STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366455	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mentor Ridge Health and Rehabilitation	8151 Norton Parkway Mentor, OH 44060

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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 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. Based on record review, interview, and facility policy review, the facility failed to notify the physician of a significant weight gain for a resident with a diagnosis of fluid overload. This affected one resident (#22) of three residents reviewed for nutrition. The facility census was 98.Findings include:Review of the medical record for Resident #22 revealed an admission date of 01/05/26 with a primary diagnosis of fluid overload and other diagnoses including unspecified fracture of the right tibia shaft, effusion of the right knee, type two diabetes, morbid (severe) obesity, hypertension (high blood pressure), and hyperlipidemia (high levels of fat in the blood).Review of Resident #22's Medication Administration Record (MAR) for January 2026 revealed an order dated 01/06/26 for a low concentrated sweet and no added salt diet, and a fluid restriction of 1500 milliliters (ml) per day, 480 ml for day shift, 300 ml for night shift, and 720 ml for dietary. Review of the MAR for January 2026 and February 2026 revealed an order dated 01/06/26 for furosemide (a diuretic) 80 milligrams (mg) twice daily for edema. On 02/13/26, the order was changed to furosemide 80 mg twice daily for fluid overload.Review of the dietary assessment progress note dated 01/12/26 at 3:29 P.M. revealed the weight for Resident #22 of 268 pounds (lbs.) at admission was a significant weight gain of 26 lbs. (10.7%).Review of Resident #22's care plan dated 01/14/26 revealed potential for alteration in nutrition and hydration related to risk for malnutrition, obesity, significant weight gain upon admission, and fluid restriction. The resident's goal was for the resident to maintain weight in range of plus or minus five percent and an intervention for weights per protocol.Review of Resident #22's recorded weights revealed an admission weight on 01/05/26 of 268.4 lbs. (gain of 26 lbs., 10.7% upon admission), on 01/13/26 of 278 lbs. (gain of 9.6 lbs., 3.6% since admission), on 01/20/26 of 278 lbs., on 01/26/26 of 289 lbs. (gain of 11 lbs., 7.7% since admission), on 02/02/26 of 286 lbs., and on 02/17/26 of 285 lbs. Interview on 02/18/26 at 10:51 A.M. with the Director of Nursing (DON) revealed residents were weighed weekly for all skilled stays throughout their stay, and monthly for long-term care residents. Weights were recorded on a sheet and given to the dietitian. Interview on 02/18/26 at 11:05 A.M. with Registered Dietician (RD) #701 revealed when a resident was admitted , the resident was weighed weekly for the first four weeks. If the weight was stable, then the resident was weighed monthly. Further, there was one caregiver that did the weights every week on the weekend. The caregiver gave the dietician a paper copy of the weights in her mailbox and then the dietician reviewed and entered the weights in the medical record followed by notifying the physician as appropriate. RD #701 verified Resident #22 had significant weight gain on 01/20/26 of 10.7% upon admission and again on 01/26/26 of 7.7% after admission. The RD confirmed there was no evidence that the physician or nurse practitioner was notified of Resident #22's significant weight gain.Review of the dietitian progress note dated 02/18/26 at 11:36 A.M. revealed Resident #22 had a significant weight gain of 20.6 lbs. and a 7.7% increase within the facility with a comparison weight on 01/05/26 of 268.4 lbs.Review of the progress note by Certified Nurse Practitioner (CNP) #523 dated 02/18/26 at 1:34 P.M. revealed Resident #22's weights were reviewed and stable over the last month.Interview on 02/18/26 at 5:13 P.M. with Resident #22 revealed he was on a fluid restriction diet and only drank the fluids provided to him by the facility. Interview on 02/19/26 at 10:35 A.M. with CNP #523 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding Resident #22's significant weight gains in January 2026 revealed that she spoke with the dietician during morning meetings about every resident, reviewed notes, and saw weights that popped up. CNP #523 stated she possibly could have been notified, but if it was not in the notes, then the weight gain was not addressed. CNP #523 added that Resident #22 was seen weekly by the primary physician or CNP and monitored for signs of fluid overload. The resident's breathing was fine and his labs were stable.Review of facility policy labeled, Weight Monitoring, dated 02/14/24, revealed a weight monitoring schedule was developed upon admission for all residents. Newly admitted residents' weights were monitored as close to weekly as possible for the initial four weeks and at least monthly thereafter. A significant weight change was defined as a 5% change in one month, 7.5% change in three months, and 10% change in six months. Significant changes in weight were reported to the practitioner.