STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366434	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Springs Nursing and Rehab	5000 Sowul Boulevard Stow, OH 44224

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to honor Resident #78's power of attorney's (POA) right to manage the residents' financial affairs by allowing the POA to select the insurance payer for the resident's stay. This affected one Resident (Resident #78) of three residents reviewed for resident rights. The facility census was 75.Findings include:Review of the medical record for Resident #78 revealed an admission date of 07/22/25. Medical diagnoses included nontraumatic intracerebral hemorrhage, metabolic encephalopathy, acute respiratory failure, hemiplegia, severe protein malnutrition, and tracheostomy. Resident #78 discharged to the hospital on [DATE] and did not return to the facility. Review of the Minimum Data Set (MDS) 3.0 Quarterly assessment dated [DATE] revealed Resident #78's cognition was severely impaired. Resident #78 was dependent on staff to provide all activities of daily living. Further review of the medical record revealed on 07/22/25 Resident #78's primary payer source was Aetna Managed Medicare. On 08/01/25 the primary payer source changed to Medicare A. On 10/30/25 the payer source changed to private pay. Review of the admission Agreement dated 07/25/25 revealed Business Office Manager (BOM) #513 was listed as the representative on the Designation of Authorized Representative page for the Ohio Department of Medicaid. The form indicated the representative was authorized to act on my behalf in all matters with the agency (agency refers to all departments of the county of job and family services, the Ohio Department of Medicaid (ODM) and all of ODMs contracted designees). At the bottom of the page, a hand-printed first initial and hand-printed last name of Resident #78's POA was listed in the box marked signature of person granting authority. There was no signature from the authorized representative. The form stated, this form has no effect unless signed by both the person granting authority and by the authorized representative. Review of the document titled [NAME] Springs Amount Due, dated 08/01/25, revealed Resident #78 was sent an invoice dated 08/01/25 for coinsurance for the period of 08/11/25 to 08/31/25 for a total of $4,399.50 that was due by 09/05/25.Further review of the medical record revealed no evidence documented that the facility had discussed at any time with Resident #78's POA the change of insurance on 08/01/25 or the invoice generated from the facility dated 08/01/25 prior to the bill due date of 09/05/25. An interview on 01/13/25 at 1:20 P.M. with Resident #78's Family Member #800 revealed when Resident #78 was admitted to the facility on [DATE] the payer source was Aetna Medicare Advantage PPO. As of 08/01/25 the insurance was changed without the family's knowledge or consent which resulted in a $209.00 per day copay while a resident at the facility. Family Member #800 stated they believed (first and last name provided) BOM #513 made the change to Resident #78's insurance without consent of the POA since Resident #78 was unable to speak for herself or sign documents. Family Member #800 stated if the insurance had not been changed, no copays would have accumulated for Resident #78. An interview on 01/20/26 at 9:15 A.M. with the Accounts Receivable Supervisor (ARS) #512 and BOM #513 verified Resident #78 had been charged 209 dollars per day due to a change in insurance payer effective 08/01/25 and verified Resident #78 (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	had been issued a bill due 09/05/25 due to that change. ARS #512 stated that change would not have been related to therapies. ARS #512 and BOM #513 both denied changing the insurance and stated they did not know who changed it or why it was changed. BOM #513 verified Resident #78 changed to private pay in the system on 10/30/25, however, Resident #78's insurance was reinstated on 11/01/25 so the facility was actively trying to receive backpay from the insurance instead of charging Resident #78 as private pay from 10/30/25 to 11/24/25. An interview on 01/21/26 at 11:53 A.M. with Resident #78's POA revealed she did not make any changes to Resident #78's insurance on 08/01/25, and the family did not authorize the transfer of insurance on 08/01/25. The POA stated that because of the disenrollment, Resident #78 accrued expenses from the facility and other providers. The POA stated she was not asked by the facility for permission to make any changes to Resident #78's insurance payer source. This deficiency represents non-compliance investigated under Complaint Number 2714382.