

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Hillside Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 18220 Euclid Ave Cleveland, OH 44112	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on observation, interview, record review and review of the facility policy, the facility did not notify the physician and/or designee regarding Resident #13's change in condition. This affected one resident (#13) out of six residents reviewed for change in condition. The facility census was 40.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), hypertension, congestive heart failure (CHF), and oxygen dependence.</p> <p>Review of the blood pressures dated from 10/24/24 to 11/07/24 revealed Resident #13's blood pressures included: 10/25/24 it was 130/76, 10/26/24 it was 138/78, 10/27/24 it was 134/76, 10/29/24 it was 106/54, 11/05/24 it was 110/76, and 11/06/24 it was 134/58. There was no documented evidence since admission, 10/24/24, that Resident #13's systolic blood pressure had been below 100.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had impaired cognition.</p> <p>Review of the November 2024 physician orders revealed Resident #13 was to receive the following medications in the morning including: amiodarone hydrochloride (HCL) 200 milligram (mg) tablet by mouth for hypertension, Lasix 20 mg tablet by mouth as a diuretic, Lasix 40 mg tablet by mouth, hydralazine HCL 100 mg tablet by mouth for hypertension, and metoprolol succinate extended release (ER) 50 mg tablet by mouth due to hypertension. There were no parameters listed for any of the above medications to be held.</p> <p>Observation on 11/07/24 at 9:07 A.M. revealed Licensed Practical Nurse (LPN) #604 obtained Resident #13's blood pressure, and it was 72/55. She repositioned Resident #13 and re-took the blood pressure which was 96/56, and his heart rate was 56. She then proceeded to prepare Resident #13's morning medications which included: amiodarone HCL 200 mg tablet, Lasix 20 mg tablet, Lasix 40 mg tablet, hydralazine HCL 100 mg tablet, and metoprolol succinate ER 50 mg tablet.</p> <p>(continued on next page)</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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/07/24 at 10:07 A.M. with LPN #604 as she walked into Resident #13's room to administer his medications regarding the amount of blood pressure medications and his current blood pressure; LPN #604 stated she would only hold if his systolic blood pressure was below 90. She revealed his blood pressure was within his normal range, proceeded into his room and administered his medications.</p> <p>Interview on 11/07/24 at 11:44 A.M. with Nurse Practitioner (NP) #661 revealed she had been coming to the facility for approximately three years and was at the facility twice a week. She revealed she was familiar with Resident #13. This surveyor reviewed the above blood pressures and medication regimen with NP #661, and she stated Resident #13's blood pressure was quite low. She would have expected LPN #604 to have contacted the physician and/or herself regarding the low blood pressure, especially with the number and the dosage of medications that he takes that not only can affect his blood pressure but his heart rate as well. She revealed she would have ordered some lab work and orthostatic blood pressures to make sure Resident #13 was not dehydrated. She also revealed she would have ordered to hold his metoprolol succinate ER 50 mg tablet and his hydralazine HCL 100 mg tablet. She would have also requested the nurse complete a full assessment including checking if the resident had complaints of dizziness.</p> <p>Interview on 11/07/24 at 12:57 P.M. with the Director of Nursing (DON) after review of Resident #13's morning blood pressures, history of blood pressures, and medication regimen, she verified LPN #604 should have contacted the physician and/or nurse practitioner prior to administering Resident #13's morning medications, especially due to the number of cardiac medications he was ordered.</p> <p>Review of the facility policy labeled, Change in a Resident's Condition, dated 11/30/23, revealed the facility shall notify the physician of a change in a resident's medical/mental condition. There were no other details in the policy regarding when to notify the physician and/ or what constitutes a change in condition.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00159487.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on record review, interview, review of the facility self-reported incident (SRI) tracking number (#)253244 and facility investigation, review of staffing schedules and punch detailed report and review of the facility abuse policy, the facility failed to enforce their abuse policy including reporting an allegation of abuse promptly, immediately investigating the allegation of staff-to-resident abuse and ensuring the alleged perpetrator did not continue providing direct care to all residents after the alleged allegation was made on 10/04/24. This affected one resident (#28) and placed a potential risk of abuse for all 40 residents residing in the facility.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes, and spinal stenosis. There was no documentation in the nursing notes from 10/04/24 to 10/23/24 regarding any allegation of staff-to-resident abuse.</p> <p>Review of the care plan dated 08/30/24 revealed Resident #28 had a self-care performance deficit related to fatigue, COPD, and weakness. Interventions included extensive assistance with toileting needs, monitoring for fatigue, and providing rest periods as needed.</p> <p>Review of the Time Entry Report from 10/03/24 to 10/23/24 revealed Certified Nursing Assistant (CNA) #602 worked on 10/03/24 from 11:00 P.M. to 6:57 A.M., 10/05/24 from 6:59 P.M. to 6:58 A.M., 10/06/24 from 7:00 P.M. to 6:55 A.M., 10/08/24 from 11:00 P.M. to 6:56 A.M., 10/11/24 from 11:00 P.M. to 7:00 A.M., 10/14/24 from 11:02 P.M. to 7:05 A.M., 10/15/24 from 10:58 A.M. to 6:56 A.M., 10/17/24 from 10:53 A.M. to 7:00 A.M., 10/18/24 6:57 A.M. to 7:00 A.M., 10/19/24 from 11:00 A.M. to 6:55 A.M., 10/20/24 from 10:54 A.M. to 6:58 A.M., and 10/22/24 from 10:57 A.M. to 6:58 A.M. He was removed from the schedule from 10/23/24 to 10/28/24 (after which he returned to work).</p> <p>Review of the facility staffing schedule dated 10/03/24 revealed the following staff worked from 11:00 P.M. to 7:00 A.M.: Registered Nurse (RN) #608, RN #617, CNA #602, CNA #644, and Former CNA #662.</p> <p>Review of the additional staffing schedules from 10/04/24 to 10/23/24 revealed CNA #602 worked on the east unit (men's unit) on 10/05/24, 10/06/24, 10/09/24, 10/11/24, and 10/14/24. He worked on the west unit (women's unit) on 10/08/24, 10/15/24, and 10/22/24. The facility had two units east and west, and CNA #602 had worked both units from 10/04/24 to 10/23/24.</p> <p>Review of the witness statement dated 10/04/24 and signed by CNA #602 revealed he was providing incontinence care to Resident #28, and she had a bowel movement and in the process of cleaning her up, she asked CNA #602 to stop as he was not cleaning her correctly. CNA #602 revealed he stopped giving her care, repositioned her in bed and went and got CNA #662. The statement revealed after CNA #662 came into the room, CNA #602 left out of the room and went to provide care to another resident.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had intact cognition and was dependent on staff assistance with rolling left and right in bed, toileting, hygiene, and transfers. She was always incontinent with urine and bowel. She had no behaviors that were identified.</p> <p>Review of the nursing note dated 10/23/24 at 3:47 P.M. and authored by the Director of Nursing (DON) revealed Resident #28 was interviewed, her chart was reviewed, and Resident #28 denied any psychological and/or psychosocial effects related to the allegation of receiving improper incontinence care. She was joyful and in a pleasant mood and stated she felt safe in the facility. A skin assessment was completed without any findings. Nurse Practitioner (NP) #661 was notified.</p> <p>Review of SRI #253244 dated 10/23/24 revealed the facility filed an allegation of neglect as Former CNA #662 reported that Resident #28 informed her that CNA #602 did not adequately clean her peri area during incontinence care after having a bowel movement. The facility initiated an investigation, and CNA #602 was suspended pending the outcome of the investigation. The SRI revealed Resident #28 denied allegations and that she felt safe and appropriately cared for by the facility. The facility unsubstantiated the allegation.</p> <p>Review of the undated Cleveland Division of Police service number 2024-313919 revealed Officer #663 responded. Officer #663 did not file an official report.</p> <p>Review of the facility timeline of events dated 10/23/24 and labeled, Timeline of Events- Resident #28- Allegation of Sexual Assault completed by the Administrator revealed on 10/03/24 at approximately 5:00 P. M. (which after clarification with Administrator should have been 10/04/24) Former CNA #662 informed the DON that Resident #28 had stated CNA #602, had used his fingers to wipe her in the front and in the back during incontinence care. The DON notified the Administrator, and they interviewed Resident #28 who stated CNA #602 did not do anything wrong, he just did not clean her up how she liked to be cleaned. Resident #28 asked him to stop and get a female aide. Resident #28 denied sexual abuse, and the facility educated CNA #602 on female hygiene including incontinence care. On 10/23/24, the Administrator was contacted by Regional Director of Operations #667 that Former CNA #662 alleged that a resident was sexually assaulted (resident or perpetrator was not identified) as a male aide stuck his finger in her butt. The timeline revealed an SRI was filed and an investigation was initiated. CNA #602 was suspended pending the investigation. The police were notified on 10/23/24 but due to high call volume, it was unsure when an officer could come. The timeline revealed on 10/25/24 the police arrived and interviewed Resident #28 and CNA #602 with no report filed.