

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Center for Rehabilitation at Hampton Woods The		STREET ADDRESS, CITY, STATE, ZIP CODE 1517 East Western Reserve Road Poland, OH 44514	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews and facility policy review, the facility failed to ensure food was safely stored and dated in both the kitchenette and the main facility kitchen. The facility also failed to maintain biannual cleaning of the hood system. This had the potential to affect all 21 residents residing in the facility. The facility identified all 21 residents as receiving food from the kitchen. Findings include: 1. Observation of the kitchenette on 12/29/25 from 8:27 A.M. to 8:37 A.M. with Food Service Supervisor (FSS) #97 revealed sitting on a tray on top of the microwave was one 24-ounce container of Mrs. [NAME] Maple Syrup open to air due to the flip top part of the cap was missing. In the refrigerator, there was one five-pound container of cottage cheese half full with a best buy date of 12/18/25. At the time of observation FSS #97 confirmed the maple syrup was open to air, and the cottage cheese was outdated and should have been thrown away. Observation of the main kitchen on 12/29/25 from 8:39 A.M. to 9:07 A.M. with FSS #97 revealed in the dry storage area of the main kitchen was one bag (approximately 12 ounces) of miniature marshmallows open to air and not dated, one undated five-pound bag half full of elbow macaroni resealed, and one two and a half pound bag of opened Oreo cookie pieces resealed and undated. In the walk-in refrigerator located in the dry storage area was one half gallon container of lactose free milk with a best buy date of 12/27/25. FSS #97 confirmed areas of concern and stated all items should have been sealed and dated, and items should be used by the best buy date. Review of the undated facility policy titled Food Purchasing and Storage revealed all food items will be properly dated and labeled and placed in containers with lids or will be wrapped. This policy did not address outdated food items. 2. Observation of the main kitchen on 12/29/25 from 8:39 A.M. to 9:07 A.M. with FSS #97 revealed a sticker on the hood which indicated the hood system was last cleaned on April 2025 and was due to be cleaned on October 2025. FSS #97 confirmed that the hood was supposed to be cleaned in October 2025, but the vendor cancelled and cleaning had not been rescheduled. Review of the Kitchen Hood Fire Suppression System log for 2025 confirmed the professional hood cleaning company had completed the semiannual cleaning of the kitchen hood in April 2025 and there had been no other professional cleaning through 12/29/25. Interview on 12/29/2025 at 11:15 A.M. with Dietary Technician Registered (DTR) #140 confirmed the kitchen hood was last cleaned in April 2025 and should be cleaned every six months. DTR #140 stated there was no facility policy for hood cleaning.		

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, record review and review of facility policy, the facility failed to ensure the commercial dryer was free from excessive lint build-up. This had the potential to affect all residents in facility. The facility census was 21. Findings include: Observation and interview with Laundry Supervisor #135 on 12/30/25 at 10:35 A.M. confirmed lint compartment on commercial dryer had quite a bit of lint and that it appeared to not have been cleaned out prior to use on 12/30/25. Laundry Supervisor #135 indicated that the lint compartment was to be cleaned twice each shift with staff initialing the sign off log located beside commercial dryer once a shift. Review of dryer lint log on 12/30/25 at 10:35 A. M. revealed it contained laundry staff initials of Laundry Supervisor #135 on 12/29/25 as having completed the lint cleaning for 12/29/25; however, during the observation and interview on 12/30/25 at 10:35 A.M., Laundry Supervisor #135 confirmed that it had not been cleaned out properly prior to being used on 12/30/25. Review of the undated laundry policy, Procedure D, titled Drying of washed linens and personal revealed that laundry staff were to clean lint from the dryers each shift and that clean linen and supplies were to be delivered to linen supply closets daily.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility policies, the facility failed to develop and implement baseline care plans that include dates of completion/implementation, goals, instructions, and necessary interventions to be able to provide effective and person-centered care for Residents #17, #20, #31, #32, #33, #34, and #36. This affected seven residents (#17, #20, #31, #32, #33, #34, and #36) out of 15 residents whose care plans were reviewed. The facility census was 21. Findings include: 1. Review of the medical record for Resident #20 revealed an admission date of 12/17/25 with diagnoses including periprosthetic fracture around the internal prosthetic left hip joint, generalized muscle weakness, difficulty in walking, gastroesophageal reflux disease (GERD) without esophagitis, neuromuscular dysfunction of the bladder, presence of unspecified artificial hip joint, anxiety disorder, essential (primary) hypertension, hypothyroidism, unspecified glaucoma, stage three chronic kidney disease, Parkinson's disease without dyskinesia, depression, vertigo of central origin, unspecified macular degeneration, pain, and