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and review of facility policy, the facility did not ensure timely notification to the physician of a change in condition for Resident #78. This affected one resident (#78) of three residents reviewed for change of condition. The facility census was 75. Findings include : Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including but not limited to hemiplegia, nontraumatic intracerebral hemorrhage, vomiting, pneumonia, metabolic encephalopathy, dysphagia, chronic pulmonary disease, severe protein malnutrition, tracheostomy, and disorder of brain, unspecified.Review of physician orders for Resident #78 dated 07/22/25 revealed residuals (the amount of stomach contents left in the stomach at a specific time during tube feeding measured to see if the stomach is emptying properly and tolerating the tube feeding) were to be checked and to call the physician if equal to or greater than 150 milliliters (ml) every shift prior to feedings every shift.Review of the care plan with a date initiated of 07/31/25 revealed Resident #78 had potential for alteration in nutrition and hydration due to intercerebral hemorrhage and did not eat by mouth (NPO) so required tube feeding and water flushes for nutrition and hydration. Interventions included providing the tube feeding and flushes per physician orders and monitor. Review of physician orders dated 10/23/25 revealed Resident #78 was receiving enteral tube feeding of Jevity 1.5 at 50 ml per hour for 22 hours with 125 ml water flush every four hours.Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #78 had severely impaired cognition and was dependent on staff for all activities of daily living (ADL). Resident #78 had an indwelling urinary catheter, received oxygen therapy, had a tracheostomy and gastrostomy tube feeding. Review of the Medication Administration Record and Treatment Administration Record for November 2025 revealed the tube feeding and water flush administration for Resident #78 was signed off as administered as ordered on 11/24/25 day turn by Licensed Practical Nurse (LPN) #509. The gastric residual check was signed off as completed on day turn by LPN #509. Review of the Practitioner Progress Note dated 11/24/25 at 10:09 A.M. authored by Nurse Practitioner (NP) of Pulmonary Medicine #510 revealed the resident was seen and examined, in no distress. There was no mention the NP was notified Resident #78 had been having emesis during the earlier morning hours, increased residuals or tube feeding on hold. Review of the Respiratory Therapy Note dated 11/24/25 at 2:46 P.M. written by Respiratory Therapist (RT) #352, revealed Resident #78 was suctioned throughout the day and resident has been throwing up throughout the day. There was nothing in the note to indicate the physician was notified. Review of the Nursing Note dated 11/24/25 at 3:37 P.M. written by LPN #509 revealed Resident #78 had increased residuals, emesis times two this shift with a lot of tf (tube feeding) output. Tube feeding on hold for this time, will continue to monitor and restart tube accordingly. There was no evidence in this note that the physician was notified. Review of the Nursing Note dated 11/24/25 at 5:59 P.M. written by LPN #509 revealed Resident #78's family at side stating the resident is in distress and shaking resident saying something is wrong with her, get help immediately. LPN #509 wrote she assured family Resident #78 displayed anxious behavior and was not in distress. LPN #509 stated family was educated Resident #78 secretions were very thick at this time and her breathing was a normal response to this . Vital signs were obtained and RT assessed resident along with suctioning and the resident tolerated it well. There was no evidence the physician had been updated regarding the tube feeding on hold, the emesis earlier in the day or that the family was expressing concern about the resident. Review of the vital signs dated 11/24/25 at 5:59 P.M. recorded by LPN #509 revealed the vital signs were within normal range with blood (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure 126/78, pulse 81, temperature 97.8 degrees Fahrenheit and oxygen 96 percent. Review of the Respiratory Therapy Note dated 11/24/25 at 7:00 P.M. written by RT #342 revealed the RT was in the room to assess the resident and Resident #78 was breathing harder than normal, breath sounds were clear, tracheostomy clear and free of obstruction, breathing not labored and respiratory rate in the 30's. Unable to get an accurate sat (oxygen saturation reading) so increased oxygen to four liters per minute. RN called to room to assess, and ambulance called to take to ER for further evaluation. Review of document titled Stow Fire Department Patient Care Record dated 11/24/25 revealed emergency services received a call at 7:04 P.M. from the facility, were dispatched at 7:05 P.M. in route at 7:06 P.M., on scene at 7:15 P.M. and at the patient at 7:18 P.M. due to Resident #78 had a change in condition and being less responsive. Resident #78 was found with a pulse and respirations with pupils unequal, shallow breathing and departed to the hospital at 7:36 P.M. Review of the Physiatry progress note dated 11/24/25 at 9:43 P.M. authored by Physiatry Physician Assistant (PPA) #511 revealed the family requested transfer to another facility due to concerns with her not getting proper care. The resident was noted to be NPO with PEG feeding tube. Per nursing the patient had an episode of vomiting. Defer management to primary care team. There was no evidence in this note that the physician was made aware of the resident's vomiting.An interview on 01/13/26 at 10:00 A.M. with Registered Nurse (RN)/Assistant Director of Nursing (ADON) #402 revealed if a resident was having a change in condition, then the nurse was expected to call the physician or 911 if it was cardiac