STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365071	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachwood Pointe Care Center	23900 Chagrin Blvd Beachwood, OH 44122

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure residents had a clean, comfortable, home-like environment due to a pervasive urine odor, the first-floor central bathroom was not maintained in a clean, sanitary manner, and failed to ensure door thresholds (a strip of wood, or metal forming the bottom of the doorway entering a room) were not missing. This affected all 40 residents on the first floor (#2, #5, #7, #12, #15, #16, #18, #21, #27, #28, #29, #32, #33, #35, #38, #39, #44, #46, #48, #50, #52, #53, #56, #57, #60, #63, #66, #68, #69, #70, #72, #76, #85, #86, #88, #91, #93, #95, #100, and #101). In addition, the facility failed to ensure door thresholds were not missing and the hallway handrail was not broken resulting in sharp edges on both sides which affected 37 residents on the second floor (#1, #3, #9, #13, #17, #19, #20, #22, #25, #26, #30, #31, #34, #42, #43, #45, #47, #49, #55, #58, #59, #61, #62, #73, #74, #75, #77, #78, #79, #80, #81, #92, #94, #97, #98, #99, and #102). The facility census was 102. Findings include: 1. Interview on 10/24/24 at 1:07 P.M. and 10/28/24 at 3:17 P.M. with Ombudsman #600 revealed she had one open case regarding Resident #1 stating she was not getting timely incontinence care. She revealed Resident #1 had stated at times she had not been changed for over 24 hours. She revealed approximately two to three weeks ago, she informed the facility, including the Director of Nursing (DON), of Resident #1's concerns, and they stated they would complete staff training on timely incontinence care. During her visits, she often found areas throughout the facility that smelled of urine. The smell of urine lingered throughout the hallways. Several residents voiced concerns regarding possible mold (black substance) in the first-floor central shower room. 2. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including spastic hemiplegia affecting the right dominant side, hypertension, and osteoarthritis. Interview and observation on 10/28/24 at 11:18 A.M. with Resident #15 revealed there was a strong urine odor in the hallway outside of Resident #15's room that got stronger when entering her room. She was lying in bed with the top sheet partially pulled down and a brown dried urine ring to the bottom of her fitted sheet was observed. Resident #15 revealed she had not been provided with incontinent care since 1:00 A.M. She stated, so I would say the day is not going good, as I am a mess. Interview on 10/28/24 at 11:26 A.M. with Certified Nurse Aide (CNA) #611 verified there was a strong urine odor outside of Resident #15's room. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/28/24 at 11:26 A.M. revealed CNA #611 provided incontinence care for Resident #15. Resident #15 was wearing a green incontinence brief that was soaked with urine. She had a bath blanket folded in four underneath her that was soaked with urine that was on top of a washable incontinence pad that was also soaked with urine. The washable incontinence pad and the bottom fitted sheet had multiple brown dried urine rings. CNA #611stated, it appeared she had not been provided with incontinence care for a prolonged time and verified that it was likely that Resident #15 was correct in stating she was last changed at 1:00 A.M. based on the condition she was in. She verified it appeared she had voided multiple times, especially since urine had soaked through the disposable incontinence brief, bath blanket, washable incontinence pad, and bottom fitted sheet. 3. Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including schizophrenia, dementia with agitation, diabetes, and frontotemporal neurocognitive disorder. Observation on 10/24/24 at 8:14 A.M. revealed a strong urine odor midway down the hallway towards Resident #48's room. Observation of Resident #48's room revealed he was not in his room. There was a bottom-fitted sheet on his bed that had large yellow and brown dried urine rings that covered almost the entire sheet; the sheet also had wet areas throughout. Observation revealed he had a urine-soaked top sheet lying on the floor that also had yellow stains throughout. There was a green incontinent brief opened, lying in the center of the floor that also contained urine. There was a garbage container next to his dresser that had a strong pungent smell of urine and fecal material as it contained three incontinent products (one green and two white). There was a pile of clothing lying against the wall containing three pants and three shirts that also smelled of urine. There was a urinal sitting on the dresser that was one third full of urine. Several flies were observed flying throughout the room, especially around the garbage container. Interview on 10/24/24 at 8:29 A.M. with Licensed Practical Nurse (LPN) #601 and LPN #602 verified the above findings and stated Resident #48 often refused care but were unable to identify when the last time staff had attempted and were unable to provide any documented evidence of attempts. Observation on 10/28/24 at 11:00 A.M. revealed a strong urine odor continued in the hallway leading to Resident #48's room. Resident #48 was not in his room, but the center of his room contained a large puddle of liquid that smelled of urine. His bed was unmade with a pile of urine-soaked sheets against the wall with dried yellow and brown rings throughout the sheets. Interview on 10/28/24 at 11:02 A.M. with Resident #46 revealed he was up in his wheelchair and resided across the hall from Resident #48's room. He stated, the smell of piss is all I smell all day long, and it is horrible. He felt staff did not do anything about it as they never go into Resident #48's room and clean, so he stated he was stuck smelling it 24-7. Interview on 10/28/24 at 12:25 P.M. and 10/29/24 at 11:20 A.M. with DON verified there was a strong urine smell throughout the hallway leading towards Resident #48's room. She verified there was a large puddle of urine in the center of Resident #48's room, and CNA #613 had just entered the room to pick up the urine-soaked sheets that were against the wall. 4. Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses including diabetes, urinary incontinence, major depression, and hypertension. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/28/24 at 12:01 P.M. as this surveyor walked by Resident #7's room, there was a strong urine odor lingering in the hallway outside of Resident #7's closed door. After knocking and receiving permission to enter from Resident #7, this surveyor observed Resident #7 sitting up in her wheelchair folding incontinent products on her over the bed table. Observation revealed a soiled washable incontinence pad lying in Resident #7's bed that had dried dark brown urine rings surrounding the length of the pad, and the top sheet also had yellow and brown stains. Interview on 10/28/24 at 12:01 P.M. with Resident #7 stated, the girl usually comes around and fixes the bed, but I have not seen her. Interview on 10/28/24 at 12:05 P.M. with LPN #610 verified the above findings that Resident #7's washable incontinent pad and top sheet had dried brown and yellow rings and stains caused by urine. She verified there was a strong urine smell in the hallway as well as in Resident #7's room. Interview and observation on 10/28/24 at 12:20 P.M. with the DON verified Resident #7's washable incontinent pad had dried brown rings, and her top sheet had yellow brown stains on it. She asked Resident #7 if staff could come in and change her bedding she stated, oh sure, they can come in. 5. Observation on 10/28/24 at 8:14 A.M. revealed the first-floor central bathroom shower had a black substance along the whole base of the left side of the shower approximately two inches in width. Interview on 10/28/24 at 8:14 A.M. with LPN/Unit Manager #607 verified there was a black substance along the entire left side of the base of the shower. She stated the substance looked like caked up Oreo cookies along the whole base. Interview on 10/28/24 at 9:09 A.M. with Maintenance Director #609 verified there was a large black substance along the base of the left side of the shower in the first-floor central bathroom. He applied a glove and began peeling off the black substance. He stated, that is just caked on dirt that needs a good cleaning which looks like has not been done for some time to have that much buildup of dirt. Interview on 10/28/24 at 11:02 A.M. with Resident #46 revealed the central bathroom shower was always dirty, and he refused to take showers in it because he believed the black substance was mold. 6. Observation on 10/28/24 at 9:09 A.M. the environmental tour revealed the second floor i hallway on both sides of the therapy door, the handrail was missing the end protective guard, and the handrail was cracked resulting in broken, sharp, jagged edges. Interview on 10/28/24 at 9:09 A.M. with Maintenance Director #609 verified the above findings and revealed he was not aware the handrail was broken. 7. Observation on 10/28/24 at 9:09 A.M. on environmental tour revealed the following door thresholds were missing: rooms 101, 108, 123, 125, 126, 127, 214, 218, first floor dining room entrance, shower room entrance, and second floor central bathroom entrance. Observation revealed there was dried black dirt the whole length of the threshold where the threshold was supposed to be. