STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365006	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Plaza	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of facility policy the facility failed to ensure Resident #23's open area to the right inner heel was identified and treated timely and failed to ensure weekly skin assessments were completed as ordered. This affected one resident (Resident #23) out of three residents reviewed for wounds. The facility census was 43. Findings include: Review of Resident #23 medical record revealed an admitted [DATE] and diagnoses included anoxic brain damage, benign intracranial hypertension, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Review of Resident #23's physician orders dated 03/15/24 revealed weekly C1 Health Documentation to be completed one time a day, every Friday for routine care. Review of Resident #23's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 had severe cognitive impairment. Resident #23 had no impairment of the upper extremities and impairment on both sides of the lower extremities. Resident #23 used a wheelchair and was dependent for toileting and personal hygiene, dressing, bathing and putting on and taking off footwear. Resident #23 was always incontinent of urine and bowel. Review of Resident #23's care plan dated 04/29/24 included Resident #23 had the potential for alteration in skin integrity related to immobility, incontinence, generalized weakness and other diagnoses. Resident #23 would not develop skin breakdown through the review date. Interventions included braden score quarterly and as needed; transfer bar to bed to enable turning and repositioning and encourage Resident #23 to assist in turning and repositioning. Further review did not reveal an intervention for weekly skin assessments or reporting abnormalities to the physician. Review of Resident #23's C1 Health Documentation and progress notes revealed no evidence of the C1 Health Documentation assessment of the residents skin assessment. Review of Resident #23's C1 Health Documentation dated 05/09/25 revealed new skin issues were not identified. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #23's Treatment Administration Record (TAR) dated 05/02/25 and 05/09/25 revealed there was a check mark for weekly C1 Health Documentation assessment to be completed every Friday indicating the assessment was completed. Review of Resident #23's C1 Health Documentation and progress notes revealed no evidence of the C1 Health Documentation assessment of the residents skin assessment. Review of Resident #23's C1 Health Documentation dated 05/09/25 revealed new skin issues were not identified. Review of Resident #23's shower sheets dated 05/04/25, 05/07/25 and 05/11/25 revealed there were no new areas noted. Observation on 05/14/25 at 10:20 A.M. of Resident #23 revealed Certified Nursing Assistant #336 was providing urinary incontinence care. During incontinence care an area to Resident #23's right inner foot was noted. The area was about a one inch by one inch square, the wound bed was dark reddish-brown and looked a little lumpy with clear tissue covering it. CNA #336 stated the area was not a new area, he had seen it before, but if it was new he would tell the nurse. CNA #336 stated the area looked older and he thought the nurses were aware Resident #23 had the open area on her right inner foot and he did not tell a nurse about it. Interview on 05/14/25 at 10:26 A.M. with Licensed Practical Nurse (LPN) #352 confirmed Resident #23 had an open area on the inner right foot. LPN #352 stated she was not sure about the area on Resident #23's foot, it looked old, like it had been there awhile, and walked out of the room and did not notify the nurse assigned to care for Resident #23 about the open area. Interview on 05/14/25 at 11:49 A.M. of LPN #339, LPN #252 and the Director of Nursing (DON) revealed LPN #339 and the DON were not aware Resident #23 had an open area on her right inner foot. LPN #339 was assigned to care for Resident #23 and stated no one told her about Resident #23's open area including CNA #336 and LPN #252. Observation with the DON and LPN #339 on 05/14/25 at 11:49 A.M. of Resident #23's right foot confirmed there was an open area and the wound bed was dark reddish-brown, looked a little lumpy and had a clear coating of tissue covering it. The DON asked Resident #23 how she got the open area and Resident #23 stated she scratched the area. Interview on 05/14/25 at 4:38 P.M. with the DON revealed Clinical Serviec Manager (CSM) #359 went with her to observe Resident #23's foot and Resident #23 was scratching her foot with a tissue and stated her foot itched. The DON stated a treatment was put in place. Observation on 05/15/25 at 9:59 A.M. of Resident #23's open area to the inner heel of the right foot with Wound Nurse Practitioner (WNP) #360 and Assistant Director of Nursing (ADON) #350 revealed WNP #360 stated the area looked like an abrasion. The area was open and the wound bed was reddish-pink. Resident #23 stated the area itched and WNP #360 stated Resident #23's skin definitely needed lotion. The area measured length 2.5 cm, width 3.0 cm and depth was less than 0.1 cm, was 100 percent granulation, with scant drainage. WNP #360 stated the area was a little macerated on the edges and the treatment would include xeroform every other day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #23's wound note dated 05/15/25 at 11:52 A.M. and written by WNP #360 included Resident #23 had a new area on the right medial foot. The wound was an abrasion, 100 percent granulation