

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/31/2024
NAME OF PROVIDER OR SUPPLIER  O'Neill Healthcare Bay Village		STREET ADDRESS, CITY, STATE, ZIP CODE  605 Bradley Rd Bay Village, OH 44140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</b></p> <p>Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure residents had their call lights within reach while unattended in their rooms. This affected three residents (#36, #39, and #43) out of 13 residents reviewed call light placement. The facility census was 108.</p> <p>Findings include:</p> <p>1. Record review for Resident #39 revealed an admitted [DATE]. Diagnoses included displaced fracture of the base of the neck of the left femur, muscle weakness and dementia.</p> <p>Review of the Functional Assessment for Resident #39 dated 12/19/24 at 4:15 P.M. completed by Licensed Practical Nurse (LPN) #241 revealed Resident #39 had no impairment to the upper extremities and impairment to one side of the lower extremities. Resident #39 was dependent on staff for bed mobility.</p> <p>Review of the Interim Care Plan for Resident #39 dated 12/19/24 at 4:12 P.M. revealed Resident #39 was at risk for falls and fall related injuries, interventions included call light/items within reach.</p> <p>Review of the Fall Risk Calculation dated 12/23/24 revealed Resident #39 was at high risk for falls.</p> <p>Review of the skilled nursing documentation for Resident #39 dated 12/29/24 at 10:34 A.M. completed by LPN #228 revealed Resident #39 was alert, responsive to name and touch, her hearing and vision were adequate, her speech was clear, and she was able to understand.</p> <p>Review of the care plan for Resident #39 dated 12/31/24 revealed Resident #39 was a fall risk characterized by a history of falls/injury and multiple risk factors related to femur fracture, weakness and dementia. Interventions included to be sure the call light was within reach and to encourage its use for assistance.</p> <p>Observation on 12/30/24 at 2:41 P.M. revealed Resident #39 was lying in bed with the bed against the wall. Resident #39 was resting with her eyes closed. Observation revealed the call light was located on the opposite side of the room on the floor, out of reach for Resident #39.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365264
		If continuation sheet Page 1 of 5

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 12/30/24 at 2:43 P.M. with LPN #219 confirmed Resident #39 was unable to reach her call light. LPN #219 revealed Resident #39's bed was moved against the wall which made it harder for the call light to reach. LPN #219 demonstrated the call light would reach Resident #39 when stretched across the room.</p> <p>2. Record review for Resident #36 revealed an admitted [DATE]. Diagnoses included multiple sclerosis (MS), paraplegia, change in retinal vascular appearance, and combined forms of age-related cataract bilateral and primary optic atrophy left eye.</p> <p>Review of the care plan updated 05/13/24 revealed Resident #36 was at risk for complications due to vision impairment related to bilateral cataracts, optic atrophy, left eye and changes on retinal vascular appearance. Intervention included ensuring the call light was always within reach and encouraging the resident to call for assistance as needed. An additional care plan updated 07/12/24 revealed Resident #36 was a fall risk characterized by a history of falls/injury, multiple risk factors related to impaired balance, impaired mobility, MS, and poor motor coordination. Interventions included ensuring the call light was within reach and encouraging its use for assistance.</p> <p>Review of the Fall Risk Calculation for Resident #36 dated 06/12/24 revealed Resident #36 was at high risk for falls.</p> <p>Review of the Modification of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was cognitively impaired. Resident #36 had no impairment to the upper extremities and impairment on both sides of the lower extremities. Resident #36's vision was adequate. Resident #36 required supervision or touch assistance with eating and substantial/maximum assistance with toileting.</p> <p>Observation on 12/30/24 at 2:48 P.M. revealed Resident #36 was sitting in a tilt chair in her room with the chair tilted back. The call light was connected to the bed, located behind Resident #36 and out of Resident #36's reach. Resident #36 verified she was unable to reach the call light.</p> <p>Observation and interview on 12/30/24 at 2:49 P.M. with Certified Nursing Assistant (CNA) #310 confirmed Resident #36's call light was out of reach for Resident #36. CNA #310 confirmed Resident #36 used her call light for assistance as needed.</p> <p>3. Record review for Resident #43 revealed an admitted [DATE]. Diagnoses included dementia, transient cerebral ischemic attack, macular degeneration, and epilepsy.</p> <p>Review of the care plan dated 06/26/24 revealed Resident #43 was at risk for vision impairment related to macular degeneration. Interventions included ensuring the call light was within reach at all times and encouraging the resident to call for assistance as needed. An additional care plan for Resident #43 updated 06/26/24 revealed Resident #43 was at risk for falls characterized by a history of falls/injury multiple risk factors related to confusion related to dementia, impaired mobility, incontinence and visual deficit. Interventions included ensuring the call light was within reach and encouraging use for assistance as needed.