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/28/24 at 9:09 A.M. with Maintenance Director #609 verified the above door thresholds were missing and stated they had been missing for a while now because as often as the residents' wheelchairs run over them, and they come loose and eventually fall off. Review of the facility policy labeled, Quality of Life- Homelike Environment, dated August 2009, revealed residents' were to be provided with safe, clean, comfortable, and homelike environment. The staff and management should maximize characteristics of the facility to reflect a personalized homelike setting including cleanliness, and pleasant neutral scents. This deficiency represents non-compliance investigated under Master Complaint Number OH00159140 and Complaint Number OH00158925.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, interview, Ohio Department of Health Gateway review, and review of the facility abuse policy, the facility failed to implement their abuse policy including investigating and reporting Resident #22's allegation that Licensed Practical Nurse (LPN) #614 verbally abused her and withheld her pain medication out of retaliation. This affected one resident (#22) out of seven residents reviewed for abuse. The facility also failed to investigate and report Resident #104's daughter-in-law's allegation that Certified Nurse Aide (CNA) #615 was yelling at residents in the third-floor dining room. This had the potential to affect 25 residents (#4, #6, #8, #10, #11, #14, #23, #24, #36, #37, #40, #41, #51, #54, #64, #65, #67, #71, #82, #84, #87, #89, #90, #96, and #103) residing on the third floor. The facility census was 102. Findings include: 1. Review of the closed medical record for Resident #104 revealed an admitted [DATE] and she was discharged the same day against medical advice (AMA) to home. Her diagnoses included Alzheimer's disease, hypertension, and major depression. Review of the nursing note dated 10/10/24 at 6:10 P.M. authored by LPN #610 revealed Resident #104's daughter-in-law was taking Resident #104 out of the facility and Nurse Practitioner #901 was notified and stated if the resident left, she had to sign AMA papers. Resident #104's daughter-in-law signed the paper and took Resident #104 home. Review of the personnel file for CNA #615 revealed a hire date of 08/29/22. There was a disciplinary action form located in the file dated 10/16/24 that revealed on 10/10/24 a family member had stated she was rude. The disciplinary action revealed that it was a violation of customer service. There was nothing else regarding the incident in her file. Review of the timecard for CNA #615 revealed on 10/10/24 CNA #615 worked from 7:01 A.M. and punched out early at 6:37 P.M. There were no other time punches after 10/10/24 that CNA #615 worked at the facility. Review of the Ohio Department of Health Gateway from 10/10/24 to 10/28/24 revealed the facility had not filed a self-reported incident (SRI) of the allegation of staff-to-resident verbal abuse after Resident #104's daughter-in-law alleged CNA #615 was yelling at residents in the third-floor dining room on 10/10/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/28/24 at 10:24 A.M. and on 10/28/24 at 2:36 P.M. with the Director of Nursing (DON) revealed on 10/10/24 she received a phone call from Resident #104's daughter-in-law who was upset and wanted to remove Resident #104 from the facility. She stated she heard CAN #615 yelling at residents in the dining room and did not feel safe leaving Resident #104 at the facility. Resident #104's daughter-in-law had not provided any details as to what CNA #615 yelled and/or specified a specific resident and/or residents CNA #615 yelled at. The nurse had immediately sent CNA #615 home, but she verified that she did not complete an investigation including interviewing and assessing residents on the third floor or obtaining witness statements of staff on duty during the incident. She revealed CNA #615 only worked at the facility as needed and had not picked up any further shifts since 10/10/24. The DON was asked why she did not complete an investigation regarding the above incident, and she revealed she only completed a full investigation and/ or filed a SRI when there was evidence that there was some truth to the allegation. Interview on 10/28/24 at 11:45 A.M. with LPN #610 revealed on 10/10/24 Resident #104's daughter-in-law was upset regarding CNA #615 yelling at residents on the third floor and telling the residents to shut up. Resident #104 was just admitted that same day and Resident #104's daughter-in- law did not feel comfortable leaving Resident #104 at the facility as she did not feel safe due to CNA #615's actions. Resident #104's daughter-in-law did not name specific residents that CNA #615 yelled at, just that it was at residents in the dining room. She sent CNA #615 immediately home. Resident #104's daughter-in-law removed Resident #104 from the facility AMA that same day, 10/10/24. An attempt to contact CNA #615 on 10/28/24 at 12:44 P.M. but the person who answered the phone stated it was the wrong number. Human Resource Director #608 revealed he had no other contact numbers. 2. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, opioid abuse, and personality disorder. Review of the care plan dated 07/29/24 revealed Resident #22 refused care and wanted care only from one nurse. She was physically and verbally aggressive towards staff and made threats towards others. Interventions included attempting one on one to de-escalate verbal aggressive behavior, educate and encourage residents to be patient and allow nursing to provide care. Review of the care plan dated 09/05/24 revealed Resident #22 had a history of telling stories or making false allegations against staff and other residents. Interventions included documenting resident behavior, do not minimize residents' concerns, and referring to social services. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had intact cognition. She had other behaviors documented one to three days of the seven-day assessment reference period. Review of the Ohio Department of Health Gateway from 08/01/24 to 10/28/24 revealed the facility had not filed an SRI regarding Resident #22's allegation that LPN #614 verbally abused her and withheld her pain medication out of retaliation (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/28/24 at 2:05 P.M. revealed Resident #22 requested to speak with this surveyor. She revealed LPN #614 had screamed and yelled at her multiple times, as well as denied her pain medication out of retaliation. She stated she was left in pain multiple times because LPN #614 refused to give her medications. She believed it was abusive and had reported it to the Administrator but that nothing was done except LPN #614 was now working on a different floor, but she was unsure how long that would last. Interview on 10/28/24 at 2:32 P.M. with Administrator verified Resident #22 told her LPN #614 walked up and down the hallway yelling and cussing at her and would not give her pain medications. She was unable to remember the date Resident #22 told her that. The Administrator revealed that she was new at the facility (less than three weeks), so she immediately talked with the DON and LPN/ Unit Manager #800 who stated Resident #22 had behaviors. She verified she had not investigated and/or reported the incident as she felt it was just behavioral. Interview on 10/28/24 at 2:36 P.M. with the Administrator and DON regarding Resident #22's allegation revealed the DON stated Resident #22 was very manipulative as she targeted and accused several nurses regarding not getting her as needed pain medication timely even if it was not due to be given. She stated this had been an ongoing pattern of Resident #22 making allegations and it was care planned as behaviors. She revealed at the time of the allegation, she had moved LPN #614 to a different floor to work but had not investigated or reported the incident because it was Resident #22's behavioral pattern that she demonstrated frequently. The DON revealed she only completed a full investigation and/or filed a SRI when there was evidence that there was some truth in the allegation. Review of the facility policy labeled, Abuse Prevention Program, dated December 2016, revealed the residents had the right to be free from abuse and neglect which included verbal abuse. The policy revealed the facility was to investigate and report any allegations of abuse within the time frames required by federal requirements. Review of the undated facility policy labeled, Abuse Investigations revealed all reports of resident abuse, and neglect shall be promptly and thoroughly investigated by facility management. The individual conducting the investigation as a minimum included interviewing the person reporting the incident, interviewing any witnesses to the incident, and interviewing the resident. The policy revealed witness reports would be obtained in writing and witnesses would be required to sign and date the reports. The results of the investigation would be recorded on approved documentation forms. The investigator would give a completed copy of the investigation to the Administrator within three working days of the incident. The administrator would provide a written report of the abuse investigation and appropriate actions taken to the state survey agency, local police, ombudsman, and others required by law within five days of the reported incident. This deficiency represents non-compliance investigated under Complaint Number OH00158925.