

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER Hudson Springs Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation and interviews, the facility failed to serve food at hot and palatable temperatures, with accurate portion sizes to meet nutritional needs, and in timely meals. This affected nine residents (Residents #7, #17, #18, #29, #38, #57, #62, #72 and #75) and had the potential to affect 67 residents who received food from the kitchen. There were six residents (Residents #8, #13, #14, #31, #64 and #84) who received no food or beverages from the kitchen. The facility census was 73. Findings include: Interview with Resident #29 on 04/19/26 at 11:10 A.M. revealed, Meals have very small portions of meat. They serve a lot of noodles, and they combine leftovers into a new meal. Interview with Resident #72 on 04/19/26 at 11:35 A.M. revealed, Food (expletive). It's cold sometimes and the presentation on the plate makes it unappealing. Interview with Resident #17 on 04/19/26 at 11:46 A.M. revealed, The food taste is poor. Interview with Resident #57 on 04/19/26 at 12:04 P.M. revealed, The food is terrible. Don't know what you are eating sometimes. I get a lot of mashed potatoes. Interview with Resident #7 on 04/19/26 at 12:10 P.M. revealed, The food is a huge concern. Food is almost always cold. Cold items are warm like milk and yogurt. The kitchen will put hot and cold food on the same plate, such as lasagna and salad. Ice cream becomes like a milkshake when served. Interview with Resident #38 on 04/19/26 at 12:16 P.M. revealed, The kitchen is the worst part. Sometimes dinner is at 7:00 P.M. or 7:15 P.M. Interview with Resident #75 on 04/19/26 at 12:20 P.M. revealed, Food is terrible and the menu is not correct. Interview with Resident #18 on 04/19/26 at 12:28 P.M. revealed, Food is warm at best. Interview with Resident #62's family on 04/19/26 at 2:06 P.M. revealed, The food is terrible. Observation of lunch tray line on 04/21/26 at 12:38 P.M. revealed the following food temperatures and portion sizes: Beef and broccoli stir fry was 151 degrees Fahrenheit (F) for regular texture and 151 degrees F for the puree. A four-ounce portion was served until it was corrected by the surveyor. Soft fried noodles were 165 degrees F for regular texture and 165 degrees F for the puree. A four-ounce portion was served. Mini egg rolls were 162 degrees F for regular texture and 168 degrees F for the puree. The cold beverage was 38 degrees F, and an eight-ounce portion was served. All items were at a safe temperature. Review of the Week at a Glance menu for 04/21/26 revealed the correct items were served. Review of the diet spreadsheet for 04/21/26 revealed the portion size of the beef and broccoli stir fry was two #8 (four-ounce) scoops. [NAME] #232 served one #8 scoop of both regular and puree broccoli stir fry until corrected by the surveyor. The plates already dished up were then corrected. This was verified by [NAME] #232 and Administrator in Training (AIT) #318 at the time of correction. Observation of a test tray on 04/21/26 revealed at 1:35 P.M. the 200-hall trays were started. At 1:51 P.M. the test tray left the kitchen, and at 1:53 P.M. the tray arrived at the 200-hall. All the 200-hall trays were passed by 1:56 P.M. and the food on the test tray was then checked for food and beverage temperatures. The mini egg roll was 122 degrees F. The soft fried noodles were 125 degrees F. The beef and broccoli stir fry was 104 degrees F. The cold beverage was 39 degrees F. The hot food, in particular the beef and broccoli stir fry, at 104 degrees F, was not at a palatable temperature. The lunch mealtimes were posted as being served from 12:30 P.M. to 1:30 P.M. The 200-hall was served at 1:53 A.M., and then 400-hall was served afterwards. The lunch meal was late. Interview at the time of the observation with Dietary Manager #304, the Administrator, and AIT #318 verified the test tray findings and the meal being late. This deficiency represents non-compliance investigated under Complaint Numbers 2746202 and 2738451.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 366434	If continuation sheet Page 1 of 4

