STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365088	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Englewood Health and Rehab	425 Lauricella Court Englewood, OH 45322

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview, and policy review, the facility failed to ensure resident representatives were notified of changes in medications. This affected one (#100) out of the three residents reviewed for notification of medication changes. The facility census was 95. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE] with medical diagnoses of acute kidney failure, diabetes mellitus, schizophrenia, and anxiety. Review of the medical record for Resident #100 revealed a quarterly Minimum Data Set (MDS) assessment, dated 12/09/24, which indicated Resident #100 had moderate cognitive impairment and required supervision with toilet hygiene, bathing, bed mobility, and transfers. The MDS indicated Resident #100 received an antipsychotic medication, but no other psychotropic medications noted. Review of the medical record for Resident #100 revealed a physician order dated 02/14/25 for sertraline 25 milligram (mg) one tablet by mouth daily for anxiety. The medical record indicated the sertraline was discontinued on 02/21/25. Review of the medical record for Resident #100 revealed the February 2025 Medication Administration Record (MAR) which indicated Resident #100 received sertraline 25 mg tablet daily from 02/16/25 through 02/19/25. The MAR revealed Resident #100 refused the sertraline on 02/20/25 and 02/21/25. Review of the medical record for Resident #100 revealed no documentation to support the facility notified Resident #100 representative of sertraline 25 mg order on 02/14/25. Review of the medical record for Resident #100 revealed a nurse's note, dated 02/21/25 at 8:09 P.M., which stated sertraline was discontinued by psychology nurse practitioner per family request. Interview on 04/02/25 at 9:08 A.M. with Director of Nursing (DON) confirmed the medical record for Resident #100 did not have documentation to support the facility notified Resident #100's representative of the order for sertraline. DON stated the facility did not have a policy for notification of order for new medication. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Change in Resident's Condition or Status, revised February 2021 stated the facility would promptly notify resident, his or her attending physician, and resident representative of changes in the resident's medical/mental condition and/or status. This deficiency represents non-compliance investigated under Complaint Number OH00162952.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview, and policy review, the facility failed to develop a comprehensive person-centered care plan to address a resident's Activities of Daily Living (ADL) and incontinence care needs. This affected one (#37) out of the three residents reviewed for care plans. The facility census was 95. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE] with medical diagnoses of sepsis, convulsions, hypertension, cerebral infarction, atrial fibrillation, diabetes mellitus, and hypothyroidism. Review of the medical record for Resident #37 revealed a quarterly Minimum Data Set (MDS) assessment, dated 01/28/25, which indicated Resident #37 was cognitively intact and required substantial/maximum assistance with toilet hygiene, bathing, transfers, and bed mobility. The MDS indicated Resident #37 had a indwelling catheter and was always incontinent of bowel. Review of the medical record for Resident #37 revealed there was no documentation to support the facility had developed a comprehensive person-centered care plan to address the residents ADL's and incontinence needs. Interview on 04/02/25 at 11:50 A.M. with Administrator confirmed the medical record for Resident #37 did not have documentation to support a comprehensive person-centered ADL or incontinence care plan had been developed for Resident #37 until 04/02/25. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022 stated the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, would develop and implement a comprehensive, person-centered care plan for each resident. The policy stated the comprehensive, person-centered care plan would include measurable objectives and timeframe's and describe the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being and includes resident's stated goals. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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 - Few	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** 46613 Based on medical record review, observations, staff and resident interviews, and policy review, the facility failed to provide timely incontinence care for a dependent resident. This affected one (#37) out of the three residents reviewed for timely incontinence care. The facility census was 95. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE] with medical diagnoses of sepsis, convulsions, hypertension, cerebral infarction, atrial fibrillation, diabetes mellitus, and hypothyroidism. Review of the medical record for Resident #37 revealed a quarterly Minimum Data Set (MDS) assessment, dated 01/28/25, which indicated Resident #37 was cognitively intact and required substantial/maximum assistance with toilet hygiene, bathing, transfers, and bed mobility. The MDS indicated Resident #37 had a indwelling catheter and was always incontinent of bowel. Review of the medical record for Resident #37 revealed there was no documentation to support the facility had developed a comprehensive person-centered care plan to address the residents Activities of Daily Living (ADL's) and incontinence needs. Observation on 03/31/25 at 2:25 P.M. revealed Resident #37 turned on his call light. The observation revealed a strong odor outside of Resident #37's door. Observation also revealed Licensed Practical Nurse (LPN) #217 was sitting at the nurses station at the time Resident #37 turned his call light on no other staff was observed on the hall. Interview on 03/31/25 at 2:30 P.M. with Resident #37 confirmed he turned on his call light at 2:25 P.M. Resident #37 stated he needed staff assistance to be cleaned up after being incontinent of bowel. Observation on 03/31/25 at 3:12 P.M. revealed Certified Nursing Assistant (CNA) #219 knocked on Resident #37's door and asked if he needed assistance. CNA #219 turned off Resident #37's call light and as she exited Resident #37's room stated she would be back soon to help him get cleaned up. Interview on 03/31/25 at 3:21 P.M. with Resident #37 confirmed CNA #219 turned off his call light and informed Resident #37 she would be back soon to help get him cleaned up. Resident #37 stated he usually has to wait up to 45 minutes for his call light to be answered. Observation on 03/31/25 at 3:23 P.M. revealed CNA #219 entered Resident #37's room and closed the door. Interview on 03/31/25 at 3:35 P.M. with CNA #219 confirmed she completed incontinence cares for Resident #37 and he had been incontinence of his bowel. CNA #219 stated she was not aware of how long Resident #37's call light had been on. CNA #219 also confirmed she entered Resident #37's room and turned off his call light and then left and came back to provide the cares about 10 minutes later. (continued on next page)

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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 - Few	Review of the facility policy titled, Activities of Daily Living (ADL's), revised March 2018 stated residents who are unable to carry out ADL's independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The policy stated staff would provide the appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care), mobility, elimination (toileting), dining, and communication. This deficiency represents non-compliance investigated under Complaint Number OH00162075.

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	365088	A. Building B. Wing	04/02/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interviews, and policy reviews, the facility failed to ensure wound care was completed as ordered and failed to send a resident to the emergency department as ordered. This affected one (#97) out of three residents reviewed for wound care and services and changes in condition. The facility census was 95. Findings include: Review of the medical record for Resident #97 revealed an admitted [DATE] with medical diagnoses of influenza, chronic kidney disease stage III, atrial fibrillation, diabetes mellitus, congestive heart failure, peripheral vascular disease. The medical record indicated Resident #97 was discharged on [DATE] to the hospital. Review of the medical record for Resident #97 revealed an Admission Data Collection assessment, dated 03/11/25, which indicated Resident #97 was cognitively intact and required limited staff assistance with bed mobility and extensive staff assistance with transfers and toileting. Review of the medical record for Resident #97 revealed a weekly non-pressure documentation assessment, dated 03/13/25, which stated Resident #97 admitted with arterial ulcers to right heel, left medical foot, left heel and right great toe. Review of the medical record for Resident #97 revealed a physician order dated 03/14/25 for left heel to clean with wound cleaner, pat dry, apply medi-honey to wound bed, cover with dry dressing and to change daily and as needed. Review of the medical record for Resident #97 revealed the March 2025 Treatment Administration Record (TAR) which did not have documentation to support the treatment to Resident #97's left heel was completed on 03/18/25. Review of the medical record for Resident #97 revealed a nurse's note, dated 03/17/25 at 7:03 P.M., written by Registered Nurse (RN) #226, which stated nurse was notified that Resident #97 was having a seizure for approximately two minutes. The note