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, interview, Ohio Department of Health Gateway review, and review of the facility abuse policy, the facility failed to report Resident #22's allegation that Licensed Practical Nurse (LPN) #614 verbally abused her and withheld her pain medication out of retaliation. This affected one resident (#22) out of seven residents reviewed for abuse. The facility also failed to report Resident #104's daughter-in-law's allegation that Certified Nurse Aide (CNA) #615 was yelling at residents in the third-floor dining room. This had the potential to affect 25 residents (#4, #6, #8, #10, #11, #14, #23, #24, #36, #37, #40, #41, #51, #54, #64, #65, #67, #71, #82, #84, #87, #89, #90, #96, and #103) residing on the third floor. The facility census was 102. Findings include: 1. Review of the closed medical record for Resident #104 revealed an admitted [DATE] and she was discharged the same day against medical advice (AMA) to home. Her diagnoses included Alzheimer's disease, hypertension, and major depression. Review of the nursing note dated 10/10/24 at 6:10 P.M. authored by LPN #610 revealed Resident #104's daughter-in-law was taking Resident #104 out of the facility and Nurse Practitioner #901 was notified and stated if the resident left, she had to sign AMA papers. Resident #104's daughter-in-law signed the paper and took Resident #104 home. Review of the personnel file for CNA #615 revealed a hire date of 08/29/22. There was a disciplinary action form located in the file dated 10/16/24 that revealed on 10/10/24 a family member had stated she was rude. The disciplinary action revealed that it was a violation of customer service. There was nothing else regarding the incident in her file. Review of the timecard for CNA #615 revealed on 10/10/24 CNA #615 worked from 7:01 A.M. and punched out early at 6:37 P.M. There were no other time punches after 10/10/24 that CNA #615 worked at the facility. Review of the Ohio Department of Health Gateway from 10/10/24 to 10/28/24 revealed the facility had not filed a self-reported incident (SRI) of the allegation of staff-to-resident verbal abuse after Resident #104's daughter-in-law alleged CNA #615 was yelling at residents in the third-floor dining room on 10/10/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/28/24 at 2:05 P.M. revealed Resident #22 requested to speak with this surveyor. She revealed LPN #614 had screamed and yelled at her multiple times, as well as denied her pain medication out of retaliation. She stated she was left in pain multiple times because LPN #614 refused to give her medications. She believed it was abusive and had reported it to the Administrator but that nothing was done except LPN #614 was now working on a different floor, but she was unsure how long that would last. Interview on 10/28/24 at 2:32 P.M. with Administrator verified Resident #22 told her LPN #614 walked up and down the hallway yelling and cussing at her and would not give her pain medications. She was unable to remember the date Resident #22 told her that. The Administrator revealed that she was new at the facility (less than three weeks), so she immediately talked with the DON and LPN/ Unit Manager #800 who stated Resident #22 had behaviors. She verified she had not investigated and/or reported the incident as she felt it was just behavioral. Interview on 10/28/24 at 2:36 P.M. with the Administrator and DON regarding Resident #22's allegation revealed the DON stated Resident #22 was very manipulative as she targeted and accused several nurses regarding not getting her as needed pain medication timely even if it was not due to be given. She stated this had been an ongoing pattern of Resident #22 making allegations and it was care planned as behaviors. She revealed at the time of the allegation, she had moved LPN #614 to a different floor to work but had not investigated or reported the incident because it was Resident #22's behavioral pattern that she demonstrated frequently. The DON revealed she only completed a full investigation and/or filed a SRI when there was evidence that there was some truth in the allegation. Review of the facility policy labeled, Abuse Prevention Program, dated December 2016, revealed the residents had the right to be free from abuse and neglect which included verbal abuse. The policy revealed the facility was to investigate and report any allegations of abuse within the time frames required by federal requirements. Review of the undated facility policy labeled, Abuse Investigations revealed all reports of resident abuse, and neglect shall be promptly and thoroughly investigated by facility management. The individual conducting the investigation as a minimum included interviewing the person reporting the incident, interviewing any witnesses to the incident, and interviewing the resident. The policy revealed witness reports would be obtained in writing and witnesses would be required to sign and date the reports. The results of the investigation would be recorded on approved documentation forms. The investigator would give a completed copy of the investigation to the Administrator within three working days of the incident. The administrator would provide a written report of the abuse investigation and appropriate actions taken to the state survey agency, local police, ombudsman, and others required by law within five days of the reported incident. This deficiency represents non-compliance investigated under Complaint Number OH00158925.

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	365071	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachwood Pointe Care Center	23900 Chagrin Blvd Beachwood, OH 44122

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, interview, and review of the facility abuse policy, the facility failed to investigate Resident #22's allegation that Licensed Practical Nurse (LPN) #614 verbally abused her and withheld her pain medication out of retaliation. This affected one resident (#22) out of seven residents reviewed for abuse. The facility also failed to investigate Resident #104 daughter-in-law's allegation that Certified Nurse Aide (CNA) #615 was yelling at residents in the third-floor dining room. This had the potential to affect 25 residents (#4, #6, #8, #10, #11, #14, #23, #24, #36, #37, #40, #41, #51, #54, #64, #65, #67, #71, #82, #84, #87, #89, #90, #96, and #103) residing on the third floor. The facility census was 102. Findings include: 1. Review of the closed medical record for Resident #104 revealed an admitted [DATE] and she was discharged the same day against medical advice (AMA) to home. Her diagnoses included Alzheimer's disease, hypertension, and major depression. Review of the nursing note dated 10/10/24 at 6:10 P.M. authored by LPN #610 revealed Resident #104's daughter-in-law was taking Resident #104 out of the facility and Nurse Practitioner #901 was notified and stated if the resident left, she had to sign AMA papers. Resident #104's daughter-in-law signed the paper and took Resident #104 home. Review of the personnel file for CNA #615 revealed a hire date of 08/29/22. There was a disciplinary action form located in the file dated 10/16/24 that revealed on 10/10/24 a family member had stated she was rude. The disciplinary action revealed that it was a violation of customer service. There was nothing else regarding the incident in her file. Review of the timecard for CNA #615 revealed on 10/10/24 CNA #615 worked from 7:01 A.M. and punched out early at 6:37 P.M. There were no other time punches after 10/10/24 that CNA #615 worked at the facility. Interview on 10/28/24 at 10:24 A.M. and on 10/28/24 at 2:36 P.M. with the Director of Nursing (DON) revealed on 10/10/24 she received a phone call from Resident #104's daughter-in-law who was upset and wanted to remove Resident #104 from the facility. She stated she heard CAN #615 yelling at residents in the dining room and did not feel safe leaving Resident #104 at the facility. Resident #104's daughter-in-law had not provided any details as to what CNA #615 yelled and/or specified a specific resident and/or residents CNA #615 yelled at. The nurse had immediately sent CNA #615 home, but she verified that she did not complete an investigation including interviewing and assessing residents on the third floor or obtaining witness statements of staff on duty during the incident. She revealed CNA #615 only worked at the facility as needed and had not picked up any further shifts since 10/10/24. The DON was asked why she did not complete an investigation regarding the above incident, and she revealed she only completed a full investigation and/ or filed a SRI when there was evidence that there was some truth to the allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/28/24 at 11:45 A.M. with LPN #610 revealed on 10/10/24 Resident #104's daughter-in-law was upset regarding CNA #615 yelling at residents on the third floor and telling the residents to shut up. Resident #104 was just admitted that same day and Resident #104's daughter-in- law did not feel comfortable leaving Resident #104 at the facility as she did not feel safe due to CNA #615's actions. Resident #104's daughter-in-law did not name specific residents that CNA #615 yelled at, just that it was at residents in the dining room. She sent CNA #615 immediately home. Resident #104's daughter-in-law removed Resident #104 from the facility AMA that same day, 10/10/24. An attempt to contact CNA #615 on 10/28/24 at 12:44 P.M. but the person who answered the phone stated it was the wrong number. Human Resource Director #608 revealed he had no other contact numbers. 2. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, opioid abuse, and personality disorder. Review of the care plan dated 07/29/24 revealed Resident #22 refused care and wanted care only from one nurse. She was physically and verbally aggressive towards staff and made threats towards others. Interventions included attempting one on one to de-escalate verbal aggressive behavior, educate and encourage residents to be patient and allow nursing to provide care. Review of the care plan dated 09/05/24 revealed Resident #22 had a history of telling stories or making false allegations against staff and other residents. Interventions included documenting resident behavior, do not minimize residents' concerns, and referring to social services. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had intact cognition. She had other behaviors documented one to three days of the seven-day assessment reference period. Interview on 10/28/24 at 2:05 P.M. revealed Resident #22 requested to speak with this surveyor. She revealed LPN #614 had screamed and yelled at her multiple times, as well as denied her pain medication out of retaliation. She stated she was left in pain multiple times because LPN #614 refused to give her medications. She believed it was abusive and had reported it to the Administrator but that nothing was done except LPN #614 was now working on a different floor, but she was unsure how long that would last. Interview on 10/28/24 at 2:32 P.M. with Administrator verified Resident #22 told her LPN #614 walked up and down the hallway yelling and cussing at her and would not give her pain medications. She was unable to remember the date Resident #22 told her that. The Administrator revealed that she was new at the facility (less than three weeks), so she immediately talked with the DON and LPN/ Unit Manager #800 who stated Resident #22 had behaviors. She verified she had not investigated and/or reported the incident as she felt it was just behavioral. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/28/24 at 2:36 P.M. with the Administrator and DON regarding Resident #22's allegation revealed the DON stated Resident #22 was very manipulative as she targeted and accused several nurses regarding not getting her as needed pain medication timely even if it was not due to be given. She stated this had been an ongoing pattern of Resident #22 making allegations and it was care planned as behaviors. She revealed at the time of the allegation, she had moved LPN #614 to a different floor to work but had not investigated or reported the incident because it was Resident #22's behavioral pattern that she demonstrated frequently. The DON revealed she only completed a full investigation and/or filed a SRI when there was evidence that there was some truth in the allegation. Review of the facility policy labeled, Abuse Prevention Program, dated December 2016, revealed the residents had the right to be free from abuse and neglect which included verbal abuse. The policy revealed the facility was to investigate and report any allegations of abuse within the time frames required by federal requirements. Review of the undated facility policy labeled, Abuse Investigations revealed all reports of resident abuse, and neglect shall be promptly and thoroughly investigated by facility management. The individual conducting the investigation as a minimum included interviewing the person reporting the incident, interviewing any witnesses to the incident, and interviewing the resident. The policy revealed witness reports would be obtained in writing and witnesses would be required to sign and date the reports. The results of the investigation would be recorded on approved documentation forms. The investigator would give a completed copy of the investigation to the Administrator within three working days of the incident. The administrator would provide a written report of the abuse investigation and appropriate actions taken to the state survey agency, local police, ombudsman, and others required by law within five days of the reported incident. This deficiency represents non-compliance investigated under Complaint Number OH00158925.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure timely incontinence care was provided to Residents #1, #7, #15, and #48. This affected four residents (#1, #7, #15, #48) out of five residents reviewed for incontinence care. This had the potential to affect 52 residents (#1, #3, #4, #6, #7, #8, #10, #13, #14, #15, #19, #23, #24, #26, #29, #30, #33, #37, #38, #41, #42, #43, #45, #46, #48, #52, #54, #55, #58, #59, #60, #64, #65, #66, #69, #70,#72, #73, #74, #75, #81, #82, #85, #88, #89, #91, #93, #96, #95, #99, #102, and #103) identified by the facility as incontinent. The facility census was 102. Findings include: 1. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including spastic hemiplegia affecting the right dominant side, hypertension, and osteoarthritis. Review of the care plan dated 07/18/24 revealed Resident #15 had bladder incontinence related to the aging process. Interventions included checking Resident #15 every two hours and as needed, monitoring for signs of urinary tract infection, and changing clothing as needed after incontinent episodes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had impaired cognition with no behaviors identified. She required substantial to maximum staff assist with toileting hygiene and supervision or touch assist with rolling left and right. She was frequently incontinent of urine and always incontinent of bowel. Review of the Resident/Family/Staff Concern dated 10/10/24 revealed Resident #15's son filed a grievance that on the weekends, Resident #15 was not being provided care on a regular basis. The form revealed Licensed Practical Nurse (LPN)/ Unit Manager #607 spoke with Resident #15 on 10/10/24 who also stated she sometimes had to wait an extended time for her care to be completed. The concern form revealed an in-service would be provided to staff regarding timeliness of care which was completed on 10/10/24. There was no additional follow-up noted except asking the resident on 10/11/24, and she stated she was ok. Review of the Visual/Bedside Kardex Report dated 10/28/24 revealed Resident #15 was to be checked and changed every two hours and as needed and provided perineal care after each incontinent episode. Interview and observation on 10/28/24 at 11:18 A.M. with Resident #15 revealed there was a strong urine odor in the hallway outside of Resident #15's room that got stronger when entering her room. She was lying in bed with the top sheet partially pulled down and a brown dried ring of urine observed to her fitted sheet. Resident #15 revealed she had not been provided with incontinence care since 1:00 A.M. She stated, so, I would say the day is not going good, as I am a mess. Interview on 10/28/24 at 11:26 A.M. with Certified Nurse Aide (CNA) #611 verified there was a strong urine odor outside of Resident #15's room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/28/24 at 11:26 A.M. revealed CNA #611 provided incontinence care for Resident #15. Resident #15 was wearing a green incontinence brief that was soaked with urine. She had a bath blanket folded in four underneath her that was soaked with urine that was on top of a washable incontinence pad that was also soaked with urine. The washable incontinence pad and the bottom fitted sheet had multiple brown dried urine rings. CNA #611stated, it appeared she had not been provided with incontinence care for a prolonged time and verified that it was likely that Resident #15 was correct in stating she was last changed at 1:00 A.M. based on the condition she was in. She verified it appeared she had voided multiple times, especially since urine had soaked through the disposable incontinence brief, bath blanket, washable incontinence pad, and bottom fitted sheet. Interview on 10/28/24 at 11:44 A.M. with Licensed Practical Nurse (LPN) #614 (nurse assigned to Resident #15) revealed CNA #616 was assigned Resident #15's room but was not sure where she was. LPN #614 revealed she was not aware the facility had pulled CNA #616 or that the assignments had changed. Interview on 10/28/24 at 11:45 A.M. with LPN #610 revealed CNA #611 had just found out that she was assigned Resident #15 as they did not realize the other CNA was not on the floor. She stated, honestly, I do not know who was assigned to care for Resident #15 from 7:00 A.M. to 11:26 A.M. She was not aware that CNA #616 was pulled to the kitchen to work. She then stated, I guess CNA #619 was to take CNA #616's spot, but she had been sick in the bathroom. She revealed she was not aware CNA #619 was off the floor and not working as scheduled. Interview on 10/28/24 at 2:49 P.M. with CNA #616 revealed she was assigned to Resident 15's room from 7:00 A.M. till approximately 9:00 A.M. when she was pulled to work in the kitchen. She verified she had not communicated with nurses on the unit (LPNs #610 and #614) that she had been pulled and/or any of the other aides on the floor as she just figured management told them. She verified she had not provided incontinence care for Resident #15 from 7:00 A.M. to 9:00 A.M. Review of the daily staffing assignment sheet for 10/28/24 revealed the first-floor unit had scheduled LPN #610, LPN #614, CNA #611 and CNA #613 from 7:00 A.M. to 7:00 P.M. CNA #616 was assigned from 7:00 A.M. till 9:00 A.M. then was pulled to work in the kitchen. CNA #617 was scheduled to work from 10:00 A.M. to 7:00 P.M. and CNA #619 was scheduled 9:00 A.M. till 7:00 P.M. but was sent home. Interview on 10/29/24 at 11:49 A.M. with Scheduler/ CNA #620 verified she pulled CNA #616 to work in the kitchen at 9:00 A.M. She revealed usually the floor nurse or unit manager updated the staffing assignment as to which residents a staff was assigned. She revealed she was not aware CNA #619 was not on the floor working as scheduled and had heard she was sent home because she was arguing with management. 2. Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including schizophrenia, dementia with agitation, diabetes, and frontotemporal neurocognitive disorder. Review of the undated care plan revealed Resident #48 was non-compliant with personal care, incontinence care, and assistance with transfers. Interventions included attempting to educate in relation to compliance, educating the resident on negative outcomes related to noncompliance, notifying the physician of noncompliance, and explaining all procedures prior to starting. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated care plan revealed Resident #48 was at risk for alteration in elimination related to occasional incontinence of bowel and bladder and his need for assistance with toileting may fluctuate. Interventions included providing incontinence care as needed, monitoring for skin irritation and redness, and monitoring for signs of urinary tract infections. Review of the care plan dated 02/10/22 revealed Resident #48 had a behavior of urinating in inappropriate places in the facility. Interventions included educating him on infection control when urinating in inappropriate places, encouraging the resident to ask for assistance, offering toileting assistance every two hours and as needed, and showing the resident appropriate places to void. Review of the quarterly MDS assessment dated [DATE] revealed Resident #48 had cognitive impairment as his brief interview of mental status (BIMS) score was a five. There was nothing identified by the MDS that he rejected care. He required partial to moderate assistance with toileting hygiene, showering, lower body dressing, and transfers. He was always incontinent of urine and occasionally incontinent of bowel. Review of the nursing notes dated from 09/01/24 to 10/24/24 revealed there was no documented evidence of Resident #48 refusing care including toileting hygiene and cleaning of his room. Review of the toileting hygiene under the task section of the electronic medical record revealed from 10/01/24 to 10/29/24 there was no documented evidence that Resident #48 refused care. The only documentation on 10/24/24 revealed Resident #48 received toileting hygiene care at 6:59 P.M., and there was no other documentation he received care on 10/24/24. There was no documented evidence that Resident #48 received toileting hygiene assistance on 10/28/24. Observation on 10/24/24 at 8:14 A.M. revealed a strong urine smell midway down the hallway towards Resident #48's room. Observation of Resident #48's room revealed he was not in his room. There was a bottom-fitted sheet on his bed that had large yellow and brown dried urine rings that covered almost the entire sheet, and the sheet had wet areas throughout. Observation revealed he had a urine-soaked top sheet lying on the floor that also had yellow stains throughout. There was a green incontinent brief opened lying in the center of the floor that also contained urine. There was a garbage container next to his dresser that had a strong pungent smell of urine and fecal material as it contained three incontinent products (one green and two white). There was a pile of clothing lying against the wall containing three pants and three shirts that also smelled of urine. There was a urinal sitting on the dresser that was one third full of urine. Several flies were observed flying throughout the room, especially around the garbage container. Interview on 10/24/24 at 8:29 A.M. with LPN #601 and LPN #602 verified the above findings and stated Resident #48 often refused care but were unable to identify when the last time staff attempted and were unable to provide documented evidence of attempts. Interview and observation on 10/24/24 at 8:35 A.M. with Resident #48 revealed he was sitting in his wheelchair in the dining room without signs of incontinence as he appeared to have clean clothing on, but there was a urine smell noted upon interview. Interview with Resident #48 revealed he had cognitive impairment as he was unable to provide details regarding his care including how often incontinence care was provided and/or how often staff assisted with cleaning his room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Visual/Bedside Kardex Report dated 10/28/24 revealed Resident #48 was to receive a check and change every two hours and as needed, and staff were to show him appropriate places to void. Observation on 10/28/24 at 11:00 A.M. revealed a strong urine smell continued in the hallway leading to Resident #48's room. Resident #48 was not in his room but in the center of his room was a large puddle of liquid that smelled of urine. His bed was unmade with a pile of sheets against the wall that appeared urine soaked with dried yellow and brown rings throughout the sheets. Interview on 10/28/24 at 11:02 A.M. with Resident #46 revealed he was up in his wheelchair and resided across the hall from Resident #48's room. He stated, the smell of piss is all I smell all day long, and it is horrible. He felt staff did not do anything about it as they never go into Resident #48's room and clean, so he stated he was stuck smelling it 24-7. Interview on 10/28/24 at 12:25 P.M. and 10/29/24 at 11:20 A.M. with Director of Nursing (DON) verified there was a strong urine smell throughout the hallway leading towards Resident #48's room. She verified there was a large puddle of urine in the center of Resident #48's room and CNA #613 had just entered the room to pick up the urine-soaked sheets that were against the wall. The DON verified there was nothing documented in Resident #48's nursing notes and/or task bar that he had refused incontinence care. 3. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, chronic pain, and muscle weakness. She was receiving hospice services. Review of the care plan dated 02/23/21 revealed Resident #1 had an alteration in elimination as she was incontinent of bowel and bladder. She was dependent on staff assistance to meet her toileting needs. Interventions included providing incontinence care as needed, monitoring for skin redness and irritation, and monitoring for signs of urinary tract infection. Review of the quarterly MD assessment dated [DATE] revealed Resident #1 had impaired cognition with no behaviors identified. She required substantial to maximum assistance with toileting hygiene and lower body dressing. She was dependent on staff for rolling left and right with bed mobility. She was always incontinent with bowel and bladder. Review of the Resident/Family/Staff Concern dated 10/09/24 revealed Resident #1 had communicated concerns to Ombudsman #600 that staff were on their cellphones while providing care, and staff were rough while completing bed baths. There was nothing identified on the grievance form regarding not receiving timely incontinence care. There was an in-service attached to the grievance form that included providing proper bed baths, and not being on personal phones, but there was no education regarding timely incontinence care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/24/24 at 1:07 P.M. and 10/28/24 at 3:17 P.M. with Ombudsman #600 revealed she had one open case regarding Resident #1 stating she was not getting timely incontinence care. She revealed Resident #1 stated at times she had not been changed for over 24 hours. She revealed approximately two to three weeks ago she informed the facility, including the DON, of Resident #1's concerns, and they stated they would complete staff training on timely incontinence care. Ombudsman #600 revealed on her visits, she often found that areas throughout the facility smelled of urine. She revealed the smell of urine lingered throughout the hallways. Review of Visual/Bedside Kardex Report dated 10/28/24 revealed Resident #1 was to be checked and changed every two hours and as needed. Interview and observation on 10/28/24 at 2:13 P.M. with Resident #1 revealed she was lying in bed covered with blankets. She revealed at times she was not provided with incontinence care for over 12 hours as she had gone whole shifts from 7:00 A.M. to 7:00 P.M. without being changed. She revealed the last time she was provided with incontinence care today, 10/28/24, was at 5:00 A.M. and had not been offered since. She revealed staff were to change her every two hours, but they did not. She stated, they will lie and say because I did not ring, but they should be changing me, not me telling them to change me. She felt it was wrong to lie in one spot and not be changed. She could feel that she was very wet at the time of the interview, but CNA #612 was her aide for the day, and she never changes her. Interview on 10/28/24 at 2:22 P.M. with CNA #612 revealed she was Resident #1's CNA from 7:00 A.M. to 7:00 P.M. She verified she had not changed Resident #1 since coming on duty at 7:00 A.M. and had not provided any morning personal care. Observation on 10/28/24 at 2:25 P.M. revealed CNA #612 provided incontinence care for Resident #1. Resident #1's incontinence brief contained dark brown, yellow urine with a strong urine smell. CNA #612 verified it appeared Resident #1 had voided multiple times. CNA #612 revealed Resident #1 usually asked when she wanted changed but verified, she had not asked her anytime from 7:00 A.M. to 2:25 P.M. if she wanted changed. Interview on 10/29/24 at 11:20 A.M. with the DON verified Ombudsman #600told her that Resident #1 had concerns regarding her care, including staff being rough with bed baths and staff on their cell phones. She revealed she was not aware Resident #1 had also voiced concern regarding not being provided with incontinence care timely but also verified she had not spoken with Resident #1 regarding the concerns. 4. Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses including diabetes, urinary incontinence, major depression, and hypertension. Review of the care plan dated 12/27/23 revealed Resident #7 had an alteration in elimination related to occasional incontinence of bladder and her toileting assistance fluctuated. Interventions included providing incontinence care as needed, monitoring for signs of urinary tract infection, and monitoring for skin redness and irritation. (continued on next page)