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interviews, the facility failed to ensure its kitchen area was maintained in a clean and sanitary condition. This had the potential to affect 67 residents who received food from the kitchen. There were six residents (Residents #8, #13, #14, #31, #64 and #84) who received no food or beverages from the kitchen. The facility census was 73. Findings include: Observation during the initial kitchen tour conducted on 04/19/26 at 1:54 P.M., the following was noted: The shelf over the stove had accumulated grease and dust. The inside of the microwave had accumulated build-up of food from splatters. The under-counter refrigerator had spills dried onto the floor. The bucket of sanitizing solution used to wipe the counters did not meet the correct level of sanitizer. Interview at the time of the observation with Dietary Manager #304 verified the findings. Observation on 04/21/26 at 12:15 P.M. of the three-compartment sink used to wash and sanitize equipment and utensils did not meet the correct level of sanitizer. Interview at the time of the observation with [NAME] #278 and Administrator in Training #318 verified the findings. This deficiency represents non-compliance investigated under Complaint Number 1397116 (OH00165273).</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation and interview, the facility failed to maintain its dumpster area in a clean and sanitary manner. This had the potential to affect all 73 residents residing in the facility. Findings include: Observation of the facilities dumpster area on 04/19/26 at 1:54 P.M. revealed the two garbage dumpsters had their top lids open. One dumpster also had the side door open. There was a pile of gloves, straws, plastic bottles and wrappers beside one dumpster. Interview at the time of the observation with Dietary Manager #304 verified the condition of the dumpster area. This deficiency represents non-compliance investigated under Complaint Number 1397116 (OH00165273).</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility policy review, and review of guidelines from the Centers for Disease Control and Prevention (CDC), the facility failed to use appropriate infection control practices by performing hand hygiene and changing gloves during incontinence care. This affected one resident (Resident #51) out of one resident observed for incontinence care. The facility identified 45 residents (Residents #2, #5, #8, #10, #12, #14, #19, #20, #21, #22, #23, #24, #29, #30, #32, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #45, #47, #48, #50, #51, #52, #56, #57, #58, #59, #60, #61, #62, #63, #65, #70, #71, #73, #74, and #75) who required incontinence care. The facility census was 73. Findings include: Review of the medical record for Resident #51 revealed an admission date of 12/18/25 and diagnoses of Parkinson's disease, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, benign prostatic hyperplasia, chronic kidney disease stage three, acute kidney failure, periodic limb movement disorder, disorder of the brain, anxiety disorder, and depression. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had intact cognition, was frequently incontinent of bowel and bladder, and dependent for incontinence care. Review of the physician's orders for Resident #51 dated 02/16/26 revealed an order to check and change every two hours and as needed per shift for incontinence care. Observation on 04/22/26 at 9:34 A.M. with Certified Nursing Assistants (CNAs) #280 and #286 of incontinence care for Resident #51 revealed both CNAs washed their hands prior to the procedure. CNA #286, while wearing clean gloves, removed Resident #51's soiled brief and cleansed the area from front to back. CNA #286 then removed the soiled gloves, performed hand hygiene and applied clean gloves. Both CNAs rolled Resident #51 to the left side and then CNA #280, wearing clean gloves, cleansed Resident #51's buttocks area. CNA #280 then obtained a clean brief with the now soiled gloves and placed it onto the resident without changing gloves or performing hand hygiene prior. Afterwards, both CNAs discarded their gloves and washed their hands. Interview at the time of the observation with both CNAs #280 and #286 confirmed CNA #280 did not change gloves or perform hand hygiene after cleansing Resident #51's buttocks area and before handling and applying a clean brief. Interview on 04/22/26 at 9:50 A.M. with the Director of Nursing verified soiled gloves should be changed and hand hygiene performed before placing a clean brief on a resident as a proper infection control practice. Review of facility policy titled, Urinary Continence and Incontinence - Assessment and Management, dated 09/2024 revealed staff would properly screen and manage individuals with urinary incontinence which would include avoidance of infection and use infection control aspects of incontinence care. Review of the guidelines from the CDC titled, Clinical Safety: Hand Hygiene for Healthcare Workers, located at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, dated 02/27/24 revealed gloves should be changed and hand hygiene performed if gloves become soiled with blood or body fluids after a task. This deficiency represents non-compliance investigated under Complaint Numbers 2746202, 2659759, and 2572446.</p>		