</p> <p>Review of the Shower/ Bath Sheet dated 10/23/24 and completed by the DON revealed Resident #28 had no skin concerns.</p> <p>Review of the witness statement dated 10/23/24 and authored by Registered Nurse (RN) #608 revealed she had worked 10/04/24 on the west hall (women side), and she was unaware of any accusations, including abuse.</p> <p>Review of the additional witness statements dated 10/25/24 and completed by Licensed Practical Nurse (LPN) #653 and CNA #635 revealed they were not aware of any allegations of abuse. There were no other witness statements including Former CNA #662 and Former Scheduler/CNA #664.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the witness statement dated 10/25/24 and authored by CNA #644 revealed she entered Resident #28's room, and Resident #28 revealed that she had just received a call from corporate and Resident #28 proceeded to tell CNA #644 that CNA #602 entered her room to clean her up, and he took a towel and wrapped the washcloth around his finger and went up one side of her vaginal area and then turned her over and went up her buttocks. The statement revealed Resident #28 stated CNA #602 did not wash her properly and as a woman, she felt it was degrading.</p> <p>Interview on 11/07/24 at 10:51 A.M. with Resident #28 revealed a guy (CNA #602) entered her room to clean her up and took his finger and swiped her as she demonstrated by taking her index finger in front of her in a slow manner. She revealed he took his finger across her buttock. She revealed she felt CNA #602's mind was on someone else during the incident as she was not sure what he was thinking. She revealed it was not right how he was doing it as she stated maybe he got into it with his girlfriend or something. She denied that the incident was abusive but stated again, it was not right the way he changed me. She revealed she had reported it because she did not want the same thing to happen to someone else. She had previous male caregivers, and that was not the issue, it was the way he did it. She remained focused during the interview regarding the way he took his finger and swiped her up and down her butt.</p> <p>Interview on 11/07/24 at 3:15 P.M. and 11/13/24 at 11:47 A.M. with Former CNA #662 revealed from 10/03/24 to 10/04/24 she worked 11:00 P.M. to 7:00 A.M. with CNA #602 and CNA #644. During that shift, she had not provided any care for Resident #28, and Resident #28 had not voiced any concerns. She denied that CNA #602 ever came and asked her to provide incontinence care for Resident #28 during that shift. Former CNA #662 revealed she then came back to work on second shift on 10/04/24 and at approximately 3:40 P.M., she had entered Resident #28's room, and Resident #28 asked who the guy was with the yellow hoodie last night. Former CNA #662 asked her what she meant, and Resident #28 stated he took his finger and inserted his finger in her butt and removed it and did it again. Former CNA #662 stated that Resident #28 stated the towel was dry and had no water and he did it twice and when Resident #28 was describing the concern, she held up her middle finger indicating he had used his middle finger. Former CNA #662 revealed Resident #28 stated she had a lot of pressure; it was hurting, and she did not want CNA #602 to take care of her again. Former CNA #662 revealed she immediately reported it to the Administrator and DON and verified she reported exactly what Resident #28 stated word for word. Former CNA #662 revealed she felt it was abuse. She stated that the Administrator and DON did go into Resident #28's room, but she did not feel the incident was thoroughly investigated as CNA #602 was never suspended, and when the Administrator left for the day, she had commented understand some people are miserable. She revealed she was terminated from the facility, and she felt it was a result of reporting the incident because CNA #602 was a relative of the Administrator. She revealed that Former Scheduler/ CNA #664 had also stated Resident #28 reported the incident to her, and she reported the incident.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 11/07/24 at 12:36 P.M. with the Administrator revealed that Former CNA #662 came into the DON's office where she and the DON were present and stated that CNA #602 had not cleaned Resident #28 properly. She revealed that Former CNA #662, DON and herself went into Resident #28's room and believed it was more a concern that CNA #602 was a new aide, and Resident #28 was concerned he did not clean her properly by getting into every, nook and cranny as well as CNA #602 did not feel comfortable cleaning a woman's anatomy. She denied at any time that Resident #28 or Former CNA #662 had communicated any allegation of potential sexual abuse. She revealed Former CNA #662 had never said anything regarding sexual abuse until she was terminated and contacted the corporate office on 10/23/24 stating Resident #28 was sexually assaulted by CNA #602. She then filed an SRI regarding the allegation.</p> <p>Interview on 11/07/24 at 12:57 P.M. with the DON revealed on 10/04/24 Former CNA #662 came to her office and said that she was the only one in the office. She verified the Administrator was not in the office at the time Former CNA #662 came to her office. The DON revealed Former CNA #662 stated CNA #602 had used his finger to wipe her: swiping up her buttock and down but stated she could not remember exactly what Former CNA #662 said. The DON revealed she immediately went to speak with Resident #28 because the way it was described by Former CNA #662 it was vulgar but again stated she could not remember the exact wording, but that it sounded off. She revealed Former CNA #662 and herself were in Resident #28's room, and Resident #28 stated he took his finger and stuck it up her butt but when she clarified by asking if she felt sexually assaulted, or violated she denied and instead revealed CNA #602 had not cleaned her properly as he did not get in her butt cheeks. She revealed Resident #28's daughter came in as well, and she got the Administrator, especially because of the verbiage Resident #28 was using and they interviewed her again. She revealed it did not sound good how Resident #28 was describing it as he was swiping his finger up and down her butt but again, she denied abuse and instead it sounded as CNA #602 had not provided proper incontinence care. They provided education to CNA #602.</p> <p>Interview on 11/07/24 at 2:54 P.M. with CNA #602 revealed on 10/04/24 he removed Resident #28's brief, and he completed one wipe using a washcloth across the front of her waistline above her genital area as she was wet from urine. CNA #602 revealed he could not remember if she was incontinent of bowel movement as he had just seen the front of Resident #28. He revealed he never rolled her over or provided any incontinence care to her rectal/buttock area as again he stated he had just wiped one time in the front. He revealed Resident #28 stated she would feel better with a female aide, so he went and got Former CNA #662 who completed the rest of her care. He denied at any time that he was sexually inappropriate or abusive. He revealed he was suspended for two or three days (could not remember the exact dates) as he stated the Administrator stated another aide had made an allegation, but that Resident #28 denied it. He did verify he was related to the Administrator.</p> <p>Interview on 11/07/24 at 3:37 P.M. with Resident #28's daughter revealed she talked with her mother on the morning of 10/04/24, and she said that a gentleman had cleaned her up the previous night. She revealed Resident #28 stated he wiped her kind of weird and she thought it was concerning as she said he wiped her by using two fingers up across her buttocks as she said, he swiped his fingers. She revealed she felt her mother may have used the wrong terminology as when she asked her mother if she felt it was sexual, she stated no, but it felt uncomfortable. She verified she was in the room when the Administrator and DON were questioning her mother, and she shared the same thing that she had on the phone that she did not feel it was sexual, but she did state, I felt it was uncomfortable how he wiped me.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 11/07/24 at 5:00 P.M. with the Administrator and DON verified they had not reported the incident, including filing an SRI, had not contacted the police and had not notified the physician on 10/04/24 regarding the incident, as they did not see it as sexual abuse after speaking with Resident #28. They verified the facility abuse policy revealed the facility was to report all allegations of abuse to the Ohio Department of Health (ODH) and then investigate the allegation. They verified that according to their abuse policy; the facility would immediately remove the alleged perpetrator from the facility and schedule pending the outcome of the investigation to protect the residents and/or residents. They also verified they had not obtained a witness statement from Former CNA #662 or from Resident #28 except what was placed in the timeline which was completed on 10/23/24.</p> <p>Interview on 11/13/24 at 8:40 A.M. with Former Human Resources (HR)/Payroll #665 revealed she was not directly involved but heard from Former Scheduler/ CNA #664 that Former CNA #662 was upset that she reported an allegation of sexual abuse involving CNA #602 and Resident #28, and it was not investigated because the Administrator was related to CNA #602. She revealed she asked the DON about the incident, and the DON stated, oh we did a soft file on it as they had talked with Resident #28, and CNA #602 had not cleaned her up properly. She revealed in her conversation with Former Scheduler/ CNA #664 it sounded more like an allegation of sexual abuse, and the facility did not report it until Former CNA #662 contacted corporate regarding the allegation. She revealed that was one of the main reasons she resigned, as she felt she should be privy to that information especially when staff feel the situation was being swept under the rug due to CNA #602 being a relative to the Administrator.