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, staff interviews, review of the Self-Reported Incident (SRI) and facility policy review, the facility failed to timely and adequately respond after identification of an incident with injury including assessing on the day of the incident, timely notification of the physician, notification to hospice, completing a skin assessment and logging the incident on the facility's incident log. This affected one resident (#86) of one resident reviewed for incidents. The facility census was 98.Findings include:Review of the medical record for Resident #86 revealed she was admitted to the facility on [DATE] with diagnoses that included senile degeneration of brain, dementia, and chronic obstructive pulmonary disease (COPD).Review of Resident #86's physician orders dated 06/24/25 revealed an order for transfers via a mechanical lift with two people every shift.Review of Resident #86's physician orders dated 10/21/25 revealed an order for the resident to be admitted to hospice care.Review of the list of hospice residents provided by the facility revealed Resident #86 was admitted to hospice care with diagnosis of senile degeneration of brain on 10/21/26.Review of the care plan dated 01/14/26 revealed Resident #86 had an alteration in skin integrity with interventions that included, but not limited to, skin assessments, report changes to hospice and physician, and assistance of two staff members for activities of daily living (ADL).Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #86 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #86 was dependent on staff for ADL.Review of Resident #86's physician orders dated 02/08/26 revealed an order for head-to-toe skin check every day shift, every Tuesday and Saturday.Review of the progress note dated 02/15/26 at 10:13 A.M. revealed Licensed Practical Nurse (LPN) #302 noted a small superficial red denuded area to the bridge of the nose with surrounding erythema. Review of the progress note revealed LPN #302 was informed by Registered Nurse (RN) #305 that Resident #86 was observed frequently touching and/or scratching nasal area and noted to hold head and face in her hands throughout the day.Review of the progress note dated 02/15/26 at 11:22 A.M. revealed Resident #86 stated they threw me to the ground and beat me. They broke both of my legs. I heard two snaps. Resident #86 was unable to provide the names or description of staff in question.Review of the progress note dated 02/15/26 at 1:04 P.M. revealed Resident #86 received a new order to apply Bacitracin (antibiotic) ointment to the nose twice a day for seven days.Review of the progress note dated 02/15/26 at 1:30 P.M. revealed Resident #86 stated they threw me to the floor, and they threw me to the bed. Resident #86 was unable to state who they were.Review of SRI #270954 dated 02/15/26 revealed the facility initiated an alleged incident of physical abuse regarding Resident #86. Review of the SRI revealed it was an ongoing investigation. However, review of the facility investigation regarding Resident #86 alleged report of abuse revealed the facility did not initiate abuse protocols until 02/17/26, approximately two days after the initial report of abuse on 02/15/26 and no mention of Resident #86's identified area of the nose.Review of Resident #86's physician orders dated 02/17/26 revealed an order to monitor bruise to left shin area, monitor bruise to area above nose, and apply Skin Prep (forms a protective barrier) to abrasion on nose.Review of the progress note dated 02/17/26 at 2:01 P.M. revealed Certified Nurse Practitioner (CNP) #523 was made aware of the abrasion noted to Resident #86 nose from over the weekend and scattered bruises to the left shin.Review of the assessments dated for the month of February 2026, revealed no documented evidence skin assessments were completed.Observation and interview on 02/17/26 at 10:29 A.M. revealed Resident #86 sitting up in bed with a bright red colored bruise located from the top of her nose to the bottom of the bridge of her nose. Resident #86 stated four days ago an aide slammed my face down onto something.Review of the facility incident log dated 02/16/25 to 02/17/26 revealed no documented incidents regarding Resident #86's nose injury, bruise, and/or abrasion.Interview on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/18/26 at 9:20 A.M. with Hospice Registered Nurse (HRN) #423 revealed she visited Resident #86 twice a week. RN #423 revealed Resident #86 required assistance with all ADL, was very weak, couldn't ambulate, required a mechanical lift of two staff members for all transfers, and