or respiratory distress. An interview on 01/13/26 at 12:10 P.M. with Primary Care Physician/Medical Director (MD) #523 revealed Resident #78's baseline was nonverbal, and cognition was at most resident could track with eyes. MD #523 stated Resident #78 was a candidate for hospice, but the family did not want hospice. MD #523 stated due to her high-risk multiple comorbidities, the tube feeding and tracheostomy, Resident #78 was an intensive care unit candidate if hospitalized . MD #523 did not mention being made aware Resident #78 had been vomiting prior to hospital transport on 11/24/25. An interview on 01/13/26 at 4:11 P.M. with Certified Nurse Assistant (CNA) # 507 revealed she worked the early morning of 11/24/25 and was Resident #78's aid. CNA #507 verified Resident #78 had been vomiting during the shift and that was not normal for her. CNA #507 stated she had told RN #424 it was not normal and the resident did not seem herself. An interview on 01/14/26 at 8:20 A.M. with CNA #326 revealed Resident #78 normally was stable and did not vomit her tube feeding. An interview on 01/14/26 at 8:40 A.M. with RN # 426 revealed Resident #78's family would visit often and would be able to see if Resident #78 was not in normal condition. Resident #78 usually was stable and tolerated her tube feeding. An interview on 01/14/26 at 10:28 A.M. with RT #352 verified she worked on 11/24/25 during the day and cared for Resident #78. RT #352 stated Resident #78 needed more suctioning on 11/24/25 than usual. RT #352 stated she notified LPN #509 that Resident #78 had emesis on 11/24/25. RT #352 stated Resident #78 needed an escalation of care considering emesis during the day and need for more suctioning than usual. An interview on 01/14/26 at 11:06 A.M. with RN #394 verified she worked 11/24/25 from 6:00 P.M. to 11/25/25 at 6:00 A.M. RN #394 stated during report LPN #509 stated Resident #78 had emesis during the day but did not say it was not reported to the physician. RN #394 stated she was alerted by RT #342 of her vitals, which she called 911 immediately. RN #394 stated she verified Resident #78 vitals after RT #342 alerted her of his concern. An interview on 01/14/26 at 12:30 P.M. with LPN # 509 verified she worked 11/24/25 from 6:00 A.M. to 6:00 P.M. and cared for Resident #78 that day. LPN #509 verified Resident #78 had high gastric residuals but did not specify nor document exactly how much. LPN #509 confirmed she did not call the physician to notify him of the residuals and multiple episodes of Resident #78 vomiting or that she had put the tube feeding on hold. LPN #509 stated she (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not remember the family reporting the resident was in distress. LPN #509 stated she had no concerns with how to notify a physician if needed.An interview on 01/14/26 at 4:46 P.M. with RT #342 verified he worked 11/24/25 from 6:00 P.M. to 11/25/25 6:00 A.M. and verified he cared for Resident #78 that night. RT #342 stated he observed Resident #78 at the start of his shift because family was concerned with how the resident was breathing. An interview on 01/15/26 at 9:18 A.M. with Nurse Practitioner (NP) of Pulmonary Medicine #510 revealed she visited Resident #78 the morning of 11/24/25 but did not obtain vitals on Resident #78 that day and was not informed that Resident #78 had been having emesis and high residuals. An interview on 01/15/26 at 1:59 P.M. with Physiatry Physician Assistant (PPA) #511 revealed she was in the facility on 11/24/25 and did visit Resident #78 in the morning. She revealed LPN #509 mentioned to her that Resident #78 had an episode of vomiting that day. PPA #511 verified she did not inform the physician or family and did not assess the resident for it or do anything about it. An observation was conducted on 01/22/26 at 4:30 P.M. with the Director of Nursing (DON) of Ring camera video footage submitted with permission by Resident #78's family from the live camera recordings in Resident #78's room. At the time of the observation, the DON verified the following time and date stamps and staff members in the room on the following video footage: On 11/24/25 at 3:42 A.M. Registered Nurse (RN) #424 and Certified Nurse Assistant (CNA) # 507 were in Resident #78's room at 3:45 A.M. CNA #507 stated oh she vomited. Observation of video revealed vomit was observed on the right side of Resident #78's mouth while RN #424 and CNA #507 were in the room. CNA #507 stated there was puke all over her. Both staff cleaned the resident up and the nurse obtained vital signs. Observation of video footage at 9:07 A.M. revealed LPN # 509 walked into Resident #78's room and stated she was going to turn this off for a minute, she is full. LPN #509 was observed to provide medication by syringe and shut off the tube feeding administration pump that was next to the resident's bed. At 10:50 A.M. PPA #511 walked into resident's room, the resident was alert and in no obvious distress. PPA #511 looked over the residents arms and legs briefly, picked up her computer and left the room. PPA #511 took no vitals or other assessments. The tube feeding pump was still off. Observation at 11:04 A.M. of RT #352 with a student-in-training revealed Resident #78 had a large amount of emesis that poured out of her mouth three times while