STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365290	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirtland Rehabilitation & Care	9685 Chillicothe Rd Kirtland, OH 44094

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation and interview the facility failed to ensure call lights were within reach at all times. This affected one (Resident #86) of five sampled residents. The facility census was 110. Findings include: Review of the medical record for Resident #86 revealed an admitted [DATE] with diagnoses including visual hallucinations, hemiplegia and hemiparesis affecting right dominant side, type two diabetes mellitus with diabetic retinopathy and macular edema, asthma, neuromuscular dysfunction of the bladder, unspecified psychosis, anxiety disorder, essential (primary) hypertension, muscle weakness, and need for assistance with personal care. Review of the admission Minimum Data Set (MDS) assessment completed on 03/20/24 revealed Resident #86 had intact cognition. Further review of the MDS revealed Resident #86 had an impairment on one side, was dependent for toileting and bathing, was always incontinent of bowel and bladder, and required maximal assistance for transfers. Review of the care plan dated 06/13/24 revealed Resident #86 required assistance with incontinence care. Interventions included assisting with toileting and incontinence care as needed and ensuring her call light was within reach when she was in bed. Observation and interview on 06/17/24 at 11:58 A.M. with Resident #68 revealed she was in bed wearing a stained tee-shirt and an incontinence brief. Resident #68's call light was wrapped on the bottom of her left side rail and dangling on the ground. At the time of this observation, Resident #86 expressed relief, stating she was hot and needed someone to adjust her air conditioner, change her incontinence brief, dress her, and assist her into her chair before lunch. Resident #86 stated she had not been changed since 4:00 A.M. that morning, was able to tell when she needed checked and changed but had been unable to call for any assistance since she could not find or reach her call light. Interview on 06/17/24 at 12:10 P.M. with Registered Nurse (RN) #326 confirmed Resident #86 did not have a call light within reach. RN #326 was observed adjusting the air conditioner setting and providing Resident #86 her call light at that time. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/17/24 at 12:42 A.M. with State tested Nurse Aide (STNA) #397 revealed she was unaware Resident #86 needed changed, adding there was a lot going on that morning. She further confirmed Resident #86 had her call light wrapped around the bottom of her side rail and not clipped to her bedding where Resident #86 could not reach.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview and review of facility policy, the facility failed to ensure choices were honored for one (Resident #86) of five residents reviewed for choices. The facility census was 110. Findings include: Review of the medical record for Resident #86 revealed an admitted [DATE]with diagnoses including visual hallucinations, hemiplegia and hemiparesis affecting right dominant side, type two diabetes mellitus with diabetic retinopathy and macular edema, asthma, neuromuscular dysfunction of the bladder, unspecified psychosis, anxiety disorder, essential (primary) hypertension, muscle weakness, and need for assistance with personal care. Review of the admission Minimum Data Set (MDS) assessment completed on 03/20/24 revealed Resident #86 had intact cognition. Further review of the MDS revealed Resident #86 had an impairment on one side, was dependent for toileting and bathing, was always incontinent of bowel and bladder, and required maximal assistance for transfers. Review of the care plan dated 06/13/24 revealed Resident #86 had an alteration in physical functioning related to impaired mobility and self-care ability. Interventions included encouraging resident choices with care and assisting Resident #86 with completion of activities of daily living (ADLs) to ensure her needs were met. Observation and interview on 06/17/24 at 11:58 A.M. with Resident #68 revealed she was in bed wearing a stained tee-shirt and an incontinence brief. Resident #86 stated during this interview she preferred to be up in her chair before lunch and assisted back into bed by 3:00 P.M. but staff often did not get her up at her preferred time and when they did, they often left her in the chair through the evening because staff were too busy, handed her off to the next shift, who left her until after dinner and then transferred her last due to her room being at the end of the hall. Observation on 06/17/24 at 12:14 P.M. revealed Resident #86 remained in bed and her lunch tray was brought into her room at that time. Continued observation on 06/17/24 revealed State tested Nurse Aide (STNA) #397 provided Resident #86's incontinence care, assisted with dressing, and then obtained the assistance of another staff member to transfer Resident #86 to her chair. Lunch was set-up for Resident #86 at 12:40 P.M. Interview on 06/17/24 at 12:42 A.M. with STNA #397 revealed she was unaware Resident #86 wanted out of bed prior to lunch, she had not worked that hall in several weeks, and was not informed of Resident #86's preferences. Review of facility policy titled Resident Rights, revised February 2021 revealed residents had the right to self-determination and to a dignified existence.

