32 had several falls within a short amount of time; she also had increased confusion. The Responsible Party revealed Resident #32 was more confused than ever and requested a UA which was ordered on 12/23/25 but not collected until 01/14/26. The results were reported to the facility on [DATE], but no treatment was started for the UTI until she went to the facility on [DATE], upset, and requested a copy of the results due to her mother's increased confusion. The daughter was given the results which confirmed a UTI and the nurse then notified the CNP, and the treatment with an antibiotic was initiated. The Responsible Party revealed she spoke to the DON who revealed this was an oversight and apologized.Interview on 02/09/26 at 12:11 P.M. with Licensed Practical Nurse (LPN) #263 revealed the facility had three different fax machines (the first floor, the second floor and the main office) that resident lab results were sent to from the lab. There were different nurses working day to day, so if a nurse was not aware the resident was waiting on a result, they did not look for it, so it gets missed, and the physician or CNP was not notified. LPN #263 stated, It's happened to a lot of residents, if the families don't watch and ask about them, then many get missed.Interview on 02/10/26 at 12:45 P.M. with the DON confirmed Resident #32 had a UA C&S ordered on 12/23/25 due to a decline including a change in mental status. The UA was not collected until 01/14/26 (22 days after it was ordered). The DON revealed she was unsure why the UA was not collected until 01/14/26, but at times, the lab person coming to the facility did not take the collected labs with them. The DON confirmed there was no documentation of CNP #350 being notified that the urine was not obtained until 01/14/26. The DON confirmed the UA with the C&S results were reported to the facility on [DATE]. (Usually a urine C&S takes about 24-48 hours for the culture and 48-72 hours for the sensitivity). The C&S results confirmed Resident #32 had an active UTI. The DON confirmed CNP #350 was not notified of the UA C&S results until 01/28/26 (five days after the results returned) and after the daughter requested the results. The DON revealed the facility had three fax machines that lab results were sent to and revealed there were intermittent times the facility did not receive the lab (continued on next page)

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	366419	A. Building B. Wing	02/10/2026

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	results back. She revealed at times there had been issues with the facility printer and at times there was no service. She revealed it should have been passed on in the nurses' report (shift to shift report) to monitor for the resident's lab results and revealed the nurses did not follow through to monitor for results. She confirmed Resident #32 continued to have increased confusion and on 01/25/26, two days after the lab result returned confirming a positive UTI, Resident #32 had a fall with a fracture. CNP #350 was not notified of the UTI results until the daughter questioned the nurses on 01/28/26 and at that time an antibiotic was ordered. She stated the nurses should have notified CNP #350 when they did not collect the urine after it was ordered on 12/23/25 when Resident #32 was noted to have an acute change in condition, and the nurses should have called the lab to inquire about the results when they did not receive them timely. The DON revealed the facility had no policy regarding labs.This deficiency represents non-compliance investigated under Master Complaint Number 2733495.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, medication administration observation, staff interview, insulin pen instruction manual review and facility policy review, the facility failed to ensure medications were administered in accordance with professional standards of practice to maintain a medication error rate of less than five percent (5%). Observation during medication administration revealed two errors were observed of 39 opportunities with a 5.12% error rate. This affected two (Residents #7 and #32) of four residents observed for medication administration. The facility census was 53.Findings include: 1. Review of the medical record for Resident #32 revealed an original admission date of 09/09/25 with diagnoses including chronic kidney disease, reduced mobility, and intervertebral disc displacement, lumbar region.Review of the care plan initiated 09/10/25 revealed Resident #32 was at risk for complications with gastrointestinal system due to constipation. Interventions included to administer medications as ordered.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #32 had moderate cognitive impairment. She required partial to moderate assistance with bed mobility and transfers and was occasionally incontinent of bladder and always continent of bowel. Review of the physician orders for Resident #32 revealed an order for MiraLAX oral powder 17 grams (gm)/scoop, give one scoop by mouth one time a day for constipation dated 01/30/26.Observation on 02/09/26 at 11:23 A.M. of medication administration with Licensed Practical Nurse (LPN) #263 provide medications for Resident #32 revealed MiraLAX was not available. LPN #263 confirmed the MiraLAX was not available and revealed Resident #32 would have it by tomorrow.2. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnosis of type II diabetes mellitus.Review of the care plan initiated 04/21/25 revealed Resident #7 had a diagnosis of diabetes and was at risk for complications. Interventions included to administer medications as ordered.Review of the physician orders for Resident #7 revealed an order for insulin lispro injection 100 units per milliliter (ml) inject six units subcutaneously (sq) before meals for diabetes hold if the blood sugar less than 150 with a start date of 11/19/25.Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of two out of 15, indicating severe cognitive impairment. He did not reject care. He was independent with eating, transfers and oral hygiene and required supervision for toileting hygiene and showers.Observation on 02/10/26 at 8:33 A.M. of medication administration with LPN #207 for Resident #7 revealed LPN #207 assessed Resident #7's blood sugar and revealed the blood sugar was 238. Observation revealed LPN #207 removed the insulin pen lispro from the medication cart, placed a needle on the pen then dialed the pen to six units. LPN #207 did not prime the insulin pen prior to dialing the six units to be administered. LPN #207 then approached Resident #7 and administered the insulin sq. Interview on 02/10/26 at 8:51 A.M. with LPN #207 confirmed she did not prime the insulin pen prior to administration. LPN #207 stated, I don't need to prime because we don't want air to get into it, you never prime pens.Review of the undated insulin pen instruction manual titled, Instruction for Use for lispro insulin pens for use guidance revealed to attach a new needle to the pen. Always do a safety test (Priming) before each injection to check your pen and the needle to make sure they are working properly and to make sure you get the correct insulin dose. Select two units by turning the dose selector until the dose pointer is at the two marks, press the injection button all the way in, when insulin is coming out of the needle tip, your pen is working correctly. If no insulin appears, you may need to repeat this step up to three times before seeing insulin. If no insulin comes out after the third time the needle may be blocked. If this happens change the needle and repeat the safety check. After the safety check is complete, select the dose to administer.Review of the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy titled, Administering Medications, dated April 2019, revealed medications are administered in a safe and timely manner, and as prescribed.This deficiency represents non-compliance investigated under Master Complaint Number 2733495.