

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 11/20/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, record review, facility policy review and interview the facility failed to ensure Resident #146, who was dependent on staff assistance for activities of daily living (ADL), received adequate and proper assistance for dressing, personal hygiene, and incontinence care. This affected one resident (#146) of three residents reviewed for ADL. The facility census was 166.</p> <p>Findings include:</p> <p>Review of Resident #146's medical record revealed an admitted [DATE] and a reentry date of 01/26/24. Resident #146's diagnoses included bradycardia, type two diabetes mellitus, vascular dementia, moderate, with psychotic disturbance, and Alzheimer's disease.</p> <p>Review of Resident #146's care plan dated 01/22/24 included Resident #146 had an activity of daily living (ADL) self-care performance deficit related to urinary tract infection, Alzheimer's disease, bradycardia and incontinence. The goal developed was for Resident #146 to maintain, improve current level of function through the review date. Interventions included Resident #146 required the staff assistance of one person for transfers.</p> <p>Review of Resident #146's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #146 was rarely, never understood and dependent (on staff) for bathing, toileting hygiene, and putting on and taking off footwear. Resident #146 required substantial to maximal assistance with upper and lower body dressing, for chair, bed-to-chair transfer and sitting to standing. Resident #46 was always incontinent of urine and bowel.</p> <p>Review of Resident #146's care plan dated 11/14/24 included Resident #146 had a urinary tract infection. The goal developed was for Resident #146's urinary tract infection to be resolved without complications by the review date. Interventions included to check Resident #146 at least every two hours for incontinence and wash, rinse and dry soiled areas. Resident #146 had bladder incontinence related to Alzheimer's disease, weakness, impaired mobility. The goal developed was for Resident #146 to remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included to provide peri-care after each episode of incontinence.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 11/18/24 at 8:03 A.M. of Resident #146 with Certified Nursing Assistant (CNA) #400 revealed Resident #146 was sitting in a wheelchair in the hall of the nursing unit he resided on. Resident #146 was not wearing socks, had one shoe on his bare right foot, no show on his left foot, the shoelaces of the shoe on the right foot were not tied and were dragging on the floor. Resident #146's bare left foot was resting directly on the floor and a Band-Aid could be seen on Resident #146's left toe. Resident #146 had black athletic pants on and was wearing an incontinence brief which was observed to be full of urine with the fullness observed even with the athletic pants covering the incontinence brief. CNA #400 stated the night shift aide told her Resident #146 needed his incontinence brief changed. Resident #146's black athletic pants were covered in what appeared to be dried food and drink stains. CNA #400 confirmed Resident #146's pants were dirty, he did not have socks on, only one shoe, and the shoelaces were dragging on the floor. CNA #400 also confirmed Resident #146's incontinence brief was full of urine and needed changed. CNA #400 pushed Resident #146's wheelchair into the common area shower room and bathroom and attempted to stand him up and transfer him to the toilet, but Resident #146 was unable to assist with the transfer and CNA #400 left the bathroom to find another staff member to assist her. CNA #400 came back to the bathroom with Licensed Practical Nurse (LPN) #401. LPN #401 observed Resident #146 only had one shoe on, and his bare left foot was resting on the bathroom floor, and left the bathroom to find his other shoe before providing incontinence care. LPN #401 entered the bathroom and stated she could not find Resident #146's other shoe, but brought non-skid socks and put them on Resident #146's feet. LPN #401 and CNA #400 transferred Resident #146 to the toilet with great difficulty. Resident #146 was unable to use his legs to assist with the transfer and CNA #400 and LPN #401 had great difficulty transferring him to the toilet. Resident #146's pants were removed and CNA #400 identified and confirmed the entire back of his pants was soaked with urine, and the incontinence brief was soaked with urine. CNA #400 and LPN #401 assisted Resident #146 to stand up and CNA #400 provided incontinence care. CNA #400 washed Resident #146's buttocks and anal area using a wash cloth and when she was finished with the buttocks and anal area she folded the wash cloth and used the same wash cloth to cleanse Resident #146's perineal area. After folding the wash cloth CNA #400 proceeded to wash Resident #146's perineal area, and cleaned Resident #146's penis last with the soiled wash cloth used for the buttock and anal area. CNA #400 picked up a towel, wet one end