tissue to the wound bed with scant clear drainage. The periwound had mild maceration. No signs of infection. Plan was to cleanse the wound, pat dry, apply xeroform, cover with clean dry dressing every other day and as needed. Hydroxyzine 25 mg every six house as needed for 14 days for itching. Interview on 05/15/25 at 3:03 P.M. of the Administrator and CSM #359 revealed Resident #23's weekly skin documentation could be either a C1 Health Documentation assessment or a skilled note regarding skin written in the progress notes. Interview on 05/15/25 at 3:50 P.M. of the DON confirmed Resident #23's C1 Health Documentation assessment or a skilled progress note regarding skin assessment was not completed on 05/02/25 but Resident #23's shower sheets on 05/04/25, 05/07/25 and 05/11/25 did not have new areas on skin noted. Review of the facility policy titled Skin Care Management undated included Residents admitted to the facility would be assessed for potential risk of skin breakdown utilizing the Braden Scale. Based on the assessment a plan of care would be developed, Resident's skin would be visualized with care daily.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of facility policy the facility failed to ensure Resident #8 had comprehensive assessments of her dialysis access site post dialysis treatments. This affected one resident (Resident #8) of one resident reviewed for dialysis. Findings include: Review of Resident #8's medical record revealed an admitted [DATE] and diagnoses included type two diabetes mellitus with diabetic neuropathy, paroxysmal atrial fibrillation, supraventicular tachycardia, and dependence on renal dialysis. Review of Resident #8's Dialysis Communication Forms dated 02/28/25 through 05/09/25 did not reveal evidence of immediate monitoring and documentation of the status of the Resident #8's access site upon return from the dialysis treatment to observe for bleeding or other complications. Review of Resident #8's care plan dated 02/13/25 included Resident #8 had renal failure related to ESRD (End Stage Renal Disease) with hemodialysis. Resident #8 would be kept comfortable in the presence of changing symptoms related to renal failure. Interventions included to notify the physician if Resident #8 presented with shunt problems including no bruit or thrill, bleeding, signs and symptoms of infection at port site. Review of Resident #8's physician orders dated 04/05/25 at 3:20 P.M. revealed Dialysis, complete and lock the LOA (leave of absence)/Dialysis Assessment and Dialysis Communication forms before and after dialysis. Print and send with patient to dialysis, one time a day every Monday, Wednesday and Friday. Further review revealed dialysis shunt assessment every shift, assess bruit, thrill and signs of infection, document abnormal findings, and report to dialysis center and the Nephrologist. If bleeding noted, apply pressure for 15 minutes, if bleeding continues, call 911 and notify the doctor. Review of Resident #8's physician orders dated 04/07/25 at 11:13 A.M. revealed Dialysis every Monday, Wednesday and Friday at 12:25 P.M. to 3:40 P.M. at a local Dialysis Center. Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact. Resident #8 had no impairment of her upper and lower extremities. Resident #8 used a wheelchair. Resident #8 required substantial to maximal assistance for toileting hygiene and bathing and partial to moderate assistance with dressing and personal hygiene. Interview on 05/13/25 at 2:27 P.M. of the Director of Nursing (DON) revealed Resident #8 rescheduled her dialysis for today. The DON stated the Dialysis Communication Form was completed by the nurses and sent with Resident #8 to dialysis, and when Resident #8 returned the Communication Form was placed in Resident #8's dialysis binder. Observation on 05/13/25 at 2:27 P.M. revealed Resident #8 was sitting in a wheelchair by the main entrance. Resident #8 stated she rescheduled her dialysis for today (Tuesday) because she was tired and not feeling well yesterday when it was scheduled. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 05/13/25 at 3:26 A.M. of the DON and Clinical Service Manager (CSM) #359 confirmed Resident #8's Dialysis Communication Form included documentation before dialysis and during dialysis, but there was no documentation on the form immediately after Resident #8 returned to the facility including if there was bleeding or other complications from the dialysis access site. The DON stated the nurses were checking Resident #8's shunt sometime during the shift after she returned from dialysis, and that covered what they need to evaluate when Resident #8 returned to the facility. The DON indicated there was an order to check Resident #8's dialysis shunt every shift and assess bruit, thrill and signs of infection. The DON confirmed there was no evidence Resident #8's dialysis shunt was evaluated immediately upon her return to the facility from dialysis for bleeding and other complications. Interview on 05/13/25 at 4:35 P.M. of the Administrator confirmed there was no evidence of immediate monitoring and documentation of the status of the Resident #8's access site upon return from the dialysis treatment to observe for bleeding or other complications. Review of the facility policy titled Dialysis Communication undated included nursing would complete the Dialysis Communication Form each time the resident had dialysis. The Dialysis Communication Form would be completed via the Residents electronic record or in the Residents hard chart.