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Form Approved OMB
No. 0938-0391

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	10/23/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, resident and staff interviews, and record review, the facility failed to ensure sufficient linens were available for resident care and ensure residents have a clean and sanitary homelike environment. This affected one (Resident #25) of the residents reviewed for hygiene and linens. The facility census was 69.Findings include: Review of the medical record for Resident #25 revealed an admission date 05/18/24. Diagnoses included morbid obesity, major depression, anxiety, and lymphedema. Interview with Resident #25 on 10/20/25 at 9:55 A.M. revealed she has been waiting to be cleaned up after having a bowel movement earlier in the morning. Resident #25 stated she put her call light on around 8 A.M. and when Certified Nursing Assistant (CNA) #819 came in, she told Resident #25 she would be right back in a few. She turned off the call light. At 10:11 A.M. CNA #819 came into Resident #25's room and again Resident #25 told her she needed changed. CNA #819 stated she came on at 7:00 A.M. and had not checked and changed Resident #25, yet. CNA #819 stated she did not have clean washcloths and towels to change her until 10:00 A.M. CNA #819 stated she could change her when she was finished with another resident's shower. Observations on 10/20/25 revealed at 10:55 A.M., Resident #25 had not been changed yet. At 10:58 A.M., CNA #819 walked by the nursing station and told the nurse there were only two more sets of linens in the closet. The nurse stated she knew about the linen situation. At 11:03 A.M., CNA #819brought clean linens into Resident #25's room and stated she was gathering her supplies. Observation on 10/20/25 at 11:12 A.M. of incontinence care for Resident #25 with CNA #819 and CNA #820 revealed Resident #25's sheets were dirty with feces Resident #25 does not wear a depends due to irritation her skin. CNA #820 had only two washcloths and had to use bathing towels to clean her up. Resident #25 had an extra-large bowel movement (BM) down her thighs and in her skin creases. CNA #819 ran out of supplies and had to go back out of the room to get more. CNA #819 stated all she could find was towels and no washcloths. Interview on 10/20/25 at 12:15 P.M. with CNA #819 and #820 revealed they run out of linens and towels all the time and have to wait to get residents cleaned up until laundry brings clean linens to their floor. CNA #819 and #820 stated they have to go to another unit or go to laundry for find clean linens, if there were some. They have to wait until laundry washes them. Observation on 10/20/25 at 12:18 P.M. of 300-Hall clean linen closet with Licensed Practical Nurse (LPN) #818 revealed no towels or washcloths were in the clean linen closet. Interview on 10/20/25 at 12:40 P.M. with Housekeeping/Laundry Supervisor (HLS) #821 verified the lack of linen supplies for staff to utilize. HLS #821 stated she does not know if staff were throwing them away or what. HLS #821 will have to do a search for the facility to see where staff were hiding all of the clean linens. Staff will put linens in empty rooms, in residents' drawers and anywhere they think someone will not find them, so they don't have to go get any when they were running low. Interview with the Administrator on 10/20/25 at 1:00 P.M. revealed management did a search, of the facility to find all the clean linens and found dozens of towels and washcloths in resident rooms, empty rooms and different hiding spots. This deficiency represents non-compliance investigated under Complaint Number 2593016.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of video camera footage, interviews with staff and a police detective, and record review, the facility failed to implement the comprehensive, person-centered care plan for Resident #2. This affected one (#2) of three residents reviewed for care plans. The facility census was 69. Findings include: Review of the medical record for Resident #2 revealed an admission date 01/24/25. Diagnoses included Parkinson's disease, wedge compression fracture of third lumbar vertebra, chronic respiratory failure, severe osteoporosis, dementia, tracheostomy, and above the knee amputee. Review of the care plan revealed Resident #2 had a self-care performance deficit related to disease process Parkinson's disease, impaired balance, limited mobility and impaired range of motion due to bilateral hand/wrist contractures. Interventions included Resident #2 required two staff assistance for repositioning, dressing, personal hygiene/oral care and toileting. A video provided on 