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	365071	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachwood Pointe Care Center	23900 Chagrin Blvd Beachwood, OH 44122

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the task bar regarding bladder continence documentation for the last 30 days revealed from 09/30/24 till 10/28/24 it was documented Resident #7 was incontinent every day except 10/03/24, 10/08/24, and 10/15/24. There was no documented evidence Resident #7 refused incontinence care during this time frame. Review of the annual MDS assessment dated [DATE] revealed Resident #7 had impaired cognition. She required supervision to touching assistance with toileting hygiene, dressing, and transfers. She was occasionally incontinent of urine and frequently incontinent of bowel. Review of the Visual/Bedside Kardex Report dated 10/28/24 revealed Resident #7 was continent of bowel and bladder. Resident #7 was able to maintain her toileting hygiene with supervision and minimal assistance. Observation on 10/28/24 at 12:01 P.M. as this surveyor walked by Resident #7 room, there was a strong urine odor lingering in the hallway outside of Resident #7's closed door. After knocking and receiving permission to enter from Resident #7, this surveyor observed Resident #7 sitting up in her wheelchair folding incontinent products on her over the bed table. Observation revealed a soiled washable incontinence pad lying in Resident #7's bed that had dried dark brown urine rings surrounding the length of the pad and the top sheet was also stained with yellow and brown urine. Interview on 10/28/24 at 12:01 P.M. with Resident #7 stated, the girl usually comes around and fixes the bed, but I have not seen her. Interview on 10/28/24 at 12:05 P.M. with LPN #610 verified the above findings that Resident #7's washable incontinent pad and top sheet had dried brown and yellow rings and stains caused by urine. She verified there was a strong urine smell in the hallway as well as in Resident #7's room. Interview on 10/28/24 at 12:14 P.M. with CNA #611 revealed she was assigned to Resident #7, and Resident #7 does her own care, including taking herself to the toilet. She verified she had not completed any checks and changes for Resident #7 regarding incontinence care from the time she came on duty at 7:00 A. M. Interview and observation on 10/28/24 at 12:20 P.M. with the DON verified Resident #7's washable incontinent pad had dried brown rings, and her top sheet had yellow brown urine stains. She asked Resident #7 if staff could come in and change her bedding she stated, oh sure, they can come in. Interview on 10/29/24 at 11:24 A.M. with Registered Nurse (RN)/MDS #618 verified the care plan and MDS revealed Resident #7 was incontinent, but the Kardex stated Resident #7 was continent. Staff utilize the Kardex on the floor to know the care needs a resident, including incontinence care, and verified the Kardex was inaccurate. Review of the facility policy labeled, Perineal Care, dated October 2010, revealed the purpose was to provide cleanliness and comfort to the resident, prevent infections, prevent skin irritation, and observe resident's skin condition. The following information should be recorded in the resident's medical record: if the resident refused the procedure, the reason for the refusal, and the intervention taken. There was nothing in the policy regarding the frequency of the incontinence care. This deficiency represents non-compliance investigated under Master Complaint Number OH00159140.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, interview, Facility Assessment review, the facility failed to ensure they maintained sufficient and competent staff on the first floor on 10/28/24. This affected three residents (#1, #7, and #15) out of seven residents reviewed for staffing. This had the potential to affect 40 residents (#2, #5, #7, #12, #15, #16, #18, #21, #27, #28, #29, #32, #33, #35, #38, #39, #44, #46, #48, #50, #52, #53, #56, #57, #60, #63, #66, #68, #69, #70, #72, #76, #85, #86, #88, #91, #93, #95, #100, and #101) residing on the first floor. The facility census was 102. Findings include: 1. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including spastic hemiplegia affecting the right dominant side, hypertension, and osteoarthritis. Review of the care plan dated 07/18/24 revealed Resident #15 had bladder incontinence related to the aging process. Interventions included checking Resident #15 every two hours and as needed, monitoring for signs of urinary tract infection, and changing clothing as needed after incontinent episodes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had impaired cognition with no behaviors identified. She required substantial to maximum staff assistance with toileting hygiene and supervision, or touch assist with rolling left and right. She was frequently incontinent of bladder and always incontinent of bowel. Review of the Resident/Family/Staff Concern dated 10/10/24 revealed Resident #15's son filed a grievance that on the weekends, Resident #15 was not being provided care on a regular basis. The form revealed Licensed Practical Nurse (LPN)/ Unit Manager #607 spoke with Resident #15 on 10/10/24 who also stated she sometimes had to wait an extended time for her care to be completed. The concern form revealed an in-service would be provided to staff regarding timeliness of care which was completed on 10/10/24. There was no additional follow-up noted except asking the resident on 10/11/24, and she stated she was ok. Review of the Visual/Bedside Kardex Report dated 10/28/24 revealed Resident #15 was to be checked and changed every two hours and as needed and provided perineal care after each incontinent episode. Interview and observation on 10/28/24 at 11:18 A.M. with Resident #15 revealed there was a strong urine odor in the hallway outside of Resident #15's room that got stronger when entering her room. She was lying in bed with the top sheet partially pulled down and a brown dried ring of urine observed to her fitted sheet. Resident #15 revealed she had not been provided with incontinence care since 1:00 A.M. She stated, so, I would say the day is not going good, as I am a mess. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/28/24 at 11:26 A.M. with Certified Nurse Aide (CNA) #611 revealed the other aide she believed went on an appointment or something as she was not aware there had not been an aide assigned to Resident #15. CNA #611 revealed she did not know Resident #15 was her resident to care for until a few minutes ago when she was told. CNA #611 verified she arrived on duty at 7:00 A.M. but had not been in Resident #15's room to provide incontinence care. Observation on 10/28/24 at 11:26 A.M. revealed CNA #611 provided incontinence care for Resident #15. Resident #15 was wearing a green incontinence brief that was soaked with urine. She had a bath blanket folded in four underneath her that was soaked with urine that was on top of a washable incontinence pad that was also soaked with urine. The washable incontinence pad and the bottom fitted sheet had multiple brown dried urine rings. CNA #611stated, it appeared she had not been provided with incontinence care for a prolonged time and verified that it was likely that Resident #15 was correct in stating she was last changed at 1:00 A.M. based on the condition she was in. She verified it appeared she had voided multiple times, especially since urine had soaked through the disposable incontinence brief, bath blanket, washable incontinence pad, and bottom fitted sheet. Interview on 10/28/24 at 11:44 A.M. with Licensed Practical Nurse (LPN) #614 (nurse assigned to Resident #15) revealed CNA #616 was assigned Resident #15's room but was not sure where she was. LPN #614 revealed she was not aware the facility had pulled CNA #616 or that the assignments had changed. Interview on 10/28/24 at 11:45 A.M. with LPN #610 revealed CNA #611 had just found out that she was assigned Resident #15 as they did not realize the other CNA was not on the floor. She stated, honestly, I do not know who was assigned to care for Resident #15 from 7:00 A.M. to 11:26 A.M. She was not aware that CNA #616 was pulled to the kitchen to work. She then stated, I guess CNA #619 was to take CNA #616's spot, but she had been sick in the bathroom. She revealed she was not aware CNA #619 was off the floor and not working as scheduled. Interview on 10/28/24 at 2:49 P.M. with CNA #616 revealed she was assigned to Resident 15's room from 7:00 A.M. till approximately 9:00 A.M. when she was pulled to work in the kitchen. She verified she had not communicated with nurses on the unit (LPNs #610 and #614) that she had been pulled and/or any of the other aides on the floor as she just figured management told them. She verified she had not provided incontinence care for Resident #15 from 7:00 A.M. to 9:00 A.M. Review of the daily staffing assignment sheet for 10/28/24 revealed the first-floor unit had scheduled LPN #610, LPN #614, CNA #611 and CNA #613 from 7:00 A.M. to 7:00 P.M. CNA #616 was assigned from 7:00 A.M. till 9:00 A.M. then was pulled to work in the kitchen. CNA #617 was scheduled to work from 10:00 A.M. to 7:00 P.M. and CNA #619 was scheduled 9:00 A.M. till 7:00 P.M. but was sent home. Interview on 10/29/24 at 11:49 A.M. with Scheduler/ CNA #620 verified she pulled CNA #616 to work in the kitchen at 9:00 A.M. She revealed usually the floor nurse or unit manager updated the staffing assignment as to which residents a staff was assigned. She revealed she was not aware CNA #619 was not on the floor working as scheduled and had heard she was sent home because she was arguing with management. Interview on 10/29/24 at 12:00 P.M. with the Director of Nursing (DON) verified on 10/28/24 CNA #616 was pulled from the first floor to work in the kitchen. She verified CNA #619 was to take her assignment but CNA #619 was in the bathroom (ill). She verified she was not aware she was not completing her assignment as scheduled until she was notified of the condition Resident #15 was found in. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including schizophrenia, dementia with agitation, diabetes, and frontotemporal neurocognitive disorder. Review of the undated care plan revealed Resident #48 was non-compliant with personal care, incontinence care, and assistance with transfers. Interventions included attempting to educate in relation to compliance, educating the resident on negative outcomes related to noncompliance, notifying the physician of noncompliance, and explaining all procedures prior to starting. Review of the undated care plan revealed Resident #48 was at risk for alteration in elimination related to occasional incontinence of bowel and bladder and his need for assistance with toileting may fluctuate. Interventions included providing incontinence care as needed, monitoring for skin irritation and redness, and monitoring for signs of urinary tract infections. Review of the care plan dated 02/10/22 revealed Resident #48 had a behavior of urinating in inappropriate places in the facility. Interventions included educating him on infection control when urinating in inappropriate places, encouraging the resident to ask for assistance, offering toileting assistance every two hours and as needed, and showing the resident appropriate places to void. Review of the quarterly MDS assessment dated [DATE] revealed Resident #48 had cognitive impairment as his brief interview of mental status (BIMS) score was a five. There was nothing identified by the MDS that he rejected care. He required partial to moderate assistance with toileting hygiene, showering, lower body dressing, and transfers. He was always incontinent of urine and occasionally incontinent of bowel. Review of the nursing notes dated from 09/01/24 to 10/24/24 revealed there was no documented evidence of Resident #48 refusing care including toileting hygiene and cleaning of his room. Review of the toileting hygiene under the task bar in the electronic medical record revealed from 10/01/24 to 10/29/24 there was no documented evidence that Resident #48 refused care. There was no documented evidence Resident #48 received toileting hygiene assistance on 10/28/24. Review of the Visual/Bedside Kardex Report dated 10/28/24 revealed Resident #48 was to receive a check and change every two hours and as needed and staff were to show him the appropriate places to void. Observation on 10/28/24 at 11:00 A.M. revealed a strong urine smell continued to surround the hallway leading to Resident #48's room. Resident #48 was not in his room but in the center of his room was a large puddle of liquid that smelled of urine. His bed was unmade, and a pile of urine-soaked sheets were against the wall with dried yellow and brown rings throughout the sheets. Interview on 10/28/24 at 12:25 P.M. and 10/29/24 at 11:20 A.M. with the Director of Nursing (DON) verified there was a strong urine smell throughout the hallway leading towards Resident #48's room. She verified there was a large puddle of urine in the center of Resident #48's room and CNA #613 had just entered the room to pick up the urine-soaked sheets that were against the wall. The DON verified there was not documented evidence in Resident #48's nursing notes and/or task bar that he refused incontinence care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses including diabetes, urinary incontinence, major depression, and hypertension. Review of the care plan dated 12/27/23 revealed Resident #7 had an alteration in elimination related to occasional incontinence of bladder and her toileting assistance fluctuated. Interventions included providing incontinence care as needed, monitoring for signs of urinary tract infection, and monitoring for skin redness and irritation. Review of the task bar regarding bladder continence documentation for the last 30 days revealed from 09/30/24 till 10/28/24 it was documented Resident #7 was incontinent every day except 10/03/24, 10/08/24, and 10/15/24. There was no documented evidence Resident #7 refused incontinence care during this time frame. Review of the annual MDS assessment dated [DATE] revealed Resident #7 had impaired cognition. She required supervision to touching assistance with toileting hygiene, dressing, and transfers. She was occasionally incontinent of urine and frequently incontinent of bowel. Review of the Visual/Bedside Kardex Report dated 10/28/24 revealed Resident #7 was continent of bowel and bladder. Resident #7 was able to maintain her toileting hygiene with supervision and minimal assistance. Observation on 10/28/24 at 12:01 P.M. as this surveyor walked by Resident #7 room, there was a strong urine odor lingering in the hallway outside of Resident #7's closed door. After knocking and receiving permission to enter from Resident #7, this surveyor observed Resident #7 sitting up in her wheelchair folding incontinent products on her over the bed table. Observation revealed a soiled washable incontinence pad lying in Resident #7's bed that had dried dark brown urine rings surrounding the length of the pad and the top sheet was also stained with yellow and brown urine. Interview on 10/28/24 at 12:01 P.M. with Resident #7 stated, the girl usually comes around and fixes the bed, but I have not seen her. Interview on 10/28/24 at 12:05 P.M. with LPN #610 verified the above findings that Resident #7's washable incontinent pad and top sheet had dried brown and yellow rings and stains caused by urine. She was unsure why Resident #7 had not received care including incontinence care and a bed change. She verified CNA #611 had not communicated with her that Resident #7 refused care. Interview on 10/28/24 at 12:14 P.M. with CNA #611 revealed she was assigned to Resident #7, and Resident #7 does her own care, including taking herself to the toilet. She verified she had not completed any checks and changes for Resident #7 regarding incontinence care from the time she came on duty at 7:00 A. M. Interview and observation on 10/28/24 at 12:20 P.M. with the DON verified Resident #7's washable incontinent pad had dried brown rings, and her top sheet had yellow brown urine stains. She asked Resident #7 if staff could come in and change her bedding she stated, oh sure, they can come in. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/29/24 at 11:24 A.M. with Registered Nurse (RN)/MDS #618 verified the care plan and MDS revealed Resident #7 was incontinent, but the Kardex stated Resident #7 was continent. Staff utilize the Kardex on the floor to know the care needs a resident, including incontinence care, and verified the Kardex was inaccurate. Review of the facility policy labeled, Perineal Care, dated October 2010, revealed the purpose was to provide cleanliness and comfort to the resident, prevent infections, prevent skin irritation, and observe resident's skin condition. The following information should be recorded in the resident's medical record: if the resident refused the procedure, the reason for the refusal, and the intervention taken. There was nothing in the policy regarding the frequency of the incontinence care. Review of the facility policy labeled, Facility Assessment, dated October 2018, revealed a facility assessment was to be conducted annually to determine and update the needs and competency care for the residents during day-to-day operations. The facility assessment was to include factors that affect the overall acuity of the residents including incontinence, need for assistance with activities of daily living, cognitive and behavioral impairments. The facility assessment also was to include a detailed review of resources available including staffing personnel (directors, managers, regular employees, contracted staff and volunteers). Review of the Facility Assessment, dated 01/18/24, revealed the facility would provide adequate staffing to meet the residents' needs, preferences and routines. This included an RN for at least eight consecutive hours a day, a designated licensed nurse to serve as a charge nurse on each tour of duty and adequate staffing on each shift to ensure residents' needs were met. There was no breakdown regarding how many nurses and direct care staff the facility would have except that the facility would not fall below the minimum daily average required by the law. This deficiency represents non-compliance investigated under Master Complaint Number OH00159140.

