

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Daughters of Miriam Center for Nursing & Rehabil		STREET ADDRESS, CITY, STATE, ZIP CODE  One David N Myers Parkway Beachwood, OH 44122	

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 0729</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808</b></p> <p>Based on review of staff schedules, review of the nurse aide registry, review of the employment verification letters, and staff interview, the facility failed to provide employment verification for State tested Nurse Aides (STNAs) in a timely manner. This had the potential to affect all 150 residents in the facility.</p> <p>Findings include:</p> <p>Review of the nurse aide registry for State tested Nurse Aide (STNA) #403 revealed no evidence of employment had been provided in a 24 month period, which resulted in their status on the nurse aide registry being changed to expired effective [DATE]. In addition, review of the nurse aide registry for STNA #400 revealed no evidence of employment had been provided in a 24 month period, which resulted in their status on the nurse aide registry being changed to expired effective [DATE].</p> <p>On [DATE] at 8:11 A.M., an interview with the Administrator confirmed the facility had not submitted employment verifications for STNAs #400 and #403. The Administrator further stated letters were not sent to the nurse aide registry to verify their employment status until [DATE].</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00156057.</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 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>44808</p> <p>Based on observation and staff interview, the facility failed to have daily staffing information posted in a prominent place on 09/05/24. This had the potential to affect all 150 residents in the facility.</p> <p>Findings include:</p> <p>On 09/05/24 at 10:45 A.M., observation of the facility revealed there was no daily staffing information available for that day.</p> <p>On 09/05/24 at 10:53 A.M., interview with the Administrator stated the daily staffing information should be in a binder at the front desk. The Administrator verified the daily staffing information for 09/05/24 was not available at the front desk and was currently being printed.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44808</p> <p>Based on observation, staff interview, and review of facility policy, the facility failed to ensure medications were stored in a secure location at all times. This had the potential to affect 40 residents (#1, #6, #7, #10, #12, #13, #15, #16, #19, #22, #24, #27, #30, #36, #37, #46, #51, #60, #62, #65, #67, #69, #77, #79, #85, #88, #91, #99, #103, #105, #106, #107, #110, #118, #119, #123, #130, #132, #147, and #148) residing on [NAME] three unit. The facility census was 150.</p> <p>Findings include:</p> <p>On 09/09/24 at 10:05 A.M., an observation of the [NAME] three unit revealed a medication cart was unattended and unlocked in the hallway between Resident #7's room and Resident #107's room. At the time of observation, there was one resident ambulating in the hallway with a walker and one family member present in the hallway.</p> <p>On 09/09/24 at 10:10 A.M., upon returning to the medication cart, Licensed Practical Nurse (LPN) #700 confirmed the medication cart was left unattended and unlocked in the hallway. LPN #700 further stated the medication cart should have been locked.</p> <p>Review of the facility census revealed 40 residents (#1, #6, #7, #10, #12, #13, #15, #16, #19, #22, #24, #27, #30, #36, #37, #46, #51, #60, #62, #65, #67, #69, #77, #79, #85, #88, #91, #99, #103, #105, #106, #107, #110, #118, #119, #123, #130, #132, #147, and #148) resided on [NAME] three unit.</p> <p>Review of the facility's policy titled Medication Administration/Treatment, dated 10/18, indicated the nurse would cover all patient information to protect privacy and lock the medication cart before leaving the cart to pass the medication.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>44808</p> <p>Based on resident interview, review of the facility menu production sheets, observation of lunch tray line, observation of a test tray, and staff interview, the facility failed to provide all food items and portion sizes that were indicated on the menu production sheets. This had the potential to affect all residents (except Residents #9, #13, #48, #54, and #64, who were identified by the facility as having orders for nothing by mouth) who received food from the kitchen. The facility census was 150.</p> <p>Findings include:</p> <p>Confidential information provided to the State agency revealed concerns that residents were only receiving half the amount of food that was supposed to be on their trays at meals.</p> <p>On 09/05/24 at 10:58 A.M., an interview with a resident's family (who wished to remain anonymous) stated the food was awful and items served did not always match what was supposed to be served.</p> <p>On 09/10/24 at 12:00 P.M., observation of the lunch tray line revealed resident trays consisted of one soft beef taco, half cup of rice, half cup of corn, and half cup of fruit. During the tray line observation, it was noted the tray tickets indicated the following were to be provided for regular meals: two soft beef tacos, half cup of rice, half cup of corn, and one piece of cornbread. There was no fruit on the tray tickets and no cornbread was served. An interview at the time of observation with Dietary Manager (DM) #602 confirmed the contents of resident trays.</p> <p>On 09/10/24 at 12:24 P.M., observation of a test tray revealed there was one soft beef taco, half cup of rice, half cup of corn, and half cup of fruit. There was no cornbread. An interview at the time of observation with DM #602 confirmed the contents of the test tray and stated there was no cornbread due to a vendor issue.</p> <p>Review of the menu production sheets for 09/10/24 indicated the following portions were to be served: two each soft beef taco, half cup of rice, half cup of corn, and one piece of cornbread. There was no indication of the number of ounces that made up each taco or the size of the taco, it simply indicated two tacos would be served.</p> <p>On 09/10/24 at 1:56 P.M., an interview with Registered Dietitian (RD) #572 confirmed only one taco was served to each resident because they were large tacos with four ounces of meat, which she stated met the protein requirement. RD #572 also confirmed the menu production sheet indicated two tacos was a serving size. In addition, RD #572 stated cornbread was supposed to be the dessert and the residents did not like that, so fruit was substituted for the cornbread and that substitution was not reflected on the menu production sheet or the resident tray tickets.</p> <p>On 09/10/24 at 2:28 P.M., an interview with the Administrator and RD #572 were adamant that it did not matter what the portion size on the menu production sheet was because they served a four ounce serving of protein which was sufficient. RD #572 confirmed the menu production sheet did not specify the size of the taco or the number of ounces of protein.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 09/10/24 at 3:30 P.M., an interview with Resident #92 stated they did not receive the planned lunch meal that day.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157273.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35768</p> <p>Based on record review, observations, and interview the facility failed to maintain standard infection control protocol when administrating medications. This affected one (Resident #137) of one resident reviewed for medication administration.</p> <p>Findings include:</p> <p>Review of medical record for Resident #137 revealed an admitted [DATE]. Diagnoses included acute kidney failure, spastic quadriplegic cerebral palsy, and neuromuscular dysfunction of the bladder. The resident had impaired cognition.</p> <p>A random observation on 09/09/24 at 9:31 A.M. revealed Licensed Practical Nurse (LPN) # 515 administering medications for Resident #137. LPN #515 placed three of 13 medications from medication cards into her bare hand.</p> <p>Interview during observations LPN#515 stated medications should be placed into the medication cup, not a bare hand.</p> <p>Review of the facility policy titled Administering Oral Medications, dated 2010 revealed staff were directed not to touch medications with their hands and to place all medications into a medication cup.</p>