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, record review and interview, the facility failed to ensure Resident #4 was free from significant medication error. This affected one resident (Resident #4) of one resident reviewed for significant medication administration. The facility census was 43. Findings include: Review of Resident #4's medical record revealed an admitted [DATE] with diagnoses including paroxysmal atrial fibrillation, pneumonia and chronic diastolic (congestive) heart failure. Review of the physician's orders revealed the resident had an order for Flecainide Acetate 50 milligrams twice a day. Flecainide acetate, sold under the brand name Tambocor is an antiarrhythmic drug used to treat certain types of abnormal heart rhythms. Review of Resident #4's care plan dated 01/12/25 included Resident #4 was at risk for decreased cardiac output and abnormal lab values related to congestive heart failure (CHF), shortness of breath, myocardial infarction, history of vascular bypass and other diagnoses. The goal developed was for Resident #4 to be kept comfortable in the presence of cardiac symptoms. Interventions included to follow up with Resident #4's cardiologist with any change in condition; give medications per physician order; monitor for signs and symptoms of heart failure, dyspnea, shortness of breath, change in mental status, complaints of chest pain and increased edema. Review of Resident #4's Medication Administration Audit Report revealed Flecainide Acetate oral tablet 50 mg was due on 03/11/25 at 8:00 P.M. However, the medication was not administered. Review of Resident #4's On Call Nurse Practitioner Note dated 03/11/25 at 11:30 P.M. included Flecainide Acetate oral tablet 50 mg was not available the last two nights and the pharmacy was not called to find out why. Heart rate 68. The treatment plan was to call the pharmacy and check on Resident #4's medication and call back with an update (may need PA). Cardiology needed updated. The note indicated Resident #4 was treated in house. The note did not clarify or provide any additional information as to what treated in house meant. Review of Resident #4's late entry progress note dated 03/12/25 at 9:59 P.M. revealed on 03/11/25 at 9:58 P. M. Resident #4's medications could not be found. Resident #4's physician services were notified. Pharmacy was contacted and stated the medication was sent to the facility on [DATE] and a replacement card could be sent with prior payment. Resident #4's medication could not be reordered by this nurse, the supervisor was notified, and the nurse would continue to try and locate the medication. Review of Resident #4's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #4 was cognitively intact. Resident #4 used a walker and required partial to moderate staff assistance with lower body dressing and bathing and required supervision or touching assistance for toileting hygiene. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 05/12/25 at 12:24 P.M. of Resident #4 revealed she was sitting in a chair by her bed. At the time of the observation, interview with Resident #4 revealed she had a heart attack and pneumonia when she was at a different facility and came to live at this facility in 01/2025. Resident #4 stated she went back to the hospital in 03/2025 because I had something wrong with my lungs. Resident #4 could not remember additional details of her hospital admission. Interview on 05/14/25 at 2:42 P.M. of LPN #328 revealed she remembered looking for Resident #4's Flecainide Acetate, could not find it in the medication cart and was unable to administer it to her. LPN #328 stated she did not administer the Flecainide Acetate to Resident #4 but could not remember what day(s) she was unable to administer it. LPN #328 stated she could not remember if she called Resident #4's cardiology service, but stated she probably called the resident's primary care physician but was not sure. LPN #328 stated Resident #4's Flecainide Acetate was eventually found in a really inconspicuous place in the med cart drawer. LPN #328 indicated she did not remember Resident #4 having any issues like chest pain, irregular heart rate as a result of the missed dose. Interview on 05/14/25 at 3:29 P.M. with Nurse Practitioner (NP) #400 confirmed Resident #4 had an order for Flecainide Acetate. The NP revealed it was an important medication and should be taken every 12 hours, two times a day but felt that missing one dose would be OK. If additional doses were missed, it could possibly cause chest pain and irregular heart rate. Interview on 05/15/25 at 9:19 A.M. with the Director of Nursing (DON) revealed the facility did not need to follow up with cardiology because the medication was found on 03/12/25. Interview on 05/15/25 at 10:36 A.M. with the DON and Administrator revealed they counted the doses given from the card and determined Resident #4 had missed a dose of Flecainide (as noted above on 03/11/25), they indicated the NP note was incorrect (reflecting two doses were missed). The medication was not administered as ordered on 03/11/25 on second shift.