</p> <p>Interview on 11/13/24 at 9:01 A.M. with Former Scheduler/CNA #664 revealed the morning of 10/04/24 she was working on the floor as there was a staffing shortage, and she was helping out. She revealed on 10/04/24 between 8:30 A.M. and 10:00 A.M. (she could not remember exact time), she was in Resident #28's room, and Resident #28 seemed upset and stated, she never wanted that man to take care of her again. Resident #28 stated CNA #602 rolled her over and took his finger and wiped up her butt crack and then rolled her back over and used his finger up and down the crack of her buttocks. Former Scheduler/CNA #664 revealed Resident #28 stated I am no damn fool; I know the difference between a finger and a towel as she repeated it was something skinny which was how she knew it was his finger. She immediately stopped the resident and went and got the DON. Resident #28 then communicated the same facts to the DON, and the DON questioned Resident #28 to see if she felt harmed or abused, and Resident #28 stated no. Resident #28 told the DON several times that she felt uncomfortable during the incident, and she stated. It ain't right, and I am not dumb. Former Scheduler/CNA #664 revealed she did not feel Resident #28 was conveying to the DON that it was a hygiene issue, but instead felt Resident #28 was reporting how uncomfortable she felt because he used his finger during her care, and that it was not right. Former Scheduler/CNA #664 revealed believed it was possible sexual abuse by the way Resident #28 described it. She heard other staff state Resident #28 shared the same story with them, and she was worried as it felt like the facility did not investigate the incident. She revealed since she was the scheduler, she knew CNA #602 had not been removed from the schedule after she had reported the incident on 10/04/24. She also verified she had not filled out a witness statement regarding the incident that she reported on 10/04/24.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 11/13/24 at 12:25 P.M. with Assistant Director of Nursing (ADON)/LPN #652 verified on review of the staffing schedules from 10/04/24 to 10/23/24 that CNA #602 worked both units (west and east). She revealed most the time he worked the east unit, but there were two residents on the men's unit (Resident #1 and Resident #18) that did not want a male caregiver, so in that situation she stated the aides would work it out themselves which rooms the male aide then would take for the female aide to have an even split. She revealed she had no documentation on which days CNA #602 worked with which residents. He most likely did pick up a few rooms on the female side the days he was assigned on the east unit.</p> <p>Interview on 11/13/24 at 1:10 P.M. with CNA #644 revealed she was providing care to Resident #28 (unsure of date), and Resident #28 stated that she had talked with corporate about an incident that had occurred. She revealed Resident #28 stated CNA #602 had used a finger to wrap the washcloth around and went up one side and turned her over and went up the other. She stated the way Resident #28 was describing the incident was odd and just did not sound right, especially how CNA #602 had used his finger. She revealed Resident #28 stated she felt degraded as a woman. She revealed she then reported it to the DON immediately.</p> <p>Review of the facility policy labeled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, dated 02/08/24, revealed the facility would immediately report all allegations to the administrator and to the ODH. In cases where a crime was suspected, the administrator would report the incident to the local law enforcement. The policy revealed an alleged violation was a situation or occurrence that was observed or reported by staff, resident, relative or others but has not yet been investigated. The policy revealed all incidents of abuse would be reported immediately. The facility would also report the incident/allegation to the attending physician. The policy revealed once the administrator and ODH were notified, then an investigation of the allegation would be conducted. The policy also revealed if a staff member was accused, the facility would immediately remove that staff member from the facility until the outcome of the investigation in order to protect the resident/residents. The policy revealed the person investigating the incident should interview the resident, the accused, and all witnesses and document evidence of the investigation. The investigation must be completed within five working days.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159263.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Hillside Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 18220 Euclid Ave Cleveland, OH 44112	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on record review, interview, review of the facility self-report incident (SRI) tracking number (#)253244 and investigation, and review of the facility abuse policy, the facility failed to promptly report an allegation of staff-to-resident sexual abuse to the Ohio Department of Health (ODH), local police department, and physician from 10/04/24 until 10/23/24. This affected one resident (#28) out of six residents reviewed for abuse. The facility census was 40.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes, and spinal stenosis. There was no documentation in the nursing notes from 10/04/24 to 10/23/24 regarding any allegation of staff-to-resident abuse.</p> <p>Review of the care plan dated 08/30/24 revealed Resident #28 had a self-care performance deficit related to fatigue, COPD, and weakness. Interventions included extensive assistance with toileting needs, monitoring for fatigue, and providing rest periods as needed.</p> <p>Review of the witness statement dated 10/04/24 and signed by CNA #602 revealed he was providing incontinence care to Resident #28, and she had a bowel movement and in the process of cleaning her up, she asked CNA #602 to stop as he was not cleaning her correctly. CNA #602 revealed he stopped giving her care, repositioned her in bed and went and got CNA #662. The statement revealed after CNA #662 came into the room, CNA #602 left out of the room and went to provide care to another resident. CNA #602 revealed Resident #28 had never stated she had any issues.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had intact cognition and was dependent on staff assistance with rolling left and right in bed, toileting, hygiene, and transfers. She was always incontinent with urine and bowel. She had no behaviors that were identified.</p> <p>Review of the nursing note dated 10/23/24 at 3:47 P.M. and authored by the Director of Nursing (DON) revealed Resident #28 was interviewed, her chart was reviewed, and Resident #28 denied any psychological and/or psychosocial effects related to the allegation of receiving improper incontinence care. She was joyful and in a pleasant mood and stated she felt safe in the facility. A skin assessment was completed without any findings. Nurse Practitioner (NP) #661 was notified.</p> <p>Review of SRI #253244 dated 10/23/24 revealed the facility filed an allegation of neglect as Former CNA #662 reported that Resident #28 informed her that CNA #602 did not adequately clean her peri area during incontinence care after having a bowel movement. The facility initiated an investigation, and CNA #602 was suspended pending the outcome of the investigation. The SRI revealed Resident #28 denied allegations and that she felt safe and appropriately cared for by the facility. The facility unsubstantiated the allegation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility timeline of events dated 10/23/24 and labeled, Timeline of Events- Resident #28- Allegation of Sexual Assault completed by the Administrator revealed on 10/03/24 at approximately 5:00 P. M. (which after clarification with Administrator should have been 10/04/24) Former CNA #662 informed the DON that Resident #28 had stated CNA #602, had used his fingers to wipe her in the front and in the back during incontinence care. The DON notified the Administrator, and they interviewed Resident #28 who stated CNA #602 did not do anything wrong, he just did not clean her up how she liked to be cleaned. Resident #28 asked him to stop and get a female aide. Resident #28 denied sexual abuse, and the facility educated CNA #602 on female hygiene including incontinence care. On 10/23/24, the Administrator was contacted by Regional Director of Operations #667 that Former CNA #662 alleged that a resident was sexually assaulted (resident or perpetrator was not identified) as a male aide stuck his finger in her butt. The timeline revealed an SRI was filed and an investigation was initiated. CNA #602 was suspended pending the investigation. The police were notified on 10/23/24 but due to high call volume, it was unsure when an officer could come. The timeline revealed on 10/25/24 the police arrived and interviewed Resident #28 and CNA #602 with no report filed.</p> <p>Review of the undated Cleveland Division of Police service number 2024-313919 revealed Officer #663 responded. Officer #663 did not file an official report.</p> <p>Interview on 11/07/24 at 10:51 A.M. with Resident #28 revealed a guy (CNA #602) entered her room to clean her up and took his finger and swiped her as she demonstrated by taking her index finger in front of her in a slow manner. She revealed he took his finger across her buttock. She revealed she felt CNA #602's mind was on someone else during the incident as she was not sure what he was thinking. She revealed it was not right how he was doing it as she stated maybe he got into it with his girlfriend or something. She denied that the incident was abusive but stated again, it was not right the way he changed me. She revealed she had reported it because she did not want the same thing to happen to someone else. She had previous male caregivers, and that was not the issue, it was the way he did it. She remained focused during the interview regarding the way he took his finger and swiped her up and down her butt.