

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  09/08/2025
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)		
F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.  (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interviews, and facility policy review, the facility failed to ensure documentation for medication administration was completed timely. This affected one resident (#10) out of three resident records reviewed for medication administration. The facility census was 38. Findings include: Review of the medical record for Resident #10 revealed an admission date of 03/13/25. Diagnoses included but were not limited to osteomyelitis of vertebra sacral and sacrococcygeal region, chronic osteomyelitis, injury at T7 - T12 thoracic spinal cord, sepsis, and paraplegia. Review of the quarterly MDS dated [DATE] revealed Resident #10 had intact cognition. Review of Resident #10's Medication Administration Record (MAR) in the electronic medical record for July 2025 revealed Cymbalta DR Particles 30 milligram (mg) give 1 capsule daily had blank spot not signed for (indicating the medication had not been received) for 7/16/25. Melatonin 3 mg give 1 tablet daily had a blank spot for 7/10/25 and 7/16/25. Bactrim Double Strength, (DS) 800-180 mg 1 tablet every 12 hours was not signed as being administered on 7/16/25. Ferrous Sulfate 325 mg 1 tablet two times a day (BID) was not signed as administered on 7/16/25. Glycolax powder give 17 gram BID was not signed as administered on 7/16/25. Omeprazole 20 mg give BID was not signed as administered on 7/16/25. Proheal liquid protein 30 milliliter (ml) BID was not signed as administered on 7/16/25. Baclofen 10 mg three times a day (TID) did not have the evening dose signed as administered, and Buprenorphine HCl-Naloxone HCl sublingual give 8-2 mg sublingually TID did not have the evening dose signed as administered. Review of Resident #10's printed MAR dated July 2025, provided by the facility, revealed the corresponding blank spaces identified in Resident #10's electronic medical record had manual initials written into the dates on which there were blank spaces. Review of Resident #10's MAR in the electronic medical record for August 2025 revealed Ceftazidime one gram (gm) intravenous every 8 hours had a blank space indicating the medication had not been administered on 08/04/25 or 08/06/25. Buprenorphine HCl-Naloxone HCl sublingual give 8-2 mg sublingually TID was not signed as administered on 08/04/25, 08/06/25, 08/13/25, 08/15/25, 08/23/25, and 08/27/25. Baclofen 10 mg TID was not signed as administered on 08/04/25, 08/06/25, 08/13/25, 08/15/25, 08/23/25, 08/24/25, or 08/27/25. Senna 8.6 mg give 1 tablet daily was not recorded as administered on 08/06/25, 08/23/25, or 08/24/25. Ascorbic Acid 500 mg 1 tablet daily was not recorded as administered on 08/06/25, 08/23/25, and 08/24/25. Glycolax powder give 17 gram BID was not recorded as administered on 08/06/25, 08/13/25, 08/23/25, and 08/24/25. Lactobacillus give 1 tablet daily was not recorded as administered on 08/06/25, 08/23/25, or 08/24/25. Ferrous Sulfate 325 mg give 1 tablet BID was not recorded as administered on 08/06/25, 08/13/25, 08/23/25, or 08/24/25. Folic Acid 1 mg give 1 mg was not recorded as administered on 08/06/25, 08/23/25, or 08/24/25. Multivitamin 1 tablet daily was not recorded as administered on 08/06/25, 08/23/25, or 08/24/25. Docusate Sodium 100 mg give one capsule daily was not recorded as administered on 08/13/25. Cymbalta DR 30 mg one capsule daily was not recorded as administered on 08/13/25. Review of the time stamped MARS for Resident #10 revealed the corresponding blank spaces identified in Resident #10's electronic medical record was electronically signed on 09/04/25. Interview on 09/04/25 at 12:05 P.M. with Assistant Director of Nursing (ADON) #100 confirmed medications are to be signed off immediately after they are administered to residents and are to be recorded in each resident's electronic medical record. ADON #100 confirmed Resident #10 had many blank spots where the nurse was to initial as given. Interview on 09/04/25 at 2:43 P.M. with Regional Nurse #200 revealed for Resident #10, she manually signed off the July 2025 MARS for the 3 staff after she called them and they reported they gave the medications to Resident #10 and forgot to sign the MARS off. Interview on 09/08/25 at 9:45 A.M. with the Director of Nursing (DON) revealed on 09/04/25 she, ADON #100, or Regional Nurse #200 checked with staff in the building or via phone to verify if medications had been administered to Resident #10 for the instances where the spaces were blank on the July 2025 and August 2025 MARs. The DON confirmed the staff reported they administered the medication but forgot to sign the administrations off on the corresponding MAR. Interview on 09/08/25 at 9:56 A.M. with Licensed Practical Nurse (LPN) #130 revealed she was approached by DON on 09/04/25 regarding not signing off medications. LPN #130 reported she gave the medications to Resident #10, but forgot to sign the medications off as administered. LPN #130 reported she was at work and signed them off electronically on 09/04/25. Interview on 09/08/25 at 10:05 A.M. with LPN #135 revealed she was approached by DON on 09/04/25 regarding not signing off medications. LPN #135 reported she gave the medications to Resident</p>		