of the towel with water, and used the end of the towel to rinse Resident #146's buttocks, penis and perineal area and used the dry end to dry his buttocks, penis and perineal area. CNA #400 confirmed she used the same wash cloth and washed Resident #146's buttocks and anal area before she cleaned his perineal area and penis. CNA #400 stated she only had one wash cloth, and she should have washed his perineal area and penis before washing Resident #146's buttocks and anal area. After finishing Resident #146's incontinence care, CNA #400 and LPN #401 assisted Resident #146 back to the wheelchair without wiping the urine off the wheelchair seat cushion with disinfectant cloths. CNA #400 and LPN #401 confirmed the cushion was not wiped with disinfectant cloths and it should have been. CNA #400 and LPN #401 were assisting Resident #146 out of the bathroom and when asked if they helped Resident #146 wash his hands after sitting on the toilet and receiving incontinence care they confirmed they did not help him wash his hands and pushed him back to the sink and assisted him to wash his hands. Further observation revealed Resident #146's fingernails were about a half inch long. LPN #401 confirmed the length of Resident #146's fingernails and stated they should have been trimmed on his shower day. CNA #400 and LPN #401 confirmed they had a difficult time transferring Resident #146 on and off the toilet and CNA #400 stated Resident #146 might need a sit-to-stand or mechanical lift.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/18/24 at 10:30 A.M. of the Director of Nursing (DON) confirmed CNA #400 and LPN #401 told her Resident #146's incontinence care was not done properly. The DON confirmed she was notified Resident #146's transfer to the toilet was difficult and stated sometimes Resident #146 could help with transfers more than other times.</p> <p>Review of Resident #146's medical record revealed a care plan revision, dated 11/18/24 indicating Resident #146 required staff assistance of one to two persons for transfers. Resident #146's care plan was revised on 11/19/24 and included Resident #146 required the use of a stand up lift with two staff.</p> <p>Review of the facility policy titled Perineal Care revised 08/2009 included the purposes of the procedure were to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Review the resident's care plan to assess for special needs of the resident. After assembling supplies for a male resident wet washcloth and apply soap or skin cleansing agent and wash the perineal area starting with the urethra and working outward, continue to wash the perineal area including the penis, scrotum, and inner thighs. Thoroughly rinse the perineal area in the same order using fresh water and a clean washcloth. Gently dry the perineum using the same sequence. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus and the buttocks, dry area thoroughly. Promptly respond to a resident's request for toileting assistance.</p> <p>Review of the facility policy titled Activities of Daily Living (ADL), Supporting revised 03/2018 included residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene, mobility, elimination (toileting), dining and communication. A resident's ability to perform ADLs would be measured using clinical tools including the MDS.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159838.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, record review, facility policy review and interview, the facility failed to implement adequate and necessary interventions to address Resident #146's constipation through implementation of the facility bowel protocol. This affected one resident (#146) of three residents reviewed for constipation.</p> <p>Findings include:</p> <p>Review of Resident #146's medical record revealed an admitted [DATE] and a reentry date of 01/26/24. Resident #146's diagnoses included bradycardia, type two diabetes mellitus, vascular dementia, moderate, with psychotic disturbance, and Alzheimer's disease.</p> <p>Review of Resident #146's care plan dated 01/22/24 included Resident #146 had an activities of daily living (ADL) self-care performance deficit related to urinary tract infection, Alzheimer's disease, bradycardia and incontinence. The goal developed was for Resident #146 to maintain, improve current level of function through the review date. Interventions included Resident #146 required the staff assistance of one person for toileting.</p> <p>Review of Resident #146's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #146 was rarely, never understood and dependent (on staff) for bathing, toileting hygiene, and putting on and taking off footwear. Resident #146 required substantial to maximal assistance with upper and lower body dressing, for chair, bed-to-chair transfer and sitting to standing. Resident #46 was always incontinent of urine and bowel.</p> <p>Review of Resident #146's electronic medical record aide charting dated 11/14/24 through 11/18/24 revealed the resident did not have a bowel movement for five days.