falls. Review of the falls risk assessment completed on 12/18/25 revealed a score of 10 (10 or above represents a high risk for falls). Further review of the falls risk assessment revealed Resident #20 was intermittently confused, experienced one to three falls in the past three months, and required assistive devices. The admission Minimum Data Set (MDS) 3.0 assessment was in progress. Review of the physician's orders revealed Resident #20 had no orders related to fall precautions or non-pharmacological pain interventions. Further review of the medication orders revealed orders dated 12/24/25 for Resident #20 to receive the following medications: oxycodone hydrochloride (HCL) (an opioid pain reliever) 5 milligrams (mg) by mouth every six hours as needed for pain for seven days, Eliquis (an anticoagulant) 5 mg by mouth two times a day for atrial fibrillation, and Ativan (an antianxiety medication) 1 mg by mouth two times a day for anxiety. Review of the resident baseline care plan dated 12/18/25 to 12/29/25 revealed Resident #20 had a history of falls with a recent left hip open reduction and internal fixation (ORIF), a surgical procedure to fix severe bone fractures by realigning broken bone fragments and stabilizing them internally with hardware like plates, screws, rods, or pins, and included no interventions or safety precautions to prevent future falls. Review of the medication section of the baseline care plan listed that Resident #20 was on a prescribed pain regimen but did not indicate the prescribed regimen included an opioid and included no other pain related interventions. The medication section included no documentation that Resident #20 received a psychotropic medication or an anticoagulant and included no interventions for staff to assess for effectiveness or adverse effects. Review of the pain tool completed on 12/20/25 revealed Resident #20 had pain described as Hurts a Whole Lot on the faces pain scale, and that the pain was exacerbated by movement. Aside from prescribed opioid, the pain tool revealed that Resident #20 indicated pain relief measures included rest, ice, and repositioning (which was not included on the baseline or the comprehensive care plans). Interview on 12/30/25 at 5:04 P.M. with the Director of Nursing (DON) confirmed that the medication section of the baseline care plan dated 12/18/25 did not indicate Resident #20 received opioid medications, and that there were no interventions related to pain management, including non-pharmacological interventions and assessing for side effects of opioids. Further interview with the DON related to fall precautions revealed that it was the facility's stance that if a resident did not (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have a fall while in the facility, fall interventions would typically not be put into place, though the DON also confirmed that residents who came to the facility after a fall with injury would most likely be at high risk for falls. During the interview, the DON also confirmed that Resident #20's care plan made no indication that Resident #20 was taking an anticoagulant or a psychotropic medication and that perhaps they were ordered after the baseline care plan was first developed, and it was not updated. Review of the undated policy titled Psychotropic Medication Use revealed residents who received any type of psychotropic medication were required to have adequate monitoring for response to treatment and adverse side effects and should have appropriate behavioral and/or non-pharmacological interventions in place to aide in resident needs and permit the lowest possible dose to meet psychosocial needs Review of the policy titled Resident Care Plan, last revised May 2020, revealed the baseline care plan was to be used until the comprehensive care plan was developed (on or before day 21 of admission) to help each resident maintain their highest practical level of mental, physical, and psychosocial well-being. The baseline care plan was to include goals and interventions that addressed all the following, but not limited to, assistance needed for activities of daily living (ADL), problems related to diagnoses and physician orders, psychosocial well-being, safety concerns, preventative care, and problems related to physical, mental, or behavioral problems. According to the policy, the resident care card, which directed nursing interventions, only contained information related to ADL. 2. Review of the medical record for Resident #31 revealed an admission date of 12/24/25 with diagnoses including other fracture of upper and lower end of the right fibula, other injury of unspecified body region, type two diabetes mellitus with diabetic chronic kidney disease, atherosclerotic heart disease, bilateral primary open-angle glaucoma, heart failure, major depressive disorder, GERD, hypotension, unspecified fall, unspecified atrial fibrillation, hyperlipidemia, and hypertension. Review of the falls risk assessment completed on 12/24/25 revealed a score of 14 (a score above 10 indicates a high risk for falls). Further review of the falls risk assessment revealed Resident #31 was alert and oriented to person, place, and time, and sustained three or more falls in the past three months. The admission MDS 3.0 assessment was in progress. Review of Resident #31's resident care card dated 12/29/25 revealed the resident was alert