the student- in-training used a [NAME] suction around resident's chest area and mouth. The tube feeding pump was still off. Review of video footage at 5:43 P.M. revealed Resident #78's daughter entered Resident #78's room, set her belongings down near the camera, walked over to Resident #78 and was observed asking the resident if she was ok. The resident was noticeably breathing heavier than in prior video segments. The DON verified these findings at the time of the observation. Further review of the medical record for Resident #78 revealed no evidence RN #424 documented that Resident #78 had emesis, if the resident was assessed and there was no evidence of the physician being notified by RN #424. Review of the facility policy titled Change in a Resident's Condition or Status dated May 2024, revealed the facility shall promptly notify the attending physician, and representative of changes in the resident medical status. This deficiency represents noncompliance investigated under Complaint Number 2714382.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a comprehensive and individualized care plan for Resident 78 to address turning and repositioning needs and interventions for pain. This affected one resident (Resident #78) of four residents reviewed for care plans. The facility census was 75.Findings include:Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including but not limited to nontraumatic intracerebral hemorrhage, vomiting, pneumonia, metabolic encephalopathy, muscle weakness, symbolic dysfunction, history of transient ischemic attack, shortness of breath, acute respiratory failure, dysphagia, chronic pulmonary disease, disease of digestive system, hemiplegia, severe protein malnutrition, malaise, tracheostomy, disorder of brain, and hypothyroid.Review of Minimum Data Set (MDS) 3.0 Quarterly assessment dated [DATE] revealed Resident #78 was nonverbal and had impaired cognition. Resident #78 was dependent on staff to roll left and right in bed and to transfer from bed to chair. Resident #78 was on a scheduled pain regimen and received as needed pain medication. Resident #78 had one unhealed pressure injury that was a stage three pressure injury. Review of the Pain assessment dated [DATE] revealed Resident #78 was unable to answer if she was hurt in the past five days, was unable to answer how much pain she experienced over the past five days, was unable to answer if pain made it difficult to fall asleep, unable to answer if unable to participate in rehab therapy related to pain, unable to answer if pain affected day to day activities. Resident #78 was unable to answer a verbal descriptor scale of worst pain over the past five days. Review of physician orders dated 07/22/25 revealed Resident #78 was to receive Acetaminophen 325 milligrams by PEG tube three times a day for pain and Acetaminophen 325 milligrams by PEG every six hours as needed for pain.Review of physician orders dated 08/19/25 revealed Resident #78 was ordered Tramadol (narcotic pain medication) 50 milligrams by PEG tube every 12 hours as needed for pain.Review of the care plan dated 07/28/25 and revised 10/20/25 revealed Resident #78 had impaired skin integrity. Interventions include assist with hygiene and general skin care and keep skin clean and dry. There were no interventions related to turning and repositioning the resident to offload pressure to promote skin integrity. There was no care plan developed for the pain medications ordered, no measurable goals pertaining to pain or the pain medications and no interventions for pain developed in the care plan. Review of Resident #78 ' s physician orders for October 2025 to November 2025 revealed no orders related to turning and repositioning. There were also no orders pertaining to an individualized pain assessment for a resident who could not verbally communicate.An interview on 01/22/26 at 8:39 A.M. with Registered Nurse (RN) #426 revealed Resident #78 had a wound on her bottom and stated staff were to turn and reposition Resident #78 at least every two hours. Also, since Resident #78 was non-verbal, staff would need to assess level of pain by physical assessment such as if Resident #78's face would tense up with care.An interview on 01/22/26 at 1:45 P.M. with the Director of Nursing (DON) confirmed Resident #78's physician orders had not included to turn and reposition Resident #78 at least every two hours and the facility should have implemented a care plan to turn and reposition. The DON also confirmed the facility did not implement a plan of care related to pain for Resident #78.Review of the facility policy titled Pain Assessment and Management, revised March 2023, revealed the pain management program was based on a facility wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan and the resident's choices related to pain management. Review of the facility policy titled Pressure Ulcer Prevention and Risk Identification,undated, revealed a care plan would be developed and updated routinely with identified skin risk and/or actual (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound development. Interventions would be implemented as indicated by the physician and as determined by the interdisciplinary team. This deficiency represents non-compliance investigated under Complaint Number 2714382.