required assistance with bed mobility. HRN #423 revealed she was not aware of Resident #86 bruise to her nose, and facility staff did not inform her. HRN #423 revealed this was her first time seeing Resident #86 face, and she would need to be updated by staff.Interview on 02/18/25 at 9:25 A.M. with Certified Nurse Assistant (CNA) #612 revealed she was aware of Resident #86 bruise to the nose and stated, I plead the fifth when asked what happened. CNA #612 revealed Resident #86 required assistance of two people for all care and could have hit her face on something. CNA #612 revealed she had not observed Resident #86 picking or scratching her face.Interview on 02/18/26 at 9:35 A.M. with RN #706 revealed she was informed Resident #86 hit her face on the mechanical lift during a transfer. RN #706 revealed she could not provide any further information.Interview on 02/18/26 at 10:42 A.M. with the Director of Nursing (DON) revealed she was not present at the time of the incident but was informed by LPN #302 that Resident #86 was rubbing and scratching her face over the weekend, Sunday 02/15/26. The DON revealed LPN #302 was on-call and received a call regarding Resident #86 bruise on the nose. The DON revealed she could not provide further details of the incident.Interview on 02/18/26 at 1:06 P.M. with RN #305 revealed CNA #716 was providing care to Resident #86 and exited the room and informed her there was a bruise on Resident #86 nose. RN #305 revealed she asked Resident #86 what happened, and Resident #86 stated Someone hit me. It was two people. RN #305 revealed Resident #86 required assistance from two people and probably was handled wrongly in bed or maybe got hit with the Hoyer lift. RN #305 revealed she did not observe Resident #86 scratching or picking at her nose or face prior to observing the bruise. RN #305 revealed Resident #86 did not have a bruise on the nose prior to 02/15/26. RN #305 revealed Resident #86 bruise to the nose and reports of physical abuse were new and she did not know exactly what happened, therefore she reported it to the Administrator.Interview on 02/19/26 at 10:45 A.M. with LPN #302 revealed she only worked Monday through Fridays, no weekends, and she was assigned to rooms 123 through 147. LPN #302 revealed she did not work the unit Resident #86 resided on. LPN #302 noted that Resident #86 resided in room [ROOM NUMBER] and was covered by another staff nurse.Follow-up interview on 02/19/26 at 11:23 A.M. with LPN #302 regarding a progress note dated 02/15/26 at 10:13 A.M. that was documented by her, on a day she stated she did not work, revealed she annotated the note but did not observe Resident #86 as stated in the progress note. LPN #302 recanted her initial interview and stated she worked on 02/15/26, a weekend, from 11:00 A.M. to approximately 1:30 P.M. However, changed the time she entered the facility to an earlier time frame after informed that her progress note was entered at 10:13 A.M. on 02/15/26, approximately 45 minutes prior to her arrival. LPN #302 revealed she received a call from RN #305 but did not come into the facility for that reason and did not complete any documentation although she was the manager on call. LPN #302 revealed she could not confirm her time of arrival and exit or verify the state of Resident #86 condition.Interview on 02/19/26 at 1:57 P.M. with CNA #716 revealed on 02/15/26 she entered Resident #86 room and noticed she had a red bruise on her nose and Resident #86 stated someone hit her in the face but did not identify the person. CNA #716 revealed she reported it to RN #305. CNA #716 revealed she did not see Resident #86 scratching or picking at her face and it was not present the day before. CNA #716 revealed Resident #86 was dependent on two staff for all care and required a mechanical lift for transfers.Interview on 02/19/26 at 2:00 P.M. with Human Resources (HR) #400 revealed there were no current staff suspended pending investigation related to allegations of abuse and no staff had received any disciplinary actions other than for attendance concerns.Interview on 02/19/26 at 3:07 P.M. with the administrative staff, including the Administrator, DON, Regional Administrator (RA) #323, and Regional Clinical Representative (RCR) #333 verified and confirmed the facility initiated an SRI for physical abuse for Resident #86's alleged abuse. Administrative staff revealed Resident #86 bruise to the nose was not present prior to the alleged abuse and was discovered at the time Resident (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#86 informed staff. However, the administrative staff revealed the alleged abuse and bruise to the nose were separate incidents but acknowledged that the first report of the bruise was documented at the same time as the alleged abuse on 02/15/26. The administrative staff was unable to confirm what happened to Resident #86 nose and