STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365267	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Neill Healthcare Lakewood	13900 Detroit Ave Lakewood, OH 44107

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on observations, record review, and interview the facility failed to ensure Resident #9 had her blood drawn in a private area to maintain infection control. The affected one resident (#9) of three residents reviewed for resident rights. The facility census was 95. Findings include: Review of the medical record for Resident #9 revealed an admitted [DATE]. Diagnoses included Parkinsonism, low back pain, cognitive communication disorder, and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had moderate cognitive impairment. Residents required supervision set-up help only for bed mobility; total dependence of two-persons for transfers; and extensive one-person assistance for eating and toilet use. Review of the physician's order dated 04/15/24 revealed Resident #9 was to have a complete blood count (CBC) and basic metabolic panel (BMP) drawn every Monday for routine labs. Review of the care plan dated 05/22/24 revealed Resident #9 had impaired cognitive function with impaired thought process. Interventions included encouraging resident and family involvement and keep the resident's routine consistent and try to provide consistent caregivers. Observation on 05/28/24 at 9:40 A.M. revealed Phlebotomist #621 drawing blood from Resident #9 in the hallway in front of the nurse's station. During the blood draw Registered Nurse (RN) #563 came out of a resident's room and looked at Phlebotomist #621 and stated, What are you doing? Do you need me to help you get her to her room? Phlebotomist #621 stated you told me I could draw her blood here. RN #563 stated, no, you asked where Resident #9 was, and I simply helped you identify her. Phlebotomist #621 then finished drawing Resident #9's blood and entered another resident room. Interview after the observation with Phlebotomist #621 confirmed she did draw Resident #9's blood in the hallway. Interview on 05/28/24 at 9:45 A.M. with Resident #9 confirmed she just had her blood drawn in the hallway, but she was not sure why. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/28/24 at 9:47 A.M. with RN #563 confirmed blood was never to be drawn outside of a resident's room. She reported she helped the phlebotomist identify Resident #9 but never told her to draw her blood right there in the hallway. This deficiency was an incidental finding identified during the 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on record review, interview, and facility policy review the facility failed to complete an accurate admission assessment for Resident #97. This affected one resident (#97) of three residents reviewed for admission assessments. The facility census was 95. Findings include: Review of the closed medical record for Resident #97 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included unspecified open wound of the abdominal wall, chronic obstructive pulmonary disorder, type two diabetes mellitus, and hypertensive chronic kidney disease with stage five end stage renal disease. Review of the admission assessment dated [DATE] for Resident #97 revealed no documentation related to Resident #97's abdominal wound. The assessment also listed absent bilateral pedal and radial pulses. Resident #97 was listed as having a colostomy with no assessment of the colostomy site. Resident #97 was listed as complaining of pain in his buttocks/coccyx area, but no skin assessment was completed. No height or weight was obtained or documented. Review of the interim care plan dated 01/12/24 revealed Resident #97 was at risk for falls and Resident #97 was at risk for skin impairment. No other information was available. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #97 was not assessed for cognition. Resident #97 required extensive two-person assistance for bed mobility, extensive one-person assistance for eating, and total dependence of one-person for toileting. Resident #97 was always incontinent of urine and had an ostomy for bowel elimination. Interview on 05/28/24 at 2:03 P.M. with Corporate Registered Nurse (RN) #623 confirmed Resident #97's admission assessments were not complete or accurate. She reported that the nurse who completed the assessment was no longer employed by the facility. Review of the undated facility policy, Admitting the Resident, revealed all resident assessment data observed during the observation should be documented. Also, the resident's height and weight should be documented. This deficiency represents noncompliance investigated under Complaint Number OH00153495.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on record review, interview, and facility policy review the facility failed to provide a diet order or baseline height and weight for Resident #97 during his stay at the facility. This affected one resident (#97) of three residents reviewed for nutrition. The facility census was 95. Findings include: Review of the closed medical record for Resident #97 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included unspecified open wound of the abdominal wall, chronic obstructive pulmonary disorder, type two diabetes mellitus, hypertensive chronic kidney disease in stage five end stage renal disease. Review of the discharge paperwork from the hospital for Resident #97 dated 01/12/24 revealed no diet order. Review of the physician's orders for January 2024 for Resident #97 revealed no orders for a diet. Review of the admission assessment dated [DATE] for Resident #97 revealed no height or weight. Review of the interim care plan dated 01/12/24 for Resident #97 revealed nothing related to diet. Review of the dietary communication form dated 01/12/24 for Resident #97 revealed he was a new admission. His diet order was listed as regular, with regular texture, and thin liquids. Resident #97 was allowed supplements with ordered meals if he ate less than 50% of his meal. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #97 required extensive one-person assistance for eating. Interview on 05/28/24 at 3:00 P.M. with the Administrator and Corporate Registered Nurse (RN) #623 confirmed that Resident #97 had no official diet order during his stay from a physician or a dietician. They also confirmed no height or weight was obtained on his admission. Corporate RN #623 confirmed the nurse who authored the dietary communication form with no physician order was no longer employed by the facility. Interview on 05/29/24 at 9:30 A.M. with Dietary Manager #531 reported that when a resident was admitted , a dietary communication form was completed by the nurse. Then the resident is assessed by the dietician and the speech therapist, and a final dietary order was obtained and placed into the electronic medical record system. Review of the undated facility policy, Diet Changes and Reports, revealed the charge nurse is responsible for notifying the dietary manager on duty of any changes in the resident's diet or meal service. The charge nurse will notify the dietary manager on duty when a new resident has been admitted and the type of diet the resident is to receive. Notification of the dietary manager will be through hand-written communication. Oral communication is permitted. However, all oral communication must be followed up with written communication. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint Number OH00153495.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on record review, interview, and facility policy review the facility failed to provide wound physician follow-up for a complicated abdominal wall wound for Resident #97 as ordered on admission. This affected one resident (#97) of three residents reviewed for physician services. The facility census was 95. Findings include: Review of the closed medical record for Resident #97 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included unspecified open wound of the abdominal wall, chronic obstructive pulmonary disorder, type two diabetes mellitus, and hypertensive chronic kidney disease in stage five end stage renal disease. Review of the hospital paperwork for Resident #97 revealed he was evaluated on 01/04/24 by a surgeon stating the reason for consultation was evaluation and management of infected abdominal wall surgical site ulcer. Resident #97 was at the hospital from 11/24/23 to 12/13/23 where he was found to have a large bowel obstruction and he underwent an exploratory laparotomy with loop transverse colostomy. He was discharged to an extended care facility and then returned on 12/16/23 with shortness of breath. He was in the hospital until 12/20/23 and was discharged with a wound vac to his abdominal wall surgical site. He was being managed with the wound vac at the extended care facility when the staff sent him in for foul smelling drainage from the site on 01/03/24. The site was found to be infected, and he was treated with antibiotics and the wound vac was discontinued. He was discharged to the facility on [DATE]. His discharge orders included oral antibiotics and no incision care orders. No follow-up appointments were made. Review of the admission assessment dated [DATE] revealed Resident #97 had no wound issues. Review of a separate skin assessment dated [DATE] revealed Resident #97 had an abdominal surgical incision that was to be assessed by the wound care team. No measurements were available, and it was listed as all granulation tissue, base was beefy red, it had moderate serosanguineous drainage with no odor, and the surrounding skin was normal. Review of the interim care plan dated 01/12/24 for Resident #97 revealed he was at risk for impaired skin integrity. Interventions included elevating heels when in bed and providing wound care per physician order. Review of the physician's orders revealed an order dated 01/13/24 Resident #97 was to be assessed by the wound care physician on 01/15/24. The order was cancelled on 01/16/24 with no reason for cancellation. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #97 required extensive two-person assistance for bed mobility, extensive one-person assistance for eating, and total dependence of one-person for toilet use. Resident #97 was always continent of urine and had an ostomy for bowel elimination. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 05/28/24 at 3:00 P.M. with the Administrator and Corporate Registered Nurse (RN) #623 reported that Resident #97 was admitted late on a Friday night and his discharge instructions did not even list a surgeon or a follow-up appointment. They reported his order for his abdominal wound to be evaluated by the wound care team on 01/15/24 was discontinued because he was being discharged . The confirmed Resident #97 was not discharged from the facility until 01/16/24. Review of the undated facility policy, Pressure Ulcer Prevention Treatment Protocol, revealed in the event a resident is admitted with, or develops a wound interventions for wound care will be implemented per the wound care protocol and or physician orders. Referrals may be made, as needed, to the wound care specialist or therapy to aid in the treatment and healing of the wound. This deficiency represents noncompliance investigated under Complaint Number OH00153495.