10/22/25 at 12:34 P.M. by Detective #850 revealed on 09/15/25 at 11:30 A.M., two staff members came into Resident #2's room to provide incontinence care. One staff member walked away and the other staff member repositioned resident one assist. On 09/21/25 at 10:53 A.M. one staff member repositioned Resident #2. At 4:08 P.M. one staff member started preforming incontinence care. Interview on 10/22/25 at 10:20 A.M. with Registered Nurse (RN) #803 revealed Resident #2 was a two-persons assist for incontinence care and repositioning. Interview on 10/22/25 at 11:30 A.M. with Certified Nursing Assistant (CNA) #819 and #820 verified Resident #2 was two-persons assistance for incontinence care and repositioning. Interview on 10/22/25 at 12:13 P.M. with Detective #850 stated she received a complaint from Resident #2's daughter and was provided with videos of Resident #2 being repositioned and incontinence care with one assist and Resident #2 was a two-persons assistance for incontinence care and repositioning. Detective #850 verified he spoke with the Administrator on 10/16/25 of the allegations. Detective #850 stated she would email her report and documents that were given to her. She stated Resident #2's daughter would not give consent to review Resident #2's medical records. Interview on 10/22/25 at 2:21 P.M. with the Administrator and Director of Nursing (DON) verified Resident #2 was a two-persons assist for all transfers, repositioning and incontinence care. The Administrator verified she was contacted by Detective #850 and was told she was looking into a complaint. At this time, the Administrator and DON were notified that the surveyor had received videos that showed Resident #2 was being repositioned and being provided with incontinence care of one staff assist. At that time, the DON verified Resident #2 was a two-persons assistant with incontinent care and repositioning. This deficiency represents non-compliance investigated under Complaint Number 2649075.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and record review, the facility failed to provide timely assistance to residents who were dependent on staff for activities daily living with incontinence care. This affected one (Resident #25) of three residents reviewed for incontinence care. The facility census was 69. Findings include: Review of the medical record for Resident #25 revealed an admission date 05/18/24. Diagnoses included morbid obesity, major depression, anxiety, chronic pain, lymphedema, urinary retention, and chronic kidney disease stage III. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was cognitively intact and was dependent on staff for toileting hygiene, was always incontinent of bowel, and had a indwelling catheter. Review of Resident #25's care plan revealed she had deficit in self-care performance related to morbid obesity and pulmonary disease. Interventions included Resident #25 was totally dependent on two staff for toilet use and bed mobility. Resident #25's care plan revealed she had impaired skin integrity to right lateral thigh due to bedfast and impaired mobility. Interventions included to check and change approximately every two-to-three hours and as needed related to incontinence, assist with hygiene and general skin care, and keep skin clean and dry. Interview with Resident #25 on 10/20/25 at 9:55 A.M. revealed she has been waiting to be cleaned up after having a bowel movement earlier in the morning. Resident #25 stated she has not been checked and changed since night shift left. Resident #25 stated she put her call light on around 8:00 A.M. and when Certified Nursing Assistant (CNA) #819 came into her room, CNA #819 told Resident #25 she would be right back in a few. CNA #819 turned off the call light. Resident #25's linens were visibly soiled with an extra-large bowel movement. Observation on 10/20/25 at 11:12 A.M. revealed CNAs #819 and #820 were going to provide Resident #25 with incontinence care for the first time on their shift. Resident #25 did not wear a depends due to irritates her skin. Resident #25 required a full bed linen change and complete perineal cleansing due to the extent of the soiling. Resident #25 had an extra-large bowel movement (BM) down her thighs, in her skin creases and all around her catheter. Interview on 10/20/25 at 12:15 P.M. with CNA #819 verified she had not changed Resident #25 since starting her shift at 7:00 A.M. and she knew earlier that Resident #25 had had a BM and needed changed. CNA #819 explained she had to assist other residents before she provided incontinence care to Resident #25. This deficiency represents non-compliance investigated under Master Complaint Number 2649075 and Complaint Number 2642045.