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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 - Few	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** 48567 Based on observation, interview, and review of the National Weather Service website (forcast.weather.gov) the facility failed to ensure a comfortable and safe ambient temperature for all residents. This affected one of five sampled residents, Resident #73. Findings include: Observations on 06/17/24 between 11:03 A.M. and 11:14 A.M. of the East wing revealed the window at the east end of the East wing was open, hot air was blowing into the building. Further observation of the common sitting area on the East wing revealed windows were on the north and south side of the room, each side had a window open, blowing hot air into the facility. Interview on 06/17/24 at 11:08 A.M. with Housekeeper #398 confirmed hot air was blowing into the facility from the open window on the east end of East wing. A follow-up interview with Housekeeper #398 on 06/17/24 at 11:25 A.M. confirmed there were screens coming loose and with tears and there was hot air coming into the facility from the open windows., Observation on 06/17/24 11:50 A.M. of the window on the East wing near room [ROOM NUMBER] revealed the window consisted of glass louvers with gaps between each louver exposing the outside. At the time of the observation, hot air was noted flowing from the window into the hallway. Interview on 06/17/24 at 11:50 A.M. with Housekeeper #398 confirmed there was a gap between each louver large enough for outside temperatures and weather to affect the area adjacent to the window. Housekeeper #398 further confirmed the knob to open and close the louvers was broken. Interview on 06/17/24 at 12:42 P.M. with State tested Nurse Aide (STNA) #397 verified the hallway near room [ROOM NUMBER] by the glass louvered window was hot and she could feel the heat coming in from the window. Interview on 06/27/24 at 1:02 P.M. with Maintenance Director #357 revealed several windows on the East wing were open and should not be left open on such hot days. He also confirmed the window by room [ROOM NUMBER] was glass louvers, had a broken control knob and gaps between louvers which allowed for temperature concerns. Observation on 06/18/24 at 11:10 A.M. of Resident #73 revealed she was in her bed, appeared restless, and was trying to remove her clothing. Further observation revealed the window above her bed was open, hot air was blowing into the window, and the room felt uncomfortably hot. Observation and interview on 06/18/24 at 11:20 A.M. with Maintenance Director #357 confirmed with his thermometer that the ambient temperature of Resident #73's room registered 82.9 degrees Fahrenheit (F) at the center of the room. During the interview, Maintenance Director #357 confirmed the window was open and there was no window air conditioner in the room. He further confirmed the room temperature was not appropriate and Resident #73 would have a window air conditioner installed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the National Weather Service website (forcast.weather.gov) revealed the average temperatures for Cleveland, Ohio and surrounding areas where the facility was located had a daily air temperature ranging between 82 degrees F and 93.9 degrees F with heat index as high as 100 degrees F on 06/17/24 and a daily air temperature ranging between 77 degrees F and 91.9 degrees F with a heat index reaching 99 degrees F on 06/18/24. This deficiency represents non-compliance investigated under Complaint Number OH00153775.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, and facility policy and procedure review, the facility failed to ensure a clean, sanitary, and homelike environment. This had the potential to affect all 110 residents residing in the facility. Findings include: Observations on 06/17/24 between 11:03 A.M. and 11:14 A.M. of the East wing revealed the window at the east end of the East wing was open, hot air was blowing in, grayish-black spots were noted on the seals of the window and along the top and bottom edges of the top and bottom windowpanes, there were multiple tears in the screen, and at least 25 dead insects on the windowsill. The light fixtures in the East halls contained multiple dark spots, some shaped like insects, under the fixture covers. Further observation of the common sitting area on the East wing revealed windows were on the north and south side of