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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. 39973 Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure the kitchen was maintained in a safe and sanitary manner. This had the potential to affect all residents residing at the facility except two residents (Residents #88 and #94) identified by the facility as receiving nothing by mouth. The facility census was 102. Findings include: 1. Observation of the dishwasher on 10/24/24 from 8:38 A.M. till 8:45 A.M. revealed Dietary Aide #605 was actively cleaning breakfast dishes through the dishwasher. Observation of the gauges on the front of the dishwasher revealed the gauges did not move when she ran each cycle: the rinse gauge was set at 152 degrees Fahrenheit (F), and the sanitizer gauge was set at 154 degrees F. There was a back gauge on the dishwasher which also did not move that was at 156 degrees F during all cycles. Interview on 10/24/24 at 8:43 A.M. with Dietary Aide/Cook #604 verified during all three cycles, the three gauges did not move from the start of the cycle to the end. She revealed she was unsure how they measured the temperature of the rinse and sanitation cycle and/or how they knew if it reached a safe temperature for proper sanitation of the dishes. She was asked if they documented the temperatures anywhere and she stated, no, I do not see where we do that; I'm not sure what that is. Interview on 10/24/24 at 8:45 A.M. with Dietary Aide #605 who was the aide running the dishes through the dishwasher revealed she had worked at the facility for a couple months, and her routine job was running the dishes through the dishwasher. She revealed she had not received any training regarding looking at the gauges to know what the appropriate temperature for a rinse cycle and/or sanitation cycle. She had never checked the temperature by means of the gauges and/or any other means. She verified she had never documented the temperatures of the dishwasher on a log sheet. Interview on 10/24/24 at 8:52 A.M. with Food Service Director #606 revealed she had just started on 10/21/24. The dishwasher was a hi-low dishwasher and according to the manufacture's sign located on the dishwasher, the wash cycle was to be from 155 to 165 degrees F, and the rinse cycle was to be from 180 to 195 degrees F. Food Service Director #606 observed a cycle of dishes and verified the gauges on the outside of the dishwasher did not move: the rinse gauge was 152 degrees F, and the sanitizer gauge was at 154 degrees F. She was not aware the gauges were not working, and that staff were not utilizing a log sheet to record the dishwasher temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and observation on 10/24/24 at 9:27 A.M. after the entrance conference, the Administrator revealed that she had been the one completing audits regarding the dishwasher temperatures and verified that she thought the gauges were to remain where they were at and not supposed to move: the rinse gauge was at 152 degrees F and the sanitizer gauge was at 154 degrees F. She stated, to be honest I thought where they were at meant they were normal. She was never trained or knew what the temperatures of the dishwasher were to be, and she completed the audits. She had a staff member come from another facility, and they had never stated that the dishwasher gauges needed to move or that there was an issue if they did not. Observation with the Administrator revealed the gauges continued to be stuck at the same reading, and she verified for the past few weeks the gauges were like that each time she looked at them; she assumed that was normal. Interview on 10/28/24 at 9:30 A.M. with the Administrator revealed the dishwasher repair contractor was out on 10/24/24 and adjusted the water temperature and that currently they were utilizing a thermometer to measure the sanitation temperature while washing the dishes as the gauges continued to be broken. 2. Review of the facility form labeled, 3-Compartment Sink Chemical Concentration Level for September 2024 revealed the facility tested the three-compartment sink concentration levels for each meal by utilizing Quat testing strips, and the level was to be 200 parts per million (ppm) per manufacture guidelines. There was no form for October 2024 located in the kitchen. Observation and interview on 10/24/24 at 8:48 A.M. with Dietary Aide/Cook #604 revealed there was a bucket filled with sanitizer in the three-compartment sink that contained a washcloth inside the bucket. Dietary Aide/Cook #604 revealed they utilized the bucket to wash off the counter tops in the kitchen. She revealed she was unsure how to test the sanitation level of the bucket and the sanitizer that comes out of the three-compartment sink as there were no testing strips. Dietary Aide/Cook #604 revealed she had not seen testing strips for a while and that they had not been documenting the concentration levels of the sanitizer for the month of October 2024. Interview on 10/24/24 at 8:52 A.M. with Food Service Director #606 verified she did not have documented evidence that staff tested the concentration level of the three-compartment sink from 10/01/24 to 10/24/24. She also verified there were no testing strips to test the concentration level. 3. Review of the freezer temperature log from 10/01/24 to 10/24/24 revealed the freezer temperature was checked twice a day and ranged from eight to ten degrees F. On 10/24/24 the freezer temperature was recorded as eight degrees F. Observation on 10/24/24 at 8:56 A.M. with Food Service Director #606 verified the thermostat outside by the entrance to the freezer was 10 degrees F. The thermostat inside the freezer was 19 degrees F. Observation revealed the food inside the freezer was not frozen solid including four large ice cream containers were semi-liquid, ravioli and chicken in a bag when touched was mushy in nature, and pies on the back wall were not frozen. Interview on 10/24/24 at 8:56 A.M. with Food Service Director #606 verified the food in the freezer was not frozen solid. She revealed she started on 10/21/24 and was not aware this was an issue. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365071	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachwood Pointe Care Center	23900 Chagrin Blvd 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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on 10/24/24 at 9:30 A.M. with the Administrator verified the food in the freezer was not frozen as most of the food was either semi-liquid and/or mushy in nature. She verified she was not aware there was an issue regarding the food not being frozen solid. Interview on 10/28/24 at 9:09 A.M. with Maintenance Director #609 revealed there was an issue on 10/24/24 with the freezer maintaining proper temperature and keeping the food frozen solid. He stated the outside coil needed to be cleaned causing the freezer not to properly work. Review of the facility policy labeled, Refrigerators and Freezer, dated 2001, revealed the facility would ensure safe refrigerator and freezer maintenance, temperatures, and sanitation. The acceptable temperature of a freezer was to be less than zero degrees F. The policy revealed monthly tracking sheets would be posted, and employees would check and record the refrigerator and freezer temperatures daily. The supervisor would take immediate action if the temperature was out of range. Review of the facility policy labeled, Dish Machine Temperature Log, dated 2023, revealed dishwashing staff would monitor and record dish machine temperatures to assure proper sanitation of dishes. The policy revealed staff would be trained to report any problems with the dish machine to the Food Service Director. The Food Service Director would post a log near the dish machine for the staff to document temperatures. Review of the facility policy labeled, Cleaning Dishes- Manual Dishwashing, dated 2023, revealed dishes and cookware would be cleaned and sanitized after each meal. The policy revealed staff were to check the sanitation of the sink frequently using test strips to assure the level of sanitation solution was appropriate. This deficiency is an incidental finding identified during the complaint survey and is an example of continued non-compliance from the surveys completed on 07/23/24 and 09/25/24.