and oriented times three (person, place, and time), Hoyer lift (a mechanical lift device) for transfers, and two person assist for bathing, personal hygiene, bathing, and toilet use. Review of the physician's orders dated 12/24/25 at 3:59 P.M. revealed Resident #31 was to receive oxycodone hydrochloride (HCL) oral tablet (an opioid analgesic) 5 mg by mouth every six hours as needed for pain for seven days, Eliquis oral tablet 5 mg by mouth two times a day for atrial fibrillation, escitalopram oxalate (an antidepressant) oral tablet 20 mg by mouth one time a day for depression. Further review of the medication orders revealed an order dated 12/26/25 at 9:00 A.M. for Resident #31 to start taking amoxicillin-potassium clavulanate oral tablet 875-125 mg (an antibiotic) one tablet by mouth two times a day for bronchitis for a total of 13 doses. Review of the undated resident baseline care plan revealed Resident #31 required total dependence for transfers, toileting, use of a Hoyer lift and standard wheelchair. Further review of the baseline care plan revealed a history of falls, and history of fall-related injury (right ankle fracture) with no interventions listed to prevent future falls. The baseline care plan also revealed no indication that (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #31 was taking a psychotropic medication and there were no interventions related to opioid use, non-pharmacological pain interventions, or monitoring for adverse effects of psychotropic medication use. Interview on 12/30/25 at 5:04 P.M. with the DON confirmed that the medication section of the undated baseline care plan did not indicate interventions for Resident #31 related to the use of opioids or psychotropic medications. Further interview with the DON related to fall precautions revealed that it was the facility's stance that if a resident did not have a fall while in the facility, fall interventions would typically not be put into place, though the DON also confirmed that residents who came to the facility after a fall with injury would most likely be at high risk for falls. Review of the undated policy titled Psychotropic Medication Use revealed residents who received any type of psychotropic medication were required to have adequate monitoring for response to treatment and adverse side effects and should have appropriate behavioral and/or non-pharmacological interventions in place to aide in resident needs and permit the lowest possible dose to meet psychosocial needs Review of the policy titled Resident Care Plan, last revised May 2020, revealed the baseline care plan was to be used until the comprehensive care plan was developed (on or before day 21 of admission) to help each resident maintain their highest practical level of mental, physical, and psychosocial well-being. The base line care plan was to include goals and interventions that addressed all the following, but not limited to, assistance needed for ADL, problems related to diagnoses and physician orders, psychosocial well-being, safety concerns, preventative care, and problems related to physical, mental, or behavioral problems. According to the policy, the resident care card only contained information related to ADL. 3. Review of the medical record for Resident #34 revealed an admission date of 12/21/25 with diagnoses including depression, heart failure, acute kidney failure, primary hypertension, type two diabetes mellitus, congestive heart failure, and repeated falls. Review of the Nursing Admission/readmission Assessment-2023 completed on 12/21/25 revealed Resident #34 was alert and oriented to person, place, time, and situation, and was verbally appropriate. The admission MDS 3.0 assessment was in progress. Review of the physician's orders dated 12/21/25 at 5:06 P.M. revealed Resident #34 was to receive Paroxetine (an antidepressant medication) 20 mg by mouth once daily for depression and bupropion hydrochloride (HCL) extended release (ER/XL) 24-hour tablet (an antidepressant medication) one 300 mg tablet by mouth daily for depression. An additional medication order, dated 12/21/25 at 5:06 P.M., included apixaban 5 mg oral tablet (an anticoagulant/blood thinner) give 5 mg by mouth two times a day for atrial fibrillation. Review of the baseline care plan revealed the care plan was undated (no date of completion or date the care plan was reviewed with Resident #34). Further review of the baseline care plan revealed Resident #34 had a history of falls with no safety goals or fall interventions indicated on the care plan. The baseline care plan indicated Resident #34 was on an anticoagulant and needed monitored for signs and symptoms of uncontrolled bleeding. The psychotropic medication area of the care plan was blank. Review of the non-pharmacological orders revealed an order dated 12/21/25 indicating that nursing interventions were to be completed per the POC/Resident Care Card. There were no orders for Resident #34 to be assessed for abnormal bleeding or side effects related to anticoagulant use or the (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use of psychotropic medications. Review of the Resident Care Card (RCC) last updated 12/24/25 revealed Resident #34 was alert and oriented to person, place, and time, was on a scheduled to be assisted with turning in bed, required two staff for assistance with bed mobility and transfers, and one