assumed that it was caused by Resident #86 scratching her nose despite her alleged report of abuse and no staff member observing her scratching at her nose.Review of Resident #86 medical record revealed no documented incidents of Resident #86 scratching her nose, no prior skin assessments identifying any previous areas of concerns, and no notifications to hospice regarding alleged reports of abuse or new bruising to the skin and/or nose.Review of the facility document titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property dated 11/21/16, revealed the facility had a policy in place to investigate all alleged violations, perform an initial assessment, report to the physician, and document in the resident's medical record. If a staff member is accused of abuse of a resident, the facility should remove that staff member from the facility pending the outcome of the investigation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. Based on record review, observation, interview, review of the facility policy and Centers for Disease Control and Prevention (CDC) informational sheet, the facility failed to ensure appropriate testing was completed to rule out multi-drug resistant organisms (MDROs) and use appropriate enhanced barrier precautions (EBP) for MDROs. This affected one Resident (#11) of four residents reviewed for urinary tract infections (UTIs). The facility census was 98.Findings include:Review of the medical record for Resident #11 revealed an admission date of 08/15/23 with diagnoses including dementia with behavioral disturbance, chronic obstructive pulmonary disease, diabetes mellitus, and anemia. Resident #11 was on hospice services.Review of the progress note dated 10/22/25 revealed Resident #11 was making unusual comments to the nurse practitioner (NP). The NP ordered a urinalysis with culture if indicated.Review of the physician order dated 10/25/25 revealed order to collect an urinalysis with culture if indicated. The sample may be collected via straight catheter.Review of progress note dated 10/30/25 revealed a partial urinalysis with culture and sensitivity results showed Resident #11 was positive for Escherichia Coli (E-coli) Extended-Spectrum Beta-Lactamases (ESBL) producing organism. The NP was notified and ordered Macrobid (antibiotic) 100 milligrams (mg) by mouth twice per day for 10 days. Resident #11's daughter was notified of the UTI. Resident #11 was placed on contact precautions.Review of the physician orders dated 10/30/25 revealed Resident #11 was ordered Macrobid 100 mg by mouth two times per day for E-coli ESBL producing organism UTI. Resident #11 was placed on contact precautions for E-coli ESBL producing organism UTI. The orders were completed as of 11/08/25.Review of a lab result dated 10/31/25 revealed a specimen for urinalysis with culture if indicated was collected on 10/27/25. Urinalysis results indicated turbid clarity, positive for leukocytes, and white blood cells greater than 50. A culture was indicated. Culture revealed greater than 100,000 colony-forming units per milliliter (CFU/ml) of E Coli. It was noted there was possible ESBL producing organism and it was recommended caution and monitoring of the resident during and after therapy.Observations on 02/17/26, 02/18/26, and 02/19/26 revealed Resident #11 was not on EBP or any other transmission-based precautions (TBP).Interview on 02/18/26 at 3:09 P.M. with Registered Nurse (RN) #706 confirmed Resident #11 was not on EBP.Interview on 02/19/26 9:12 A.M. with Assistant Director of Nursing (ADON) #804 revealed she was the facility's infection preventionist (IP). ADON IP #804 indicated Resident #11 was treated for UTI with an antibiotic (ATB) and was put on contact precautions for the duration of the ATB. ADON IP #804 indicated there was no additional testing to rule out the possibility of ESBL producing organism. ADON IP #804 indicated it was not the facility's policy to rule out possibility of MDROs.Review of the facility policy Multi-Drug Resistant Organisms dated 05/05/17 revealed precautions would be taken to prevent transmission of MDROs including ESBL. The facility policy had not been updated to include EBP.Review of the facility policy Standard and Transmission-based Precautions dated 03/24/24 revealed it was the policy of the facility to take appropriate precautions including isolation to prevent transmission of infectious agents. Enhanced barrier precautions were defined as an infection control intervention to reduce transmission of MDROs.Review of the CDC informational sheet titled ESBL-Producing Enterobacterales dated 06/12/25 revealed ESBLs were resistant to common antibiotics and may require complex treatments. These bacteria can live within a patient without causing infection symptoms known as colonization. Healthcare providers should send a specimen for antimicrobial susceptibility testing to verify presence of ESBL.