stated vital signs were obtained and the physician on call was notified. The note stated orders were given for stat (immediate) labs and to send Resident #97 to the emergency department (ED) if he had another seizure. The note stated Resident #97's wife was at the bedside and verbalized understanding. Further review of Resident #97's nurse's note dated 03/18/25 at 6:28 P.M., stated the resident had a seizure for two minutes and his wife was present. The note did not have documentation to support Resident #97's physician was notified of second seizure or Resident #97 was sent to the ED as ordered on 03/17/25. Interview on 04/02/25 at 9:10 A.M. with Director of Nursing (DON) confirmed the medical record for Resident #97 did not have documentation to support wound care was done to left heel as ordered on 03/18/25. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/02/25 at 9:16 A.M. with RN #226 confirmed Resident #97 had a seizure on 03/17/25 and she had been given orders for stat labs and to send Resident #97 to the ED if he had another seizure. RN #226 stated she entered the orders for the labs into the electronic health record and noted on the nurse report sheet that if Resident #97 had another seizure to send to the ED. RN #226 stated she was not aware Resident #97 had a seizure on 03/18/25 until she returned to work on 03/19/25. RN #226 stated on 03/19/25 Resident #97's daughter requested Resident #97 be sent to the hospital due to second seizure on 03/18/25 and as per physician order on 03/17/25. Review of the facility policy titled, Dressings, dry/clean, revised September 2013 stated staff are to verify physician order for the procedure, check treatment record, review resident's care plan, and current orders, assemble equipment and supplies and explain procedure to the resident. Review of the facility policy titled, Change in Resident's Condition or Status, revised February 2021 stated the facility would promptly notify resident, his or her attending physician, and resident representative of changes in the resident's medical/mental condition and/or status. This deficiency represents non-compliance investigated under Complaint Number OH00164034.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview, and policy review, the facility failed to administer medication as ordered. This affected one (#100) out of the three reviewed for medication administration. The facility census was 95. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE] with medical diagnoses of acute kidney failure, diabetes mellitus, schizophrenia, and anxiety. Review of the medical record for Resident #100 revealed a quarterly Minimum Data Set (MDS) assessment, dated 12/09/24, which indicated Resident #100 had moderate cognitive impairment and required supervision with toilet hygiene, bathing, bed mobility, and transfers. The MDS indicated Resident #100 received an antipsychotic medication, but no other psychotropic medications noted. Review of the medical record for Resident #100 revealed a physician order dated 02/14/25 for sertraline 25 milligram (mg) one tablet by mouth daily for anxiety. The medical record indicated the sertraline was discontinued on 02/21/25. Review of the medical record for Resident #100 revealed the February 2025 Medication Administration Record (MAR) which indicated Resident #100 received sertraline 25 mg tablet daily from 02/16/25 through 02/19/25. The MAR revealed Resident #100 refused the sertraline on 02/20/25 and 02/21/25. Review of the medical record for Resident #100 revealed an initial psychiatry consult note, dated 01/31/25, which stated Resident #100 was seen for schizophrenia and anxiety. The note stated Resident #100 reported to feel depressed and anxious at times. The note stated to start sertraline 25 mg one tablet by mouth daily. Further review of the medical record for Resident #100 revealed a psychiatry note dated 02/12/25 which stated Resident #100 denied depression or anxiety and to continue sertraline 25 mg one tablet daily. Review of the psychiatry note dated 02/26/25 stated discussed Resident #100's medication with power of attorney and requested sertraline be discontinued. Interview on 04/02/25 at 9:08 A.M. with Director of Nursing (DON) stated some physician or nurse practitioners will give verbal orders for medications and some write orders in the electronic health record. DON confirmed Resident #100's initial psychiatry note dated 01/31/25, had an order to start sertraline 25 mg one tablet by mouth daily and the medication was not ordered until 02/14/25. DON also confirmed the medical record for Resident #100 revealed documentation Resident #100 did not receive sertraline as ordered on 02/15/25. Review of the facility policy titled, Administering Medications, revised April 2019 stated medications are to be administered in a safe and timely manner, and as prescribed. This deficiency represents non-compliance investigated under Complaint Number OH00162952.