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of medication administration, interview, record review, review of insulin pen instruction manual and facility policy review, the facility failed to ensure Resident #7 was free from a significant medication error when the resident received an incorrect dose of insulin as ordered by the physician. This affected one (Resident #7) and had the potential to affect four additional (Residents #1, #6, #24, and #60) identified by the facility as also receiving insulin pen injections. The facility census was 53.Findings include: Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnosis of type II diabetes mellitus.Review of the care plan initiated 04/21/25 revealed Resident #7 had a diagnosis of diabetes and was at risk for complications. Interventions included to administer medications as ordered.Review of the physician orders for Resident #7 revealed an order for insulin lispro injection 100 units per milliliter (ml) inject six units subcutaneously (sq) before meals for diabetes hold if the blood sugar less than 150 with a start date of 11/19/25.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of two out of 15, indicating severe cognitive impairment. He did not reject care. He was independent with eating, transfers and oral hygiene and required supervision for toileting hygiene and showers.Observation on 02/10/26 at 8:33 A.M. of medication administration with Licensed Practical Nurse (LPN) #207 for Resident #7 revealed LPN #207 assessed Resident #7's blood sugar and revealed the blood sugar was 238. Observation revealed LPN #207 removed the insulin pen lispro from the medication cart, placed a needle on the pen then dialed the pen to six units. LPN #207 did not prime the insulin pen prior to dialing the six units to be administered. LPN #207 then approached Resident #7 and administered the insulin sq. Interview on 02/10/26 at 8:51 A.M. with LPN #207 confirmed she did not prime the insulin pen prior to administration. LPN #207 stated, I don't need to prime because we don't want air to get into it, you never prime pens.Review of the undated insulin pen instruction manual titled, Instruction for Use for lispro insulin pens for use guidance revealed to attach a new needle to the pen. Always do a safety test (Priming) before each injection to check your pen and the needle to make sure they are working properly and to make sure you get the correct insulin dose. Select two units by turning the dose selector until the dose pointer is at the two mark, press the injection button all the way in, when insulin is coming out of the needle tip, your pen is working correctly. If no insulin appears, you may need to repeat this step up to three times before seeing insulin. If no insulin comes out after the third time the needle may be blocked. If this happens change the needle and repeat the safety check. After the safety check is complete, select the dose to administer.Review of the facility policy titled, Administering Medications, dated April 2019, revealed medications are administered in a safe and timely manner, and as prescribed.The deficiency represents an incidental finding identified during the complaint investigation.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of medication administration, record review, staff interview and facility policy review, the facility failed to ensure accurate documentation of medication administration in accordance with professional standards of practice. This affected one (Resident #32) of four residents reviewed for medication administration. The facility census was 53.Findings include:Review of the medical record for Resident #32 revealed an original admission date of 09/09/25 with diagnoses including chronic kidney disease, reduced mobility, and intervertebral disc displacement, lumbar region.Review of the care plan initiated 09/10/25 revealed Resident #32 was at risk for complications with gastrointestinal system due to constipation. Interventions included to administer medications as ordered.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #32 had moderate cognitive impairment. She required partial to moderate assistance with bed mobility and transfers and was occasionally incontinent of bladder and always continent of bowel. Review of the physician orders for Resident #32 revealed an order for MiraLAX oral powder 17 grams (gm)/scoop, give one scoop by mouth one time a day for constipation dated 01/30/26.Interview on 01/29/26 at 4:34 P.M. with Resident #32's daughter revealed Resident #32 was not getting her medications as she was supposed to, staff were leaving them in her room, not making sure Resident #32 was taking them then would sign the medication administration record (MAR), that they were administered.Observation on 02/09/26 at 11:23 A.M. of medication administration with Licensed Practical Nurse (LPN) #263 provide medications for Resident #32 revealed MiraLAX was not available. LPN #263 confirmed she was still doing the morning medications for Resident #32 and confirmed the MiraLAX was not available. LPN #263 revealed Resident #32 would have it by tomorrow. Observation revealed LPN #263 signed the MAR confirming the MiraLAX was administered for 02/09/26.Record review on 02/10/26 of the MAR for Resident #32 revealed the MiraLAX scheduled to be administered on 02/09/26 at 9:00 A.M. was documented as administered. Record review of the progress notes and the MAR notes revealed no documentation regarding the MiraLAX administration for 02/09/26 or thereafter.Interview on 02/10/26 at 8:57 A.M. with LPN #263 confirmed during the medication administration with the surveyor on 02/09/26, Resident #32's MiraLAX was not available. LPN #263 confirmed Resident #32 did not receive the MiraLAX at all on 02/09/26 and confirmed she signed the MAR on 02/09/26 indicating the MiraLAX was administered. LPN #263 confirmed she never placed a note in Resident #32's medical record indicating the MAR was signed in error. LPN #263 revealed she will put a note in now. Review of the undated facility policy titled, Charting and Documentation revealed all services provided to the resident, progress toward the care plan goals or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Medication administration is documented in the resident's medical record. Documentation in the medical record will be objective, complete, and accurate.This deficiency represents non-compliance investigated under Master Complaint Number 2733495.