

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  12/17/2024
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</b></p> <p>Based on medical record review, observation, and staff interview, the facility failed to ensure care plans were updated to include new interventions for falls. This affected two (Residents #1 and #29) of three residents reviewed for falls. The facility census was 41 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including kidney failure, congestive heart failure (CHF), insomnia, muscle weakness and history of stroke.</p> <p>Review of the care plan for Resident #1 dated 10/26/24 revealed the resident was at risk for falls due to an unstable health condition. Interventions included assistance with all transfers and mobility, bed in a low position, call light within reach, and commonly used articles within reach.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 11/01/24 revealed the resident was moderately cognitively impaired and required setup help for eating, and substantial or maximum assistance for oral hygiene, toileting and personal hygiene.</p> <p>Review of the nurses' note for Resident #1 dated 11/07/24 timed at 2:15 A.M. revealed the resident had an unwitnessed fall from bed at 1:30 A.M. The aide notified the nurse Resident #1 was on the floor with both legs bent on the right side. Resident #1 denied hitting his head and had no complaints of pain.</p> <p>Review of the fall review for Resident #1 dated 11/07/24 revealed new interventions to prevent further falls included placing a mattress to the floor in the resident's room and 30-minute safety checks.</p> <p>Review of the fall care plan for Resident #1 revealed the new fall prevention interventions were not added to the resident's care plan.</p> <p>Observation on 12/16/24 at 8:45 A.M. revealed there was no mattress to the floor in Resident #1's room.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/16/24 at 9:49 A.M. with the Director of Nursing (DON) confirmed there was no mattress to the floor of Resident #1's room and the facility had not updated the resident's care to include the mattress to the floor and 30-minute safety checks as recommended by the facility fall review.</p> <p>2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including breast cancer, diabetes, abnormalities in mobility, muscle weakness and history of falling.</p> <p>Review of the physician's orders for Resident #29 revealed an order dated 10/20/23 for non-skid strips to the open side of the resident's bed.</p> <p>Review of the MDS assessment for Resident #29 dated 09/15/24 revealed the resident was cognitively intact and was independent in eating and oral hygiene, required partial to moderate assistance for toileting, and required supervision or touch assistance for showering, dressing and personal hygiene.</p> <p>Review of the care plan for Resident #29 dated 09/15/24 revealed the resident was at risk for falls due to a history of falls, poor safety awareness and unstable health conditions. Interventions included the bed in the lowest position, a sign to remember to call for assistance with transfers, the call light within reach, non-skid socks, assistance with toileting upon rising, after meals at night and as needed, a night light and ensuring commonly used items, such as a walker, were in reach.</p> <p>Review of the nurses' notes for Resident #29 dated 09/19/24 through 12/12/24 revealed documentation of multiple refusals from the resident to wear non-skid socks or to use her call light for assistance.</p> <p>Review of the nurses' note for Resident #29 dated 11/16/24 at 5:39 A.M. revealed the resident had an unwitnessed fall and was found sitting on the floor in her room, at the foot of the bed. Resident #29 said she fell coming out of the bathroom by herself.</p> <p>Review of the fall review for Resident #29 dated 11/16/24 revealed the resident had an unwitnessed fall and was found sitting on the floor in her room, at the foot of the bed. The facility recommended new intervention of adding a tab alarm while in bed.</p> <p>Review of the fall care plan for Resident #29 revealed it was not updated regarding the resident's refusal to wear nonskid socks and to use her call light or with the new interventions of adding a tab alarm while in bed.</p> <p>Interview on 12/16/24 at 8:41 A.M. with the Administrator confirmed the facility had not updated Resident #29's care plan regarding the resident's refusal to use the call light or wear nonskid socks and the use of a bed alarm while in bed.</p> <p>Review of the facility policy titled Comprehensive Care Plans dated 06/08/22 revealed the facility would update resident care plans as needed.</p> <p>Review of the facility policy titled Falls - Clinical Protocol dated 11/30/23 revealed the facility would evaluate and document falls including information related to when and where they happened, and review and revise the care plan as appropriate.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00159960.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45441</p> <p>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure fall prevention interventions were implemented. This affected two (Residents #1 and #29) of three reviewed for falls. The facility census was 41 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including kidney failure, congestive heart failure (CHF), insomnia, muscle weakness and history of stroke.</p> <p>Review of the care plan for Resident #1 dated 10/26/24 revealed the resident was at risk for falls due to an unstable health condition. Interventions included assistance with all transfers and mobility, bed in a low position, call light within reach, and commonly used articles within reach.