</p> <p>Review of the Fall Risk Calculation for Resident #43 dated 08/18/24 revealed Resident #43 was at high risk for falls.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #43 was cognitively impaired. Resident #43 had no impairment of the upper or lower extremities, used a wheelchair for mobility, required partial/moderate assistance to wheel 50 feet with two turns, required set up or clean up assistance with meals, and was dependent on staff for toileting and chair to bed transfers.</p> <p>Observation and interview on 12/30/24 at 3:06 P.M. revealed Resident #43 was up in her wheelchair in her room. Resident #43's call light was located behind her bed, out of reach for Resident #43. Resident #43 verified she was unable to reach the call light.</p> <p>Observation and interview on 12/30/24 at 3:08 P.M. with CNA #311 confirmed Resident #43 was able to use her call light normally but was unable to reach her call light located behind her bed.</p> <p>Interview on 12/30/24 at 5:51 P.M. with the Administrator and Director of Nursing (DON) revealed it was the expectation of the facility to have residents' call lights within reach.</p> <p>Review of the facility policy titled, Call Light Response Time Policy, updated December 2023, revealed it was the policy of the facility to ensure residents' needs and requests were responded to in a timely manner. Staff members were responsible for answering call lights.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160465.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42011</p> <p>Based on record review, interview, review of the facility self-reported incident (SRI) and review of the facility policy, the facility failed to timely report an allegation of abuse for Resident #111. This had the potential to affect one resident (#111) of three residents reviewed for abuse. The facility census was 108.</p> <p>Findings include:</p> <p>Record review for Resident #111 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included metabolic encephalopathy, cirrhosis of the liver, acute respiratory failure with hypoxia, muscle weakness, atherosclerotic heart disease, history of transient ischemic attack (TIA), acute kidney failure, and atrial fibrillation.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) assessment for Resident #111 revealed the resident was cognitively intact. Resident #111 used a walker for mobility, had no impairment to upper extremities, impairment on one side of the lower extremities, was independent with eating, dependent on staff for toileting, partial moderate assistance with bed mobility, dependent for sit to stand and transfers. Resident #111 was occasionally incontinent of bowel and bladder.</p> <p>Review of the SRI tracking number 254754 dated 12/04/24 at 6:21 P.M. completed by Administrator revealed on 12/04/24 at 3:45 P.M. the daughter of Resident (#111) alleged neglect during her mom's stay in a conversation with the Administrator and Director of Nursing (DON). The allegation was investigated and unsubstantiated on 12/11/24 by the Administrator.</p> <p>Review of the investigation for the SRI tracking number 254754 completed 12/04/24 for the allegation related to Resident #111 revealed the written statement dated 11/30/24, untimed, completed by Licensed Practical Nurse (LPN) #222 revealed - This nurse answered the phone, the granddaughter of patient in room [ROOM NUMBER] (Resident #111) called upset asking to speak to the Administrator regarding a male Certified Nursing Assistant (CNA) that worked on night shift last night. The granddaughter stated her grandmother (Resident #111) told her that a man answered her call light and when she asked to go to the bathroom, he refused to take her and told her she had to use the bedpan. The resident's granddaughter also said her grandmother also told her the same man took her call light and TV remote away from her and put it on the floor. Also, he took her personal cell phone away from her and told her, you don't need to call anyone, it's time to go to sleep. The on-call manager and DON were notified. The handwritten statement was signed by LPN #222.</p> <p>Interview on 12/31/24 at 3:09 P.M. with Administrator, DON, and Director Clinical Services #313 included the Director Clinical Services #313 and DON reviewed the written statement dated 11/30/24 completed by LPN #222. The DON revealed LPN #222 wrote the statement on 11/30/24 and called her to inform her of the allegations on 11/30/24. The DON again read the statement completed by LPN #222 and confirmed everything written in the statement was what LPN #222 told her on 11/30/24. The DON stated, She called me on the 30th and reported the allegations. I called the Administrator and told her. Per the Administrator, the DON only told her about the cell phone, she did not find out the rest until the 12/04/24. The Administrator confirmed the SRI was initiated 12/04/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Abuse, Neglect, Involuntary Seclusion, Misappropriation Prevention, revised 10/2017, revealed ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment , including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials in accordance with state law through established procedures.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160465.</p>