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/07/24 at 3:15 P.M. and 11/13/24 at 11:47 A.M. with Former CNA #662 revealed from 10/03/24 to 10/04/24 she worked 11:00 P.M. to 7:00 A.M. with CNA #602 and CNA #644. During that shift, she had not provided any care for Resident #28, and Resident #28 had not voiced any concerns. She denied that CNA #602 ever came and asked her to provide incontinence care for Resident #28 during that shift. Former CNA #662 revealed she then came back to work on second shift on 10/04/24 and at approximately 3:40 P.M., she had entered Resident #28's room, and Resident #28 asked who the guy was with the yellow hoodie last night. Former CNA #662 asked her what she meant, and Resident #28 stated he took his finger and inserted his finger in her butt and removed it and did it again. Former CNA #662 stated that Resident #28 stated the towel was dry and had no water and he did it twice and when Resident #28 was describing the concern, she held up her middle finger indicating he had used his middle finger. Former CNA #662 revealed Resident #28 stated she had a lot of pressure; it was hurting, and she did not want CNA #602 to take care of her again. Former CNA #662 revealed she immediately reported it to the Administrator and DON and verified she reported exactly what Resident #28 stated word for word. Former CNA #662 revealed she felt it was abuse. She stated that the Administrator and DON did go into Resident #28's room, but she did not feel the incident was thoroughly investigated as CNA #602 was never suspended, and when the Administrator left for the day, she had commented understand some people are miserable. She revealed she was terminated from the facility, and she felt it was a result of reporting the incident because CNA #602 was a relative of the Administrator. She revealed that Former Scheduler/ CNA #664 had also stated Resident #28 reported the incident to her, and she reported the incident.</p> <p>Interview on 11/07/24 at 12:36 P.M. with the Administrator revealed that Former CNA #662 came into the DON's office where she and the DON were present and stated that CNA #602 had not cleaned Resident #28 properly. She revealed that Former CNA #662, DON and herself went into Resident #28's room and believed it was more a concern that CNA #602 was a new aide, and Resident #28 was concerned he did not clean her properly by getting into every, nook and cranny as well as CNA #602 did not feel comfortable cleaning a woman's anatomy. She denied at any time that Resident #28 or Former CNA #662 had communicated any allegation of potential sexual abuse. She revealed Former CNA #662 had never said anything regarding sexual abuse until she was terminated and contacted the corporate office on 10/23/24 stating Resident #28 was sexually assaulted by CNA #602. She revealed she then filed an SRI regarding the allegation that was made on 10/23/24. She verified she had not filed an SRI on 10/04/24 as she did not see it as abuse after speaking with Resident #28. She also verified she had not obtained a witness statement from Former CNA #662 or from Resident #28 except for what was placed in the timeline which was completed on 10/23/24. She did verify CNA #602 was a relative of hers.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/07/24 at 12:57 P.M. with the DON revealed on 10/04/24 Former CNA #662 came to her office and said that she was the only one in the office. She verified the Administrator was not in the office at the time Former CNA #662 came to her office. The DON revealed Former CNA #662 stated CNA #602 had used his finger to wipe her: swiping up her buttock and down but stated she could not remember exactly what Former CNA #662 said. The DON revealed she immediately went to speak with Resident #28 because the way it was described by Former CNA #662 it was vulgar but again stated she could not remember the exact wording, but that it sounded off. She revealed Former CNA #662 and herself were in Resident #28's room, and Resident #28 stated he took his finger and stuck it up her butt but when she clarified by asking if she felt sexually assaulted, or violated she denied and instead revealed CNA #602 had not cleaned her properly as he did not get in her butt cheeks. She revealed Resident #28's daughter came in as well, and she got the Administrator, especially because of the verbiage Resident #28 was using and they interviewed her again. She revealed it did not sound good how Resident #28 was describing it as he was swiping his finger up and down her butt but again, she denied abuse and instead it sounded as CNA #602 had not provided proper incontinence care. They provided education to CNA #602. She verified she had not filed an SRI, contacted the police or notified the physician on 10/04/24 as she did not see it as abuse after speaking with Resident #28. She also verified she had not obtained a witness statement from Former CNA #662 or from Resident #28 except what was placed in the timeline, which was completed on 10/23/24.</p> <p>Interview on 11/07/24 at 2:54 P.M. with CNA #602 revealed on 10/04/24 he removed Resident #28's brief, and he completed one wipe using a washcloth across the front of her waistline above her genital area as she was wet from urine. CNA #602 revealed he could not remember if she was incontinent of bowel movement as he had just seen the front of Resident #28. He revealed he never rolled her over or provided any incontinence care to her rectal/buttock area as again he stated he had just wiped one time in the front. He revealed Resident #28 stated she would feel better with a female aide, so he went and got Former CNA #662 who completed the rest of her care. He denied at any time that he was sexually inappropriate or abusive. He revealed he was suspended for two or three days (could not remember the exact dates) as he stated the Administrator stated another aide had made an allegation, but that Resident #28 denied it. He did verify he was related to the Administrator.</p> <p>Interview on 11/07/24 at 3:37 P.M. with Resident #28's daughter revealed she talked with her mother on the morning of 10/04/24, and she said that a gentleman had cleaned her up the previous night. She revealed Resident #28 stated he wiped her kind of weird and she thought it was concerning as she said he wiped her by using two fingers up across her buttocks as she said, he swiped his fingers. She revealed she felt her mother may have used the wrong terminology as when she asked her mother if she felt it was sexual, she stated no, but it felt uncomfortable. She verified she was in the room when the Administrator and DON were questioning her mother, and she shared the same thing that she had on the phone that she did not feel it was sexual, but she did state, I felt it was uncomfortable how he wiped me.</p> <p>Interview on 11/07/24 at 5:00 P.M. with the Administrator and DON verified they had not reported the incident including filing an SRI, contacted the police or notified the physician on 10/04/24 regarding the incident as they stated they did not see it as abuse after speaking with Resident #28. They verified the facility abuse policy revealed the facility was to report all allegations of abuse to ODH and then investigate the allegation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/13/24 at 8:40 A.M. with Former Human Resources (HR)/Payroll #665 revealed she was not directly involved but heard from Former Scheduler/ CNA #664 that Former CNA #662 was upset that she reported an allegation of sexual abuse involving CNA #602 and Resident #28, and it was not investigated because the Administrator was related to CNA #602. She revealed she asked the DON about the incident, and the DON stated, oh we did a soft file on it as they had talked with Resident #28, and CNA #602 had not cleaned her up properly. She revealed in her conversation with Former Scheduler/ CNA #664 it sounded more like an allegation of sexual abuse, and the facility did not report it until Former CNA #662 contacted corporate regarding the allegation. She revealed that was one of the main reasons she resigned, as she felt she should be privy to that information especially when staff feel the situation was being swept under the rug due to CNA #602 being a relative to the Administrator.</p> <p>Interview on 11/13/24 at 9:01 A.M. with Former Scheduler/CNA #664 revealed the morning of 10/04/24 she was working on the floor as there was a staffing shortage, and she was helping out. She revealed on 10/04/24 between 8:30 A.M. and 10:00 A.M. (she could not remember exact time), she was in Resident #28's room, and Resident #28 seemed upset and stated, she never wanted that man to take care of her again. Resident #28 stated CNA #602 rolled her over and took his finger and wiped up her butt crack and then rolled her back over and used his finger up and down the crack of her buttocks. Former Scheduler/CNA #664 revealed Resident #28 stated I am no damn fool; I know the difference between a finger and a towel as she repeated it was something skinny which was how she knew it was his finger. She immediately stopped the resident and went and got the DON. Resident #28 then communicated the same facts to the DON, and the DON questioned Resident #28 to see if she felt harmed or abused, and Resident #28 stated no. Resident #28 told the DON several times that she felt uncomfortable during the incident, and she stated. It ain't right, and I am not dumb. Former Scheduler/CNA #664 revealed she did not feel Resident #28 was conveying to the DON that it was a hygiene issue, but instead felt Resident #28 was reporting how uncomfortable she felt because he used his finger during her care, and that it was not right. Former Scheduler/CNA #664 revealed believed it was possible sexual abuse by the way Resident #28 described it. She heard other staff state Resident #28 shared the same story with them, and she was worried as it felt like the facility did not investigate the incident. She revealed since she was the scheduler, she knew CNA #602 had not been removed from the schedule after she had reported the incident on 10/04/24. She also verified she had not filled out a witness statement regarding the incident that she reported on 10/04/24.