

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/18/2026
NAME OF PROVIDER OR SUPPLIER  O'Neill Healthcare Lakewood		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review and interview, the facility failed to supervise a cognitively impaired resident while at an outside appointment. This affected one (Resident #60) of three residents reviewed for outside appointments. The total census was 91. Findings include: Record review of Resident #60 revealed he was admitted to the facility 11/29/24 and had diagnoses including prostate cancer and neuromuscular bladder. His minimum data set assessment on 12/29/25 identified him to have moderate cognitive impairment. There was no documentation of him going out to an appointment on 12/31/25. Interview with Veterans Affairs (VA) Social Worker (SW) #701 on 02/17/26 at 10:40 A.M. revealed the facility sent Resident #60 to a VA appointment on 12/31/25 with no escort. The resident had limited cognitive status and could not participate in the appointment. An attempt to interview Resident #60 on 02/18/26 at 11:36 A.M. revealed he was not interviewable. Interview with Unit Manager Licensed Practical Nurse (LPN) #202 and the Director of Nursing (DON) on 02/18/26 revealed the facility did not maintain a record of assigned escorts for past appointments. Interview with VA Registered Nurse (RN) #702 on 02/17/26 at 4:09 P.M. revealed Resident #60 came for his appointment on 12/31/26 without any escort or spokesperson. He was not able to answer any questions except his name and did not know why he was there. VA staff reached out to his family but was not able to reach them. She described it as a wasted appointment due to the lack of ability to exchange any substantial information. Interview with Unit Manager LPN #801 and the DON on 02/18/26 at 10:25 A.M. revealed the facility normally sent an escort with cognitively impaired residents and could not speak for why this was not done for Resident #60. Record review of VA documentation revealed a physician note dated 12/31/25 which identified Resident #60 as having a history of dementia. Resident #60 presented unaccompanied from the nursing home, was oriented to name only, and was not able to participate in conversation. A VA social worker note dated 01/06/26 revealed Resident #60 was sent to an appointment on 12/31/25 with no escort despite his dementia and was not able to answer questions beyond his name. Interview with the Administrator on 02/17/26 at 4:40 P.M. verified Resident #60 was sent to an appointment with limited cognition and no escort. This deficiency represents noncompliance investigated under Complaint Number 2709380.</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: 365267	If continuation sheet Page 1 of 3

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review and interview, the facility failed to notify the receiving facility when a resident with Influenza A was sent to an outside appointment or reschedule the appointment as needed appropriately. The facility also failed to use enhanced barrier precautions appropriately during wound care. This affected two (Residents #17 and #60) of three residents reviewed for infection control. The total census was 91. Findings include: 1. Record review of Resident #60 revealed he was admitted to the facility 11/29/24 and had diagnoses including prostate cancer and neuromuscular bladder. His minimum data set assessment on 12/29/25 identified him to have moderate cognitive impairment. A nasal swab result dated and reported 12/28/25 tested him positive for Influenza A. Review of his orders and treatment administration record revealed him to have been on droplet precautions for influenza from 12/29/25 to 01/05/26. There was no documentation of him going out to an appointment on 12/31/25. Interview with Veterans Affairs (VA) Social Worker #701 on 02/17/26 at 10:40 A.M. revealed the facility sent Resident #60 to a VA appointment on 12/31/25 without giving notice the resident was on droplet isolation for testing positive for Influenza A. An attempt to interview Resident #60 on 02/18/26 at 11:36 A.M. revealed he was not interviewable. Interview with VA Registered Nurse (RN) #702 on 02/17/26 at 4:09 P.M. revealed Resident #60 came for his appointment on 12/31/25 with no notice that he tested positive for the flu. After the appointment, his VA doctor saw that he had the flu while checking his chart. Resident #60 attends appointments on an oncology floor and so everyone including him wore masks as part of their general policy, however it was not an urgent appointment and would have been rescheduled had the VA staff known he had the flu. She said the event presented a risk to other patients on that unit, many of whom were immunocompromised. Interview with Unit Manager Licensed Practical Nurse (LPN) #801 and the Director of Nursing on 02/18/26 at 10:25 A.M. revealed the facility sent Resident #60 to his appointment with paper orders, including that he was on isolation for influenza. It was not their process to call specific report before sending residents out to appointments. Record review of VA documentation revealed a physician note dated 12/31/25 which identified Resident #60 as having a history of dementia. Resident #60 presented unaccompanied from the nursing home, was oriented to name only, and was not able to participate in conversation. A VA social worker note dated 01/06/26 revealed Resident #60 was sent to an appointment on 12/31/25 after testing positive for the flu. Per her interview with a facility representative, the resident was to have been isolated from 12/29/25 to 01/07/26. The VA was not made aware of this until after the appointment. Record review of the facility's infection control log revealed Resident #60 was identified to have Influenza A starting on 12/28/25 and resolving on 01/03/26. Record review of the facility's undated droplet isolation policy revealed staff were to wear masks when working within three feet of an isolated resident, to limit unnecessary transport of the resident, and to have them wear surgical masks when essential transportation required them to leave the room. Interview with the Administrator on 02/17/26 at 4:40 P.M. verified Resident #60 was sent to an appointment with influenza A with no advance notice given to the receiving facility. 2. Record review of Resident #17 revealed he was admitted [DATE] and had diagnoses including prostate cancer, cerebral palsy, and stage four pressure sores. He had wound care orders in place and enhanced barrier precautions (EBP) ordered as of 01/23/26. His most recent wound assessment dated [DATE] revealed he had two stage four pressure sores which were present on admission, which improved during his stay and had no documented evidence of current infection. Observation of Resident #17's room on 02/18/26 at 10:46 A.M. revealed he had an EBP sign on his door which included specific instructions to wear a gown and gloves for high contact activities including wound care. Observation of a wound</p> <p>(continued on next page)</p>		

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