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure a sanitary kitchen. This had the potential to affect all 43 of 43 residents who resided in the facility and received meals. Findings include: Observation on 05/12/25 at 8:05 A.M. of the soap dispenser with Dietary Manager #360 and Dietary Aide #306 revealed it was located above the hand washing station and it did not have soap in it. Dietary Aide #306 stated she would let housekeeping know the soap dispenser needed refilled. Observation on 05/12/25 at 8:07 A.M. of the facility kitchen revealed the floor had dried food bits and multiple dried, dark brown and clear, sticky fluid spills. Observation of metal counters, metal meal carts, metal shelves, doors and sides to the freezer, cooler, and oven revealed they were covered with whitish colored drip marks and what appeared to be dried food and liquid smudges. All the surfaces appeared grubby. Interview on 05/12/25 at 8:07 A.M. of Dietary Aide (DA) #306 and Dietary Manager (DM) #360 confirmed the floor had dried food bits and dried liquid spill marks, the metal counters, doors and sides to the freezer, cooler, and oven revealed they were covered with whitish colored drip marks and what appeared to be dried food and liquid smudges. DA #306 confirmed the surfaces looked grubby, she just arrived for work and could tell no one yesterday did any cleaning. DA #306 stated the staff were young and needed education about cleaning. DM #360 stated he just started working for the facility six days ago and he was trying to get the kitchen in order. DM #360 confirmed the kitchen was not clean, he did not work yesterday and would make sure it was cleaned today. Review of the facility policy titled Food Preparation and Storage undated included the kitchen would be kept neat and orderly, the kitchen surfaces and equipment would be cleaned and sanitized as appropriate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure appropriate infection control practices were implemented during Resident #10's medication administration and Resident #23's incontinence care. This affected one resident (Resident #10) of five residents reviewed for medication administration and one resident (Resident #23) of one resident reviewed for incontinence care. Findings include: 1. Review of Resident #10's medical record revealed an admitted organ-limited amyloidosis, vascular dementia, and acute kidney failure. Observation on 05/14/25 at 8:02 A.M. of Licensed Practical Nurse (LPN) #339 revealed she prepared Resident #10's medications, placed them in a small plastic cup, and walked into his room to administer the medications to him. Resident #10 was sitting on the edge of his bed, LPN #339 handed him the plastic cup and a cup of water and as Resident #10 was putting the pills in his mouth he dropped two of the pills on the floor. LPN #339 picked the two medications off the floor with her bare hands, discarded the pills in a container hanging on the side of the medication cart, and opened the medication cart drawer to find Resident #10's medications and replace the dropped pills. LPN #339 did not wash her hands or use hand sanitizer after picking the pills off the floor and discarding them. LPN #339 did not wash her hands or use hand sanitizer before opening the medication cart drawer to find the replacement pills. LPN #339 administered the replacement pills to Resident #10 and did not use hand sanitizer or wash her hands before administering Resident #10 the medications. Interview on 05/14/25 at 8:05 A.M. of LPN #339 confirmed she did not wash her hands or use hand sanitizer after she picked Resident #10's pills off the floor and discarded them. LPN #339 confirmed she did not wash her hands or use hand sanitizer before opening the medication cart and preparing Resident #10's replacement medications, or before administering the medications to Resident #10. 2. Review of Resident #23 medical record revealed an admitted [DATE] and diagnoses included anoxic brain damage, benign intracranial hypertension, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Review of Resident #23's care plan dated 04/29/24 included Resident #23 had the potential for alteration in skin integrity related to immobility, incontinence, generalized weakness and other diagnoses. Resident #23 would not develop skin breakdown through the review date. Interventions included braden score quarterly and as needed; transfer bar to bed to enable turning and repositioning and encourage Resident #23 to assist in turning and repositioning. Further review did not reveal an intervention for weekly skin assessments or reporting abnormalities to the physician. Review of Resident #23's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 had severe cognitive impairment. Resident #23 had no impairment of the upper extremities and impairment on both sides of the lower extremities. Resident #23 used a wheelchair and was dependent for toileting and personal hygiene, dressing, bathing and putting on and taking off footwear. Resident #23 was always incontinent of urine and bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/14/25 at 10:20 A.M. of Resident #23 revealed Certified Nursing Assistant (CNA) #336 was providing incontinence care. CNA #336 threw Resident #23's soiled bed linens, towels, and urine saturated incontinence brief directly on the floor. CNA #336 did not place the soiled items in a plastic bag or appropriate container, but left them lying on the floor during the incontinence care. Interview on 05/14/25 at 10:20 A.M. of CNA #336 confirmed he threw Resident #23's soiled bed linens, towels and her urine soaked incontinence brief on the floor without using a proper container. CNA #336 stated he should not have done that because it could cause cross contamination. Review of the facility policy titled Handwashing-Hand Hygiene undated included all personnel should be trained on the importance of hand hygiene in preventing the transmission of healthcare-associated infection. Hand hygiene was done including before or after direct resident contact, before preparing or handling medications, after handling soiled or used linens, supplies, equipment or utensils.