staff for locomotion in the wheelchair. Further review of the RCC revealed there was no information related to the use of an anticoagulant or psychotropic medications and no interventions in place for monitoring Resident #34 for adverse effects. Interview on 12/30/25 at 3:36 P.M. with Certified Nurse Aide (CNA) #24 revealed the aides knew what interventions residents needed by looking at the RCC. During the interview, CNA #24 confirmed not knowing who needed to be monitored for side effects of blood thinners (anticoagulants) or psychotropic medications and that the care cards did not contain information related to monitoring or reporting resident behaviors or side effects of medications. Interview on 12/30/25 at 3:45 P.M. with CNA #26 revealed the aides were not informed of what residents were on high-risk medications or who needs monitored for certain adverse effects of the high-risk medications and further confirmed that there was no area on the RCC to indicate when a resident needed monitored for adverse medication effects. Interview on 12/30/25 at 5:04 P.M. with the DON confirmed that the medication section of the undated baseline care plan did not indicate Resident #34 received psychotropic medications and that there were no interventions related to psychotropic medications. During the interview, the DON also confirmed residents on anticoagulants should have an order for nurses to sign-off as documentation that the resident was being assessed every shift for abnormal bleeding, but there was no such order in Resident #34's medical record. Further interview with the DON related to fall precautions revealed that it was the facility's stance that if a resident did not have a fall while in the facility, fall interventions would typically not be put into place, though the DON also confirmed that residents who came to the facility after a fall with injury would most likely be at high risk for falls. Review of the undated policy titled Psychotropic Medication Use revealed residents who received any type of psychotropic medication were required to have adequate monitoring for response to treatment and adverse side effects and should have appropriate behavioral and/or non-pharmacological interventions in place to aide in resident needs and permit the lowest possible dose to meet psychosocial needs. Review of the policy titled Resident Care Plan, last revised May 2020, revealed the baseline care plan was to be used until the comprehensive care plan was developed (on or before day 21 of admission) to help each resident maintain their highest practical level of mental, physical, and psychosocial well-being. The base line care plan was to include goals and interventions that addressed all the following, but not limited to, assistance needed for ADL, problems related to diagnoses and physician orders, psychosocial well-being, safety concerns, preventative care, and problems related to physical, mental, or behavioral problems. According to the policy, the resident care card only contained information related to ADL. 4. Record review revealed Resident #17 was admitted on [DATE] with diagnoses of encounter for surgical aftercare following surgery on the circulatory system, heart failure, unspecified, unspecified asthma, uncomplicated, muscle weakness (generalized), difficulty in walking, benign prostatic hyperplasia without lower urinary tract symptoms, GERD without esophagitis, hyperlipidemia, atrial (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fibrillation, type II diabetes mellitus with other diabetic neurological complication, essential (primary) hypertension, malaise, polyneuropathy, unspecified, acute myocardial infarction, presence of aortocoronary bypass graft, ventricular tachycardia, respiratory failure, unspecified whether with hypoxia or hypercapnia, sleep apnea, acute diastolic (congestive) heart failure, and critical illness myopathy. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #17 had no cognitive impairment. Review of functional abilities revealed Resident #17 required maximal assistance with toileting, dressing, showers, and moderate assistance with transfers. Review of the baseline care plan revealed Resident #17 had baseline care plan on 12/11/25. No evidence was found in the record to indicate a baseline care plan ensured to include any documentation of any interventions to ensure Resident #17 could meet goals to discharge to community, become independent in functional goals and ensure completion dates on the baseline care plan. Interview on 12/30/25 at 3:43 P.M. with the DON and Regional Quality Measures (RQM) Nurse #3 confirmed the missing intervention and completion date documentation on the baseline care plan for Resident #17. Review of the policy titled Resident Care Plan, last revised May 2020, revealed the baseline care plan was to be used until the comprehensive care plan was developed (on or before day 21 of admission) to help each resident maintain their highest practical level of mental, physical, and psychosocial well-being. The base line care plan was to include goals and interventions that addressed all the following, but not limited to, assistance needed for ADL, problems related to diagnoses and physician orders, psychosocial well-being, safety concerns, preventative care, and problems related to physical, mental, or behavioral problems. According to the policy, the resident