</p> <p>Review of Resident #146's progress notes dated 11/14/24 through 11/18/24 revealed no evidence the resident had a bowel movement during this time period. The medical record did not contain evidence the resident's bowel sounds, pain, tenderness, and firmness of the abdomen were assessed during this time period.</p> <p>Review of Resident #146's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 11/14/24 through 11/18/24 revealed he regularly received Polyethylene Glycol 3350 powder 17 grams (gm) by mouth one time a day for constipation but he did not receive any other medications or treatment related to not having a bowel movement during these five days.</p> <p>Observation on 11/18/24 at 8:03 A.M. of Resident #146 revealed the resident was sitting in a wheelchair and his incontinence brief was observed to be full and the resident needed to be changed. Certified Nursing Assistant (CNA) #400 and Licensed Practical Nurse (LPN) #401 assisted Resident #146 to the toilet in the common area shower room and bathroom to provide incontinence care. While Resident #146 was on the toilet CNA #400 asked Resident #146 if he needed to have a bowel movement and Resident #146 stated no. There was no bowel movement observed during the incontinence care.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/19/24 at 11:03 A.M. with CNA #402 revealed the aides charted bowel movements in a resident's electronic record. CNA #402 stated if a resident had diarrhea or was constipated she reported it to the nurse, and if a resident was on the facility bowel protocol it popped up on her computer screen. CNA #402 reviewed the list of residents on the bowel protocol and revealed Resident #146 was on the list of residents who were on the bowel protocol. CNA #402 stated she was assigned to care for Resident #146 today, and was unaware Resident #146 was on the bowel protocol and did not tell the nurse he was on the bowel protocol. CNA #402 stated even though she did not tell the nurse Resident #146 was on the bowel protocol, the nurses also had the residents who were on the bowel protocol pop up on their computer screen. CNA #402 stated Resident #146 required total assistance with care.</p> <p>Interview on 11/19/24 at 11:10 A.M. with LPN #403 revealed Resident #146 popped up on her computer screen to implement a bowel protocol. LPN #403 stated she did not know before now Resident #146 was on the bowel protocol because she had not looked at residents' on the bowel protocol since she arrived for work at 7:00 A.M. LPN #403 indicated a resident popped up on the clinical alert area on the dashboard of the electronic record when they did not have a bowel movement for three days (six shifts).</p> <p>Interview on 11/19/24 at 11:20 A.M. with Unit Manager (UM) #404 revealed she was the unit manager for the nursing unit Resident #146 resided on and stated Resident #146 was on the bowel protocol list from the weekend. UM #404 stated nurses could check the dashboard in the electronic record to check if any residents were on the bowel protocol. UM #404 stated as a back-up measure for residents on the bowel protocol she usually checked the list every morning and alerted the nurses which residents were on the bowel protocol. UM #404 stated yesterday (11/18/24) she was too busy to check the list and she did not get to the list today. UM #404 indicated on 11/18/24 she told the nurses to check the dashboard for residents on the bowel protocol, but she did not know if the nurses checked the bowel protocol list after she told them to do it. UM #404 confirmed Resident #146 did not have a documented bowel movement for five days.</p> <p>Review of the facility undated policy titled Bowel Protocol revealed nursing staff should maintain a record of bowel evacuation on each resident in POC (electronic record). A bowel elimination protocol was initiated by nursing staff when the resident had no recorded results after six shifts, or per resident's pattern. When the BM record shows no bowel elimination by the third day or six shifts, the 7:00 A.M. to 7:00 P.M. charge nurse initiated the bowel protocol unless contraindicated by resident condition or physician (or the resident had existing orders for constipation); the first step was on the third day or after six shifts, the charge nurse gave resident 30 cubic centimeters (cc's) of Milk of Magnesia in the morning; the second step was if the Milk of Magnesia was ineffective, the second shift nurse may administer Dulcolax Suppository 10 mg rectally, consult with physician or the Nurse Practitioner for Dulcolax tablets; if there were no results from the suppository or oral tablets a Fleets type enema (sodium phosphate) was administered by the nurse; bowel routine may be started at any time, but preferable in the morning. Bowel routine may be recorded on the 24 hour report, clinical record, and verbally communicated to oncoming shifts, in report. Note bowel sounds, pain, tenderness, and firmness of the abdomen. Notify physician if bowel routine was ineffective.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159838. This deficiency is also an example of continued non-compliance from the survey dated 11/08/24.</p>		