</p> <p>Review of the facility policy labeled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, dated 02/08/24, revealed the facility would immediately report all allegations to the administrator and to the ODH. In cases where a crime was suspected, the administrator would report the incident to the local law enforcement. The policy revealed an alleged violation was a situation or occurrence that was observed or reported by staff, resident, relative or others but has not yet been investigated. The policy revealed all incidents of abuse would be reported immediately. The facility would also report the incident/allegation to the attending physician. The policy revealed once the administrator and ODH were notified, then an investigation of the allegation would be conducted.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159263.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on record review, interview, review of the facility self-report incident (SRI) tracking number (#)253244 and investigation, staffing schedules and punch detailed report, and review of the facility abuse policy, the facility failed to immediately investigate and implement protective measures upon receiving an allegation of staff-to-resident abuse to prevent further abuse including not allowing the alleged perpetrator to continue to provide direct care from 10/04/24 to 10/23/24 while a thorough investigation was completed. This affected one resident (#28) and had the potential to affect all 40 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes, and spinal stenosis. There was no documentation in the nursing notes from 10/04/24 to 10/23/24 regarding any allegation of staff-to-resident abuse.</p> <p>Review of the care plan dated 08/30/24 revealed Resident #28 had a self-care performance deficit related to fatigue, COPD, and weakness. Interventions included extensive assistance with toileting needs, monitoring for fatigue, and providing rest periods as needed.</p> <p>Review of the Time Entry Report from 10/03/24 to 10/23/24 revealed Certified Nursing Assistant (CNA) #602 worked on 10/03/24 from 11:00 P.M. to 6:57 A.M., 10/05/24 from 6:59 P.M. to 6:58 A.M., 10/06/24 from 7:00 P.M. to 6:55 A.M., 10/08/24 from 11:00 P.M. to 6:56 A.M., 10/11/24 from 11:00 P.M. to 7:00 A.M., 10/14/24 from 11:02 P.M. to 7:05 A.M., 10/15/24 from 10:58 A.M. to 6:56 A.M., 10/17/24 from 10:53 A.M. to 7:00 A.M., 10/18/24 6:57 A.M. to 7:00 A.M., 10/19/24 from 11:00 A.M. to 6:55 A.M., 10/20/24 from 10:54 A.M. to 6:58 A.M., and 10/22/24 from 10:57 A.M. to 6:58 A.M. He was removed from the schedule from 10/23/24 to 10/28/24 (after which he returned to work).</p> <p>Review of the facility staffing schedule dated 10/03/24 revealed the following staff worked from 11:00 P.M. to 7:00 A.M.: Registered Nurse (RN) #608, RN #617, CNA #602, CNA #644, and Former CNA #662.</p> <p>Review of the additional staffing schedules from 10/04/24 to 10/23/24 revealed CNA #602 worked on the east unit (men's unit) on 10/05/24, 10/06/24, 10/09/24, 10/11/24, and 10/14/24. He worked on the west unit (women's unit) on 10/08/24, 10/15/24, and 10/22/24. The facility had two units east and west, and CNA #602 had worked both units from 10/04/24 to 10/23/24.</p> <p>Review of the witness statement dated 10/04/24 and signed by CNA #602 revealed he was providing incontinence care to Resident #28, and she had a bowel movement and in the process of cleaning her up, she asked CNA #602 to stop as he was not cleaning her correctly. CNA #602 revealed he stopped giving her care, repositioned her in bed and went and got CNA #662. The statement revealed after CNA #662 came into the room, CNA #602 left out of the room and went to provide care to another resident. CNA #602 stated that Resident #28 never stated that she had any issues.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had intact cognition and was dependent on staff assistance with rolling left and right in bed, toileting, hygiene, and transfers. She was always incontinent with urine and bowel. She had no behaviors that were identified.</p> <p>Review of the nursing note dated 10/23/24 at 3:47 P.M. and authored by the Director of Nursing (DON) revealed Resident #28 was interviewed, her chart was reviewed, and Resident #28 denied any psychological and/or psychosocial effects related to the allegation of receiving improper incontinence care. She was joyful and in a pleasant mood and stated she felt safe in the facility. A skin assessment was completed without any findings. Nurse Practitioner (NP) #661 was notified.</p> <p>Review of SRI #253244 dated 10/23/24 revealed the facility filed an allegation of neglect as Former CNA #662 reported that Resident #28 informed her that CNA #602 did not adequately clean her peri area during incontinence care after having a bowel movement. The facility initiated an investigation, and CNA #602 was suspended pending the outcome of the investigation. The SRI revealed Resident #28 denied allegations and that she felt safe and appropriately cared for by the facility. The facility unsubstantiated the allegation.</p> <p>Review of the facility timeline of events dated 10/23/24 and labeled, Timeline of Events- Resident #28- Allegation of Sexual Assault completed by the Administrator revealed on 10/03/24 at approximately 5:00 P. M. (which after clarification with Administrator should have been 10/04/24) Former CNA #662 informed the DON that Resident #28 had stated CNA #602, had used his fingers to wipe her in the front and in the back during incontinence care. The DON notified the Administrator, and they interviewed Resident #28 who stated CNA #602 did not do anything wrong, he just did not clean her up how she liked to be cleaned. Resident #28 asked him to stop and get a female aide. Resident #28 denied sexual abuse, and the facility educated CNA #602 on female hygiene including incontinence care. On 10/23/24, the Administrator was contacted by Regional Director of Operations #667 that Former CNA #662 alleged that a resident was sexually assaulted (resident or perpetrator was not identified) as a male aide stuck his finger in her butt. The timeline revealed an SRI was filed and an investigation was initiated. CNA #602 was suspended pending the investigation. The police were notified on 10/23/24 but due to high call volume, it was unsure when an officer could come. The timeline revealed on 10/25/24 the police arrived and interviewed Resident #28 and CNA #602 with no report filed.</p> <p>Review of the undated Cleveland Division of Police service number 2024-313919 revealed Officer #663 responded. Officer #663 did not file an official report.</p> <p>Review of the facility investigation dated 10/23/24 revealed six residents (three male residents #1, #6, #18 and three female residents #24, #30, and #43) were interviewed and asked the following questions: do you feel safe in the facility, are you comfortable with male caregivers, and has any care giver, male or female, provided care to you that made you feel uncomfortable. No concerns were identified.</p> <p>Review of the witness statement dated 10/23/24 and authored by Registered Nurse (RN) #608 revealed she had worked 10/04/24 on the west hall (women side), and she was unaware of any accusations, including abuse.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the additional witness statements dated 10/25/24 and completed by Licensed Practical Nurse (LPN) #653 and CNA #635 revealed they were not aware of any allegations of abuse. There were no other witness statements including Former CNA #662 and Former Scheduler/CNA #664.</p> <p>Review of the witness statement dated 10/25/24 and authored by CNA #644 revealed she entered Resident #28's room, and Resident #28 revealed that she had just received a call from corporate and Resident #28 proceeded to tell CNA #644 that CNA #602 entered her room to clean her up, and he took a towel and wrapped the washcloth around his finger and went up one side of her vaginal area and then turned her over and went up her buttocks. The statement revealed Resident #28 stated CNA #602 did not wash her properly and as a woman, she felt it was degrading.</p> <p>Interview on 11/07/24 at 10:51 A.M. with Resident #28 revealed a guy (CNA #602) entered her room to clean her up and took his finger and swiped her as she demonstrated by taking her index finger in front of her in a slow manner. She revealed he took his finger across her buttock. She revealed she felt CNA #602's mind was on someone else during the incident as she was not sure what he was thinking. She revealed it was not right how he was doing it as she stated maybe he got into it with his girlfriend or something. She denied that the incident was abusive but stated again, it was not right the way he changed me. She revealed she had reported it because she did not want the same thing to happen to someone else. She had previous male caregivers, and that was not the issue, it was the way he did it. She remained focused during the interview regarding the way he took his finger and swiped her up and down her butt.