care card only contained information related to ADL. 5. Record review revealed Resident #32 was admitted on [DATE] with diagnoses of pyothorax without fistula, acute respiratory failure with hypoxia, pneumonia, unspecified organism, osteoarthritis, unspecified site, difficulty in walking, essential (primary) hypertension, arthropathic psoriasis, and other acute postprocedural pain. Review of the admission MDS 3.0 assessment dated [DATE] revealed it was in progress status for Resident #32, and no information was available. Review of the baseline care plan revealed Resident #32 had baseline care plan on 12/23/25. No evidence was found in the record to indicate a baseline care plan ensured to include any documentation of interventions to ensure Resident #32 could meet goals to discharge to community, become independent in functional goals and ensure completion dates on the baseline care plan. Interview on 12/30/25 at 3:43 P.M. with the DON and RQM Nurse #3 confirmed the missing interventions and completion date documentation on the baseline care plan for Resident # 32. Review of the policy titled Resident Care Plan, last revised May 2020, revealed the baseline care plan was to be used until the comprehensive care plan was developed (on or before day 21 of admission) to help each resident maintain their highest practical level of mental, physical, and psychosocial well-being. The base line care plan was to include goals and interventions that addressed all the (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following, but not limited to, assistance needed for ADL, problems related to diagnoses and physician orders, psychosocial well-being, safety concerns, preventative care, and problems related to physical, mental, or behavioral problems. According to the policy, the resident care card only contained information related to ADL. 6. Record review revealed Resident #33 was admitted [DATE] with diagnoses of wedge compression fracture of the fourth lumbar vertebra, subsequent encounter for fracture with routine healing, frequency of micturition, dorsalgia, paroxysmal atrial fibrillation, cardiomegaly, mixed hyperlipidemia, chronic atrophic gastritis without bleeding, chronic diastolic (congestive) heart failure, GERD without esophagitis, hypothyroidism, Vitamin D deficiency, essential (primary) hypertension, age-related osteoporosis without current pathological fracture, hyperuricemia without signs of inflammatory arthritis and tophaceous disease, prediabetes, bilateral primary osteoarthritis of knee, and other nonspecific abnormal finding of lung field. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #33 had cognitive impairment. Review of functional abilities revealed Resident #33 required maximal assistance with toileting, dressing, showers, and moderate assistance with transfers. Review of the baseline care plan revealed Resident #33 had baseline care plan on 12/21/25. No evidence was found in the record to indicate a baseline care plan ensured to include documentation of any interventions to ensure Resident # 33 could meet goals to discharge to community and ensure completion dates on the baseline care plan. Interview on 12/30/25 at 3:43 P.M. with the DON and RQM Nurse #3 confirmed the missing interventions and completion date documentation on the baseline care plan for Resident # 33. Review of the policy titled Resident Care Plan, last revised May 2020, revealed the baseline care plan was to be used until the comprehensive care plan was developed (on or before day 21 of admission) to help each resident maintain their highest practical level of mental, physical, and psychosocial well-being. The base line care plan was to include goals and interventions that addressed all the following, but not limited to, assistance needed for ADL, problems related to diagnoses and physician orders, psychosocial well-being, safety concerns, preventative care, and problems related to physical, mental, or behavioral problems. According to the policy, the resident care card only contained information related to ADL. 7. Review of the medical record for Resident #36 revealed an admission date of 12/24/25 with diagnosis including non-infective gastroenteritis and colitis, acidosis, elevated white blood cell count, nausea with vomiting, diarrhea, and sepsis. Review of the Brief Interview for Mental Status (BIMS) evaluation dated 12/26/25 revealed Resident #36 had intact cognition. Review of Resident #36's care card dated 12/26/25 revealed the resident required assistance of one staff member for bed mobility, transfers, ambulating, dressing, toilet use, personal hygiene, and bathing. The resident was incontinent of bowel and bladder and required a pressure reduction mattress and wheelchair gel pad cushion. Review of Resident #36's undated baseline care plan revealed under that area of skin concerns revealed the only two interventions were to turn and reposition and cream buttock. Further review of the interventions under skin concerns revealed there was no specialty mattress or wheelchair cushion intervention listed. There was no documented evidence of when the baseline care plan was completed. Interview with RQM Nurse #3 on 12/30/25 at 5:00 P.M. confirmed there was no completion date for Resident #36's base line care plan and pressure reducing mattress and gel pad wheelchair cushion mattress interventions to help keep skin intact had not been listed on the baseline (continued on next page)		