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 11/01/24 revealed the resident was moderately cognitively impaired and required setup help for eating, and substantial or maximum assistance for oral hygiene, toileting and personal hygiene.</p> <p>Review of the nurses' note for Resident #1 dated 11/07/24 timed at 2:15 A.M. revealed the resident had an unwitnessed fall from bed at 1:30 A.M. The aide notified the nurse Resident #1 was on the floor with both legs bent on the right side. Resident #1 denied hitting his head and had no complaints of pain.</p> <p>Review of the fall review for Resident #1 dated 11/07/24 revealed new interventions to prevent further falls included placing a mattress to the floor in the resident's room and 30-minute safety checks.</p> <p>Review of the fall care plan for Resident #1 revealed the new fall prevention interventions were not added to the resident's care plan.</p> <p>Observation on 12/16/24 at 8:45 A.M. revealed there was no mattress to the floor in Resident #1's room.</p> <p>Interview on 12/16/24 at 9:49 A.M. with the Director of Nursing (DON) confirmed there was no mattress to the floor of Resident #1's room and the facility had not updated the resident's care plan to include the mattress to the floor and 30-minute safety checks as recommended by the facility fall review.</p> <p>2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including breast cancer, diabetes, abnormalities in mobility, muscle weakness and history of falling.</p> <p>Review of the physician's orders for Resident #29 revealed an order dated 10/20/23 for non-skid strips to the floor to the open side of the resident's 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>Review of the quarterly MDS assessment for Resident #29 dated 09/15/24 revealed the resident was cognitively intact and was independent in eating and oral hygiene, required partial to moderate assistance for toileting, and supervision or touch assistance for showering, dressing and personal hygiene.</p> <p>Review of the care plan dated for Resident #29 dated 09/15/24 revealed the resident was at risk for falls due to a history of falls, poor safety awareness and unstable health conditions. Interventions included the bed in the lowest position, a sign to remember to call for assistance with transfers, the call light within reach, non-skid socks, assistance with toileting upon rising, after meals at night and as needed, a night light and ensuring commonly used items, such as a walker, were in reach.</p> <p>Review of the quarterly fall risk assessment for Resident #29 dated 09/18/24 revealed the resident was at high risk for falls.</p> <p>Observation on 12/12/24 at 11:06 A.M. revealed Resident #29 did not have non-skips strips on the floor to the open side of her bed as ordered by the physician on 10/20/23.</p> <p>Interview on 12/12/24 at 11:07 A.M. with Licensed Practical Nurse (LPN) #200 confirmed Resident #29 was ordered to have non-skid strips to the floor of her room to the open side of the bed, but the strips were not in place.</p> <p>Observation on 12/16/24 at 10:02 A.M. revealed Resident #29 was lying in bed, and her walker was under the television, in the middle of the room and out of the resident's reach.</p> <p>Interview on 12/16/24 at 10:03 A.M. with the Administrator confirmed Resident #29 should have her walker within reach to prevent falls. The Administrator confirmed Resident #29's walker was not within reach.</p> <p>Review of the facility policy titled Falls - Clinical Protocol dated 11/30/23 revealed the facility would evaluate and document falls including information related to when and where they happened. Falls would be identified as a witnessed or unwitnessed events. The facility would attempt to define possible causes and review and revise the care plan as appropriate and implement interventions to prevent further falls.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00159960.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</b></p> <p>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure oxygen tubing was changed as ordered. This affected one (Resident #1) of three residents reviewed for oxygen administration. The facility identified three (Residents #1, #7 and #25) who received oxygen. The facility census was 41 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including kidney failure, congestive heart failure (CHF), and history of stroke.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 11/01/24 revealed the resident was moderately cognitively impaired and required setup help for eating, and substantial or maximum assistance for oral hygiene, toileting and personal hygiene.</p> <p>Review of the care plan for Resident #1 dated 10/26/24 revealed the resident had an ineffective breathing patterns as a result of shortness of breath. Interventions included administering medications and respiratory treatments as ordered, administering oxygen per physician's order and monitoring for signs of shortness of breath.</p> <p>Review of the physician's orders for Resident #1 revealed an order dated 11/20/24 to change oxygen tubing and clean the filter every week.</p> <p>Observation on 12/12/24 at 10:56 A.M. of Resident #1 revealed the oxygen tubing in use was dated 11/21/24.</p> <p>Interview on 12/12/24 at 10:57 A.M. with Registered Nurse (RN) #201 confirmed Resident #1's oxygen tubing was dated 11/21/24. RN #201 confirmed the resident's oxygen tubing should be changed weekly.</p> <p>Review of the facility policy titled Oxygen Administration dated 11/30/23 revealed oxygen would be administered, and tubing, nasal cannulas, and humidifiers would be changed according to the physician's orders.</p> <p>This deficiency is a recite to the survey dated 11/14/24.</p>