</p> <p>Interview on 11/07/24 at 3:15 P.M. and 11/13/24 at 11:47 A.M. with Former CNA #662 revealed from 10/03/24 to 10/04/24 she worked 11:00 P.M. to 7:00 A.M. with CNA #602 and CNA #644. During that shift, she had not provided any care for Resident #28, and Resident #28 had not voiced any concerns. She denied that CNA #602 ever came and asked her to provide incontinence care for Resident #28 during that shift. Former CNA #662 revealed she then came back to work on second shift on 10/04/24 and at approximately 3:40 P.M., she had entered Resident #28's room, and Resident #28 asked who the guy was with the yellow hoodie last night. Former CNA #662 asked her what she meant, and Resident #28 stated he took his finger and inserted his finger in her butt and removed it and did it again. Former CNA #662 stated that Resident #28 stated the towel was dry and had no water and he did it twice and when Resident #28 was describing the concern, she held up her middle finger indicating he had used his middle finger. Former CNA #662 revealed Resident #28 stated she had a lot of pressure; it was hurting, and she did not want CNA #602 to take care of her again. Former CNA #662 revealed she immediately reported it to the Administrator and DON and verified she reported exactly what Resident #28 stated word for word. Former CNA #662 revealed she felt it was abuse. She stated that the Administrator and DON did go into Resident #28's room, but she did not feel the incident was thoroughly investigated as CNA #602 was never suspended, and when the Administrator left for the day, she had commented understand some people are miserable. She revealed she was terminated from the facility, and she felt it was a result of reporting the incident because CNA #602 was a relative of the Administrator. She revealed that Former Scheduler/ CNA #664 had also stated Resident #28 reported the incident to her, and she reported the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 11/07/24 at 12:36 P.M. with the Administrator revealed that Former CNA #662 came into the DON's office where she and the DON were present and stated that CNA #602 had not cleaned Resident #28 properly. She revealed that Former CNA #662, DON and herself went into Resident #28's room and believed it was more a concern that CNA #602 was a new aide, and Resident #28 was concerned he did not clean her properly by getting into every, nook and cranny as well as CNA #602 did not feel comfortable cleaning a woman's anatomy. She denied at any time that Resident #28 or Former CNA #662 had communicated any allegation of potential sexual abuse. She revealed Former CNA #662 had never said anything regarding sexual abuse until she was terminated and contacted the corporate office on 10/23/24 stating Resident #28 was sexually assaulted by CNA #602. She then filed an SRI regarding the allegation.</p> <p>Interview on 11/07/24 at 12:57 P.M. with the DON revealed on 10/04/24 Former CNA #662 came to her office and said that she was the only one in the office. She verified the Administrator was not in the office at the time Former CNA #662 came to her office. The DON revealed Former CNA #662 stated CNA #602 had used his finger to wipe her: swiping up her buttock and down but stated she could not remember exactly what Former CNA #662 said. The DON revealed she immediately went to speak with Resident #28 because the way it was described by Former CNA #662 it was vulgar but again stated she could not remember the exact wording, but that it sounded off. She revealed Former CNA #662 and herself were in Resident #28's room, and Resident #28 stated he took his finger and stuck it up her butt but when she clarified by asking if she felt sexually assaulted, or violated she denied and instead revealed CNA #602 had not cleaned her properly as he did not get in her butt cheeks. She revealed Resident #28's daughter came in as well, and she got the Administrator, especially because of the verbiage Resident #28 was using and they interviewed her again. She revealed it did not sound good how Resident #28 was describing it as he was swiping his finger up and down her butt but again, she denied abuse and instead it sounded as CNA #602 had not provided proper incontinence care. They provided education to CNA #602.</p> <p>Interview on 11/07/24 at 2:54 P.M. with CNA #602 revealed on 10/04/24 he removed Resident #28's brief, and he completed one wipe using a washcloth across the front of her waistline above her genital area as she was wet from urine. CNA #602 revealed he could not remember if she was incontinent of bowel movement as he had just seen the front of Resident #28. He revealed he never rolled her over or provided any incontinence care to her rectal/buttock area as again he stated he had just wiped one time in the front. He revealed Resident #28 stated she would feel better with a female aide, so he went and got Former CNA #662 who completed the rest of her care. He denied at any time that he was sexually inappropriate or abusive. He revealed he was suspended for two or three days (could not remember the exact dates) as he stated the Administrator stated another aide had made an allegation, but that Resident #28 denied it. He did verify he was related to the Administrator.</p> <p>Interview on 11/07/24 at 3:37 P.M. with Resident #28's daughter revealed she talked with her mother on the morning of 10/04/24, and she said that a gentleman had cleaned her up the previous night. She revealed Resident #28 stated he wiped her kind of weird and she thought it was concerning as she said he wiped her by using two fingers up across her buttocks as she said, he swiped his fingers. She revealed she felt her mother may have used the wrong terminology as when she asked her mother if she felt it was sexual, she stated no, but it felt uncomfortable. She verified she was in the room when the Administrator and DON were questioning her mother, and she shared the same thing that she had on the phone that she did not feel it was sexual, but she did state, I felt it was uncomfortable how he wiped me.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 11/07/24 at 5:00 P.M. with the Administrator and DON verified they had not completed an investigation until 10/23/24. They verified that the facility policy revealed if a staff member was accused of abuse, the facility would immediately remove that staff member from the facility until the outcome of the investigation in order to protect the resident/residents. They verified the policy revealed that the person investigating the incident should interview the residents, the accused, and all witnesses and document evidence of the investigation. They also verified the investigation must be completed within five working days.</p> <p>Interview on 11/13/24 at 8:40 A.M. with Former Human Resources (HR)/Payroll #665 revealed she was not directly involved but heard from Former Scheduler/ CNA #664 that Former CNA #662 was upset that she reported an allegation of sexual abuse involving CNA #602 and Resident #28, and it was not investigated because the Administrator was related to CNA #602. She revealed she asked the DON about the incident, and the DON stated, oh we did a soft file on it as they had talked with Resident #28, and CNA #602 had not cleaned her up properly. She revealed in her conversation with Former Scheduler/ CNA #664 it sounded more like an allegation of sexual abuse, and the facility did not report it until Former CNA #662 contacted corporate regarding the allegation. She revealed that was one of the main reasons she resigned, as she felt she should be privy to that information especially when staff feel the situation was being swept under the rug due to CNA #602 being a relative to the Administrator.</p> <p>Interview on 11/13/24 at 9:01 A.M. with Former Scheduler/CNA #664 revealed the morning of 10/04/24 she was working on the floor as there was a staffing shortage, and she was helping out. She revealed on 10/04/24 between 8:30 A.M. and 10:00 A.M. (she could not remember exact time), she was in Resident #28's room, and Resident #28 seemed upset and stated, she never wanted that man to take care of her again. Resident #28 stated CNA #602 rolled her over and took his finger and wiped up her butt crack and then rolled her back over and used his finger up and down the crack of her buttocks. Former Scheduler/CNA #664 revealed Resident #28 stated I am no damn fool; I know the difference between a finger and a towel as she repeated it was something skinny which was how she knew it was his finger. She immediately stopped the resident and went and got the DON. Resident #28 then communicated the same facts to the DON, and the DON questioned Resident #28 to see if she felt harmed or abused, and Resident #28 stated no. Resident #28 told the DON several times that she felt uncomfortable during the incident, and she stated. It ain't right, and I am not dumb. Former Scheduler/CNA #664 revealed she did not feel Resident #28 was conveying to the DON that it was a hygiene issue, but instead felt Resident #28 was reporting how uncomfortable she felt because he used his finger during her care, and that it was not right. Former Scheduler/CNA #664 revealed believed it was possible sexual abuse by the way Resident #28 described it. She heard other staff state Resident #28 shared the same story with them, and she was worried as it felt like the facility did not investigate the incident. She revealed since she was the scheduler, she knew CNA #602 had not been removed from the schedule after she had reported the incident on 10/04/24. She also verified she had not filled out a witness statement regarding the incident that she reported on 10/04/24.</p> <p>Interview on 11/13/24 at 12:25 P.M. with Assistant Director of Nursing (ADON)/LPN #652 verified on review of the staffing schedules from 10/04/24 to 10/23/24 that CNA #602 worked both units (west and east). She revealed most the time he worked the east unit, but there were two residents on the men's unit (Resident #1 and Resident #18) that did not want a male caregiver, so in that situation she stated the aides would work it out themselves which rooms the male aide then would take for the female aide to have an even split. She revealed she had no documentation on which days CNA #602 worked with which residents. He most likely did pick up a few rooms on the female side the days he was assigned on the east unit.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 11/13/24 at 1:10 P.M. with CNA #644 revealed she was providing care to Resident #28 (unsure of date), and Resident #28 stated that she had talked with corporate about an incident that had occurred. She revealed Resident #28 stated CNA #602 had used a finger to wrap the washcloth around and went up one side and turned her over and went up the other. She stated the way Resident #28 was describing the incident was odd and just did not sound right, especially how CNA #602 had used his finger. She revealed Resident #28 stated she felt degraded as a woman. She revealed she then reported it to the DON immediately.