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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, interview and facility policy review, the facility failed to develop a person-centered care plan for Resident #22. This affected one resident (#22) out of 15 residents reviewed for care plans. The facility census was 21. Findings include: Review of the medical record for Resident #22 revealed an admission date of 11/15/25 with diagnoses including abscess of the liver, cerebral infarction (stroke), atherosclerotic heart disease, cognitive communication deficit, neoplasm (tumor) of liver, non-ST elevation myocardial infarction (heart attack). Review of Resident #22's Fall Risk Assessments dated 11/15/25 revealed the resident was assessed to be a high fall risk. Review of Resident #22's care plan, initiated on 11/18/25, didn't address the resident was a high risk for falls. Review of facility document titled Investigation Report Record, dated 11/23/25, revealed while Resident #22 was sitting on the edge of the bed, the resident slid off the bed onto the floor with a new intervention to place bed in low position while the resident was in bed. Review of the discharge return anticipated Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #22 was independent for daily decision making and required partial/moderate assistance from staff for chair/bed to chair transfer, toilet transfer, sit to stand, and walking ten feet. Review of Resident #22's Fall Risk Assessments 12/15/25 revealed the resident was assessed to be a high fall risk. Review of the Investigation Report Record, dated 12/15/25, revealed on 12/15/25 Resident #22 reported to a certified nursing assistant (CNA) that she had fallen this A.M. since her legs were not working right. The resident was assessed to have no injuries; however, the physician ordered the resident to be sent to the emergency room for further evaluation. Review of the Investigation Report Record, dated 12/16/25, revealed an unidentified nurse was walking up hallway and noticed Resident #22 sitting on the floor in front of her wheelchair. The resident stated she slid out with a new intervention placing Dycem (a nonslip material) to the seat of the wheelchair. Review of Resident #22's Fall Risk Assessments 12/22/25 revealed the resident had was to be a high fall risk. Review of Resident #22's care plan, last revised on 12/30/25, didn't address the resident was a high risk for falls and/or that she had three falls since admission. Additionally, there were no interventions listed in the care plan to help prevent any future falls. Interview on 12/30/25 at 3:17 P.M. with the Director of Nursing (DON) confirmed the care plan for Resident #22 hadn't addressed the resident was at a high risk for falls and had falls since admission, and the fall prevention interventions of bed in low position while the resident was in bed or Dycem to the seat of the wheelchair hadn't been listed in the care plan and should have been. Review of the facility policy Resident Care Plans, revised May 2020, revealed the care plan serves to assist in assessing the resident and establishing a formal plan to reach or maintain the resident's highest practicable level of physical well-being. The resident care plan is the tool used to coordinate all care provided to the resident to be sure care is necessary, appropriate, and planned to meet the individual needs of the resident consistent with the physician's plan of care. The care plan must be reviewed and evaluated for effectiveness and revised (updated) as necessary, but at least every three months.		

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NAME OF PROVIDER OR SUPPLIER Center for Rehabilitation at Hampton Woods The		STREET ADDRESS, CITY, STATE, ZIP CODE 1517 East Western Reserve Road Poland, OH 44514	
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F 0689 Level of Harm - Minimal harm or potential for 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 record review, observation, interviews and facility policy review, the facility failed to ensure fall prevention interventions were in place for Resident #22, who was at high risk for falls and had a history of falls at the facility. This affected one resident (#22) out of two residents reviewed for accidents. The facility census was 21. Findings include: Review of the medical record for Resident #22 revealed an admission date of 11/15/25 with diagnoses including abscess of the liver, cerebral infarction (stroke), atherosclerotic heart disease, cognitive communication deficit, neoplasm (tumor) of liver, non-ST elevation myocardial infarction (heart attack). Review of Resident #22's Fall Risk Assessments dated 11/15/25 revealed the resident was assessed to be a high fall risk. Review of Resident #22's care plan, initiated on 11/18/25, didn't address the resident was a high risk for falls. Review of facility document titled Investigation Report Record, dated 11/23/25, revealed while Resident #22 was sitting on the edge of the bed, the resident slid off the bed onto the floor with a new intervention to place bed in low position while the resident was in bed. Review of the discharge return anticipated Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #22 was independent for daily decision making and required partial/moderate assistance