</p> <p>Review of the facility policy labeled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, dated 02/08/24, revealed once the administrator and ODH were notified, then an investigation of the allegation would be conducted. The policy also revealed if a staff member was accused of abuse, the facility would immediately remove that staff member from the facility until the outcome of the investigation in order to protect the resident/residents. The policy revealed the person investigating the incident should interview the resident, the accused, and all witnesses and document evidence of the investigation. The investigation must be completed within five working days.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159263.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on observation, interview, record review and facility policy review, the facility failed to ensure call lights were within reach. This affected two residents (#33 and #36) out of six residents reviewed for call lights. This had the potential to affect 38 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #22, #23, #24, #25, #26, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, and #40) identified by the facility as capable of utilizing their call light to ring for assistance. The facility census was 40.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #36 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes, and paranoid schizophrenia.</p> <p>Review of the care plan dated 03/13/24 revealed Resident #36 was at risk for falls due to impaired mobility, poor safety awareness, and unstable health condition. Interventions included maintaining her bed in the lowest position and ensuring the call light was within reach when in room.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 had intact cognition. She required substantial to maximum staff assist with rolling left and right in bed, and was dependent on staff for transfers, toileting, hygiene, dressing, and personal hygiene.</p> <p>Observation on 11/07/24 at 11:13 A.M. revealed Resident #36 was lying in her bed which was against the window, and there was no call light within reach. Observation revealed Resident #36's call light was on the other bed in her room approximately ten feet away out of reach.</p> <p>Interview on 11/07/24 at 11:13 A.M. with Resident #36 revealed she did utilize her call light to call for staff assistance as she was dependent on staff for most of her care. She verified she was unable to reach her call light.</p> <p>Interview on 11/07/24 at 11:16 A.M. with the Director of Nursing (DON) verified Resident #36's call light was not within reach.</p> <p>2. Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses including arthritis and hypertension.</p> <p>Review of the care plan dated 10/29/24 revealed Resident #33 was at risk for falls related to impaired mobility and pain. Interventions included providing assistance with transfers, maintaining her bed in the lowest position, and ensuring her call light accessible when she was in her room.</p> <p>Review of the admission MDS assessment dated [DATE] revealed Resident #33 had intact cognition. She had impairment on both her upper and lower extremities. She required staff assistance with her activities of daily living including dressing, toileting, hygiene, and rolling left and right in bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 11/07/24 at 1:29 P.M. revealed Resident #33 was lying in her bed, and her call light was on her night stand out of reach.</p> <p>Interview on 11/07/24 at 1:29 P.M. with Resident #33 revealed she was unable to reach her call light and stated, the lady moved my call light and did not put it back.</p> <p>Interview on 11/07/24 at 1:31 P.M. with Certified Nursing Assistant (CNA) #618 verified Resident #33's call light was on her night stand out of reach.</p> <p>Interview on 11/23/24 at 1:00 P.M. with the DON revealed all residents residing in the facility were able to utilize their call light to ring for assistance except Residents #21 and #27 due to their cognitive ability.</p> <p>Review of the facility policy labeled, Call Light, Use Of, dated 11/30/23, revealed staff were to be sure call lights were always placed within reach of the resident.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00159487.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure oxygen was being administered according to physician orders and failed to ensure there was appropriate signage indicating oxygen was in use. This affected one resident (#13) out of two residents reviewed for oxygen use. This had the potential to affect six additional residents (#15, #20, #21, #24, #28, and #38) identified by the facility with an order for oxygen. The facility census was 40.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and dependence of oxygen.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had impaired cognition and received oxygen therapy.</p> <p>Review of the November 2024 physician orders revealed Resident #13 had a current order for three liters per minute of continuous oxygen due to shortness of breath.</p> <p>Review of the care plan dated 11/07/24 revealed Resident #13 had ineffective breathing patterns as evidenced by shortness of breath, labored respirations, and COPD. Interventions included administering oxygen per physician order, keeping the head of the bed elevated, monitoring respiration rate and depth, breathing sounds and reporting any abnormal findings.</p> <p>Observation on 11/07/24 at 9:07 A.M. revealed Resident #13 had an oxygen concentrator as well as one green oxygen e-cylinder tank (high pressure oxygen stored in a cylinder) secured in a portable oxygen holder in his room. Observation revealed Resident #13 was receiving oxygen per nasal cannula at 4.5 liters per minute that was connected to his oxygen concentrator. There was no signage outside of his room that indicated he had oxygen in use.</p> <p>Observation on 11/07/24 at 9:12 A.M. revealed Licensed Practical Nurse (LPN) #604 removed the green oxygen e-cylinder from Resident #13's room and placed it in a room labeled, Central Supply behind the entry door. In the room there were four empty oxygen e-cylinders and one other e-cylinder that was approximately one third full of oxygen. There was no signage outside the central supply that indicated the room contained oxygen.</p> <p>Interview on 11/07/24 at 10:10 A.M. with LPN #604 verified Resident #13's room did not have a sign on the outside of his room indicating he had oxygen in use. She also verified there was no sign on the central supply room that she had placed Resident #13's oxygen e-cylinder that was one third full of oxygen behind the entry door as well as contained five other oxygen e-cylinders. LPN #604 revealed the primary oxygen storage was outside in a shed, but they also stored oxygen in the central supply room. She verified Resident #13 was receiving 4.5 liters of oxygen per minute per nasal cannula.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/07/24 at 12:57 P.M. with the Director of Nursing (DON) verified Resident #13 had an order for three liters of continuous oxygen per minute and not 4.5 liters. She also revealed the facility utilized an outside storage shed to store oxygen, and she did not know that staff were utilizing the central supply room to store oxygen. She verified any room that had oxygen should have an oxygen in use sign on the outside of the room, including Resident #13's room and the central supply room.</p> <p>Review of the facility policy labeled, Oxygen Administration, dated 11/30/23, revealed staff would check the physician order for liter flow and method of administration. The policy revealed an oxygen in use sign would be placed.</p> <p>This deficiency was an incidental finding identified during the complaint investigation.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>39973</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview, record review and review of facility policy, the facility failed to ensure the Quality Assurance Performance Improvement (QAPI) committee that met at least quarterly consisted of the required members, including the medical director or his/her designee. This had the potential to affect all 40 residents residing in the facility.</p> <p>Finding include:</p> <p>Review of the QAPI sign-in sheets from 10/20/23 to 08/21/24 revealed a QAPI meeting was held on 03/01/24, and Medical Director #660 attended the meeting. A QAPI sign-in sheet revealed a meeting was held on 06/27/24, and Medical Director #660 or designee had not attended. A QAPI meeting sign-in sheet revealed a meeting was held on 08/21/24, and Nurse Practitioner #661 attended the meeting as the medical director's designee. There was no evidence from 03/02/24 to 08/21/24 (over five months) that the facility had a QAPI meeting that the medical director and/or his designee attended.</p> <p>Interview on 11/13/24 at 9:00 A.M. with the Administrator verified she had no documented evidence from 03/02/24 to 08/21/24 (over five months) that the facility had a QAPI meeting that the medical director and/or his designee attended.</p> <p>Review of the facility policy labeled, Quality Assurance Performance Improvement, dated 07/01/24, revealed the facility would systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care, resolve identified problems, and identify opportunities for improvement. The policy did not include the required members that would attend these meetings, including the medical director and/or designee.</p> <p>This deficiency was an incidental finding identified during the complaint investigation.</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** 39973</p> <p>Based on observation, interview, record review, facility policy review, and review of the memorandum from the Department of Health & Human Services, the facility failed to ensure proper infection control measures were implemented at all times.</p> <p>The facility failed to initiate and use enhanced barrier precautions (EBP) for Resident #13. This affected one resident (#13) of one resident observed for EBP and had the potential to affect 11 residents (#1, #7, #11, #12, #13, #18, #20, #21, #24, #26, and #38) identified by the facility that were to be on EBP.</p> <p>The facility failed to ensure staff did not carry medications against their chest/body potentially causing infection control cross contamination affecting one resident (#13) of three residents reviewed for medication administration.</p> <p>The facility failed to cleanse the blood pressure cuff/monitor between resident use which affected one resident (#13) out of two residents reviewed for monitoring of blood pressure.</p> <p>The facility failed to ensure Resident #35's bed pan was stored in a sanitary manner which affected one resident (#35) out of one resident reviewed for bed pan storage. The facility census was 40.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), acute kidney failure, congestive heart failure (CHF), and dependence on supplemental oxygen.</p> <p>Review of the Medicare five- day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had impaired cognition. He required substantial to maximum assistance with rolling left and right regarding bed mobility and transfers.</p> <p>Review of the November 2024 physician orders revealed Resident #13 had a treatment dated 10/30/24 to his coccyx pressure wound to cleanse, pat dry, apply Medi honey (wound and burn gel), pack with calcium alginate, and cover with a dry dressing daily and as needed. There was no physician order for EBP.</p> <p>Review of the care plan dated 11/07/24 revealed Resident #13 had an alteration in skin integrity as he had a coccyx wound. Interventions included EBP with high contact care and treatments as ordered.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Hillside Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 18220 Euclid Ave Cleveland, OH 44112	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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>Observation on 11/07/24 at 9:07 A.M. revealed Resident #13 had a sign on the outside of his doorway that indicated Resident #13 was on EBP, indicating staff were to wear gloves and a gown during high contact resident care activities. Licensed Practical Nurse (LPN) #604 entered Resident #13's room and applied gloves and no gown. LPN #604 leaned over Resident #13's bed to auscultate his lung sounds with her stethoscope as the top of her uniform encountered his gown. She then proceeded to reposition Resident #13 in bed which required substantial assistance as she rolled him from his right side to his back lifting his right shoulder region to continue to listen to his lungs as well as to obtain his blood pressure. While repositioning resident #13, LPN #604 came in direct contact with Resident #13. She then left the room to prepare his medications including Advair diskus inhaler, Spiriva Respimat inhaler, budesonide aerosol treatment, a medication cup with nine oral medications and a cup of water in which she gathered all at once with her bilateral arms and held tightly against her chest region against her uniform as she walked to Resident #13's room. She proceeded then to reapply gloves but no gown and assisted Resident #13 from a lying position to sitting by placing both arms underneath his arms and her uniform and upper body in direct contact with his upper body as he was dependent on her transferring him from lying to sitting position to the edge of his bed.</p> <p>Interview on 11/07/24 at 10:10 A.M. with LPN #604 verified she had carried his medications including holding his Advair diskus inhaler (glucocorticoid), Spiriva Respimat inhaler (bronchodilator), and budesonide aerosol (corticosteroid) treatment against her chest region coming in contact with her uniform. She stated, so much stuff to carry that she did not have a choice. She also verified Resident #13 had a sign on the outside of his door indicating he was to be on EBP including during high contact care, and she verified she had repositioned him in bed and transferred him from a lying to sitting position. She revealed she had not received anything in report that Resident #13 had a contagious disease and stated, I do not believe he has anything. She revealed EBP was to protect the staff from getting something from a resident including a contagious disease.</p> <p>Interview on 11/07/24 at 12:57 P.M. with the Director of Nursing (DON) revealed she the infection control preventionist. She verified Resident #13 had a pressure wound and required EBP during high contact care. She verified high contact care would include repositioning a resident with bed mobility and transferring from lying to sitting positions that required substantial to dependent staff assistance. She verified EBP was to reduce transmission of multidrug-resistant organisms (MDRO) from staff to resident. She also verified a nurse should not carry medication, including inhalers against her chest/body while carrying them into a resident room.</p> <p>Review of the facility policy labeled, Medication Administration- General Guidelines, dated November 2021, revealed staff administering medications were to adhere to good handwashing. There was nothing in the policy regarding ensuring medications were not held against a staff's body while carrying the medications into a resident's room.</p> <p>Review of facility policy labeled, Enhanced Barrier Precautions, dated 11/30/23, revealed EBP were an infection control intervention designed to reduce transmission of MDRO. EBP were to be used for residents with wounds, indwelling medical devices, and known infection. The policy revealed gowns and gloves were to be used for high contact resident care activities including dressing, transferring, providing hygiene, and changing linens.</p> <p>(continued on next page)</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>Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed EBP were an infection control intervention designed to reduce MDRO. EBP are used in conjunction with standard precautions and expand the use of Personal Protective Equipment (PPE) by donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP were indicated for residents with any of the following including wounds. EBP were indicated for high-contact resident care activities including transferring. The effective date for implementation of EBP under the guidelines was 04/01/24.</p> <p>2. Observation revealed on 11/07/24 at 8:50 A.M. LPN #604 obtained Resident #14's blood pressure utilizing an electric blood pressure monitor by applying the blood pressure cuff to Resident #14's right arm. LPN #604 then removed the blood pressure cuff and returned to the nursing medication cart lying the electric blood pressure monitor on top of the cart without cleaning the cuff and/or monitor.</p> <p>Observation revealed on 11/07/24 at 9:07 A.M. LPN #604 picked up the same electric blood pressure monitor without cleaning the device and entered Resident #13's room to obtain his blood pressure. LPN #604 applied the blood pressure cuff to Resident #13's left arm to obtain his blood pressure. LPN #604 then removed the blood pressure cuff and returned to the nursing medication cart lying the electric blood pressure monitor on top of the cart without cleaning the cuff and/ or monitor.</p> <p>Interview on 11/07/24 at 10:10 A.M. with LPN #604 verified she had not cleaned the blood pressure cuff and/or monitor between taking Resident #14's blood pressure and Resident #13's blood pressure. LPN #604 stated, I forgot.</p> <p>Interview on 11/07/24 at 12:57 P.M. with the DON also verified a blood pressure cuff and/or monitor was to be cleaned between each resident.</p> <p>Review of the facility policy labeled, Equipment and Supplies for administering Medications, dated November 2021, revealed the charge nurse on duty was to ensure equipment related to medication administration was clean and orderly. There was nothing identified specially in the policy regarding cleaning the blood pressure cuff and/or monitor between each resident.</p> <p>3. Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses included emphysema, hemiplegia following cerebral infarction affecting left dominant side, and congestive heart failure.</p> <p>Review of the admission MDS assessment dated [DATE] revealed Resident #35 had intact cognition and was dependent on staff with toileting hygiene. She was frequently incontinent with urine and always incontinent of bowel.</p> <p>Review of the care plan dated 10/29/24 revealed Resident #35 had an activities of daily living performance deficit related to hemiplegia, weakness and difficulty walking. Interventions included offering and assisting with bedpan per resident request.</p> <p>Observation on 11/07/24 at 10:48 A.M. revealed Resident #35 was on the bed pan and had requested Certified Nursing Assistant (CNA) #618 provide toileting hygiene including removing her from the bed pan. Resident #35 requested the surveyor not observe, and her request was honored.</p> <p>(continued on next page)</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>Observation on 11/07/24 at 1:30 P.M. revealed there was a grey bed pan lying on the floor in Resident #35's bathroom under the sink without covering.</p> <p>Interview on 11/07/24 at 1:31 P.M. with CNA #618 verified that the bed pan was Resident #35's and that it was lying on the floor without covering. She was asked how the facility stored bedpans, and she stated usually like that in the bathroom on the floor.</p> <p>Interview on 11/13/24 at 1:00 P.M. with the DON revealed the facility did not have a policy regarding the storage bedpans. She verified bedpans should be maintained in the resident's bathroom but in a bag, not directly on the floor.</p> <p>This deficiency was an incidental finding identified during the complaint investigation.</p>