from staff for chair/bed to chair transfer, toilet transfer, sit to stand, and walking ten feet. Review of Resident #22's Fall Risk Assessments 12/15/25 revealed the resident was assessed to be a high fall risk. Review of the Investigation Report Record, dated 12/15/25, revealed on 12/15/25 Resident #22 reported to a certified nursing assistant (CNA) that she had fallen this A.M. since her legs were not working right. The resident was assessed to have no injuries; however, the physician ordered the resident to be sent to the emergency room for further evaluation. Review of the Investigation Report Record, dated 12/16/25, revealed an unidentified nurse was walking up hallway and noticed Resident #22 sitting on the floor in front of her wheelchair. The resident stated she slid out with a new intervention placing Dycem (a nonslip material) to the seat of the wheelchair. Review of Resident #22's Fall Risk Assessments 12/22/25 revealed the resident had was to be a high fall risk. Review of Resident #22's care plan, last revised on 12/30/25, didn't address the resident was a high risk for falls and/or that she had three falls since admission. Additionally, there were no interventions listed in the care plan to help prevent any future falls. Interview on 12/30/25 at 7:31 A.M. with Resident #22 revealed she thought she had fallen twice since being a resident at the facility. She indicated for one of her falls she reached too far for something and fell out of her wheelchair. She stated sometimes the facility staff would place Dycem on the seat of her wheelchair to help prevent her from falling out of the wheelchair, but there were other times when the Dycem was not placed on the seat of her wheelchair. She was unaware of any other interventions which had been put into place to help prevent any future falls. Observation at the time of the interview revealed Resident #22 was in bed, and the bed was not in the lowest position and the blue Dycem was lying on the armrest of a chair in the resident's room. Resident #22's wheelchair was in the bathroom, and there was no Dycem on the seat of the wheelchair. Observation on 12/30/25 at 11:29 A.M. revealed Resident #22 was sitting in a wheelchair. There was no Dycem on the wheelchair, and the Dycem remained on the armrest of a chair in the resident's room. Interview on 12/30/25 at 12:30 P.M. with CNA #145 revealed if a resident had fall interventions, they would be listed on a sheet of paper in a blue folder at the nurse's station or on the resident's care card located in the care card binder in the wall cabinet located at the nurse's station. CNA #145 confirmed the only two places she would look for fall interventions would be the blue folder or the resident's care card. CNA #145 indicated Resident #22 had no fall interventions and confirmed Resident #22's bed was at normal height when she was in bed, and there was no Dycem on her wheelchair. Observation of the blue folder and the care card binder at the time of the interview with CNA #145 revealed there were no interventions documented in the folder for Resident #22, and there (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were no fall interventions listed on the 12/23/25 care card for Resident #22, which was confirmed by CNA #145 at the time of observation. Interview on 12/30/25 at 1:31 P.M. with Licensed Practical Nurse (LPN) #41 revealed she would go into a resident's chart to look for any orders for fall interventions to determine if a resident needed any fall interventions. She indicated Resident #22 was a stroke victim and she believed she would have fall interventions in place, but she would need to look at the chart to determine what fall interventions had been put into place for Resident #22. An additional interview on 12/30/25 at 2:58 P.M. with LPN #41 revealed she had just got done looking through Resident #22's chart and the only fall intervention which she saw had been put into place for Resident #22 was Dycem to the wheelchair. Interview on 12/30/25 at 3:17 P.M. with the Director of Nursing (DON) revealed she would initially fill out an intervention sheet when new fall interventions had been initiated for a resident and would place the sheet in the blue folder at the nurse's station until the resident's care card could be updated. She indicated staff were to look at both the blue folder and the resident's care card for fall interventions for residents. The DON confirmed currently there was no intervention paper for Resident #22 in the blue folder, and Resident #22's care card dated 12/23/25 did not indicate the resident's bed should be in low position while in bed and Dycem should be placed on the seat of the resident's wheelchair. She also confirmed Resident #22's bed should have been in low position while the resident was in bed and Dycem should have been applied to the seat of the resident's wheelchair. Review of the facility policy titled Falls, revised June 2025, revealed the supervisor will evaluate the interventions that should be in place to prevent any further occurrence. The interdisciplinary team will review all falls for appropriate intervention/implementation to prevent further events and/or injuries.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review, observation, interview and facility policy review, the facility failed to provide nutritional supplements as ordered by the physician to Resident #22. This affected one resident (#22) out of three residents reviewed for nutrition. The facility census was 21. Findings include: Review of the medical record for Resident #22 revealed an admission date of 11/15/25 with diagnoses including abscess of liver, type two diabetes mellitus with hyperglycemia (unusually high amount of glucose present in blood), cerebral infarction (stroke), atherosclerotic heart disease, cognitive communication deficit, neoplasm (tumor) of liver, and non-ST elevation myocardial infarction (heart attack). Review of 12/08/25 discharge return anticipated Minimum Data Set (MDS) 3.0 assessment revealed Resident #22 was independent for daily decision making, was independent for eating, and had a nonprescribed weight loss and was on a therapeutic diet. Review of Resident #22's 12/29/25 Minimum Data Set (MDS) Medicare five-day assessment and 12/18/25 MDS Medicare five day/End of PPS part A stay assessment revealed both assessments were still in progress. Review of meal intakes from 12/01/25 to 12/30/25 revealed Resident #22 consumed 26-75% of most meals. Further review of Resident #22's medical record revealed the resident had experienced a 24.6 pound (17.3%) weight loss from 11/30/25 when the resident weighed 141.6 pounds to 12/30/25 when the resident weighed 117.0 pounds. Continued review of Resident #22's medical record revealed a progress note dated 12/28/25 and authored by Dietitian #141 which confirmed the resident had a significant weight loss of 17.1% weight loss for one month with a recommendation to increase Glucerna (nutritional supplement) from two times a day to three times a day with meals. Another progress note dated 12/29/25 and authored by Dietitian #141 revealed the dietitian was recommending Magic Cups (nutritional supplement) with lunch and dinner. Review of physician orders for Resident #22 revealed an order dated 12/28/25 for Glucerna with all meals and an order dated 12/29/25 for Magic Cups two times a day. Observation on 12/30/25 at 8:29 A.M. revealed a container of Ensure Plus (nutritional supplement) sitting on the overbed table of Resident #22. At the time of observation, Certified Nursing Assistant (CNA) #145 revealed she had placed the supplement on the overbed table and confirmed the supplement was Ensure Plus. Observation on 12/30/25 at 8:50 A.M. revealed Resident #22 had drunk all her Ensure Plus supplement, which the resident confirmed at the time of the observation. Observation on 12/30/25 at 5:30 P.M. revealed the resident had been served a meal tray consisting of potato soup, crackers, applesauce, and a Glucerna supplement. There was no Magic Cup on the meal tray. Interview with CNA #145 confirmed there was no Magic Cup on the meal tray and stated the kitchen staff were responsible for adding the Magic Cup to the meal trays. Review of the meal ticket for Resident #22 with CNA #145 at the time of observation on 12/30/25 at 5:30 P.M. revealed the resident was to receive a Glucerna supplement with all meals but there was no indication on the meal ticket the resident was to receive Magic Cups at lunch and dinner, which CNA #145 confirmed at the time of the observation. Interview on 12/31/25 at 8:44 A.M. with Dietitian #141 confirmed Resident #22 had lost a significant amount of weight since admission. She stated since the resident was drinking her Glucerna well she had increased the supplement to all meals, and, since the resident and her family had indicated she had liked the special ice cream she had received in the past, she recommended to add Magic Cups to lunch and dinner. Dietitian #141 confirmed Resident #22 should have been receiving supplements as ordered. Review of undated facility policy titled Nutritional Supplements revealed residents are to receive supplements as ordered.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and review of facility policy, the facility failed to ensure proper storage of clean Hoyer lift pads (slings designed to cradle a person who is being transferred with a mechanical lift device). This had the potential to affect all residents in facility. The facility census was 21. Findings include: Observation of the dirty laundry room (the enclosed room where the soiled linen is stored, sorted, and washed) on 12/30/25 at 10:33 A.M. revealed clean Hoyer lift pads were stored on hook beside commercial washer on the dirty laundry side of the laundry room. Interview with Laundry Supervisor #135 on 12/30/25 at 10:33 A.M. confirmed the Hoyer pads hanging on the hook beside the commercial washing machines were clean. During the interview, Laundry Supervisor #135 stated that the proper storage site is in the clean laundry room (the adjacent room where clean laundry is brought to be dried, folded or hung to dry, then packed on linen carts to bring to the clean linen closets on the units) and that staff had been told several times that they were not to hang the clean Hoyer lift pads in the dirty laundry room. Interview with Housekeeper #33 on 12/30/25 at 3:10 P.M. revealed she put the Hoyer lift slings that were hanging beside the commercial washer in the dirty linen room onto the clean linen closet. Review of the undated laundry policy, Procedure D, titled Drying of washed linens and personal revealed that clean items were to be taken to the dryer room (clean laundry area) and dried items were to be taken to the folding room.		