the room, each side had a window open, blowing hot air into the facility. Closer observation of the sitting area on the East wing revealed one window with no screen, one with the screen partially detached, and one with several tears. The windowsills had dead insects, dust and debris, and black and gray spots around the seals of the windows and on the windows. The wall next to the table in the sitting area contained thick yellow-like hardened substance splashed and dried to the wall and there were thick yellow dried drip-shaped spots on the wall near the trash can. Interview on 06/17/24 at 11:08 A.M. with Housekeeper #398 confirmed hot air was blowing into the facility from the open window on the east end of East wing and that there were several holes large enough for insects to enter. He further confirmed there was a broken vinyl blind panel, a greasy black substance along the edges of the window, dead insects, stating the majority were stink bugs, and confirmed there were insects under the light covers in the halls. A follow-up interview with Housekeeper #398 on 06/17/24 at 11:25 A.M. confirmed that there were thick dried splashes on the walls in the sitting area on the East wing that should have been cleaned, there were screens coming loose and with tears, there was hot air coming into the facility from the open windows, and there were blackish spots scattered along the inside and outside edges of the windows, as well as the seals along the windows that he was unable to remove with cleaning attempts at the time of the interviews. Housekeeper #398 indicated he did not know who was responsible for window cleaning at the facility. Observation on 06/17/24 11:50 A.M. of the window on the East wing near room [ROOM NUMBER] revealed the window consisted of glass louvers with gaps between each louver exposing the outside. At the time of the observation, hot air was noted flowing from the window into the hallway. Interview on 06/17/24 at 11:50 A.M. with Housekeeper #398 confirmed there was a gap between each louver large enough for insects to enter and for outside temperatures and weather to affect the area adjacent to the window. Housekeeper #398 further confirmed the knob to open and close the louvers was broken and there was no screen or additional windowpane covering the window from the outside elements. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 06/17/24 at 12:42 P.M. with State tested Nurse Aide (STNA) #397 verified the hallway near room [ROOM NUMBER] by the glass louvered window was hot and she could feel the heat coming in from the window. She further confirmed two insects were flying around the light fixture closest to that window and there were several dark spots under the light cover. Observation on 06/17/24 at 12:52 P.M. of Shower Room C revealed a foul odor that got stronger near a floor drain on the side of the room where the sink and the toilet were located. Closer observation revealed hair and lint-like substances on top of the drain and standing water, with several black flecks floating in the water, in front of and to the right of the toilet. Interview on 06/27/24 at 1:02 P.M. with Maintenance Director #357 confirmed the following: a. An odor emitting from floor drain on side of the room with sink, some hair-like substance observed on top of the drain, standing water by toilet, one light inside the entrance of shower room was not working. b. Maintenance Director #357 was uncertain who was responsible for cleaning the outside of the facility windows but was trying to find out whether it was a service they contracted out or not. c. Several windows on the East wing were open and should not be left open on such hot days. d. Several screen with tears, one in the common area coming loose and another bowed. e. The window by room [ROOM NUMBER] was glass louvers, had a broken control knob and gaps between louvers which allowed for temperature concerns and did not prevent insects from entering the building. f. Light covers in the East wing were dirty, some visibly containing dead bugs. During this interview, Maintenance Director #357 revealed it only took a few days for insects to build-up under the light fixtures once cleaned. Observation on 06/17/24 at 3:10 P.M. revealed two sit to stand mechanical devices located in the hallway of the East-2 wing were soiled. Lift number 34410F+4L23G140 was missing a handle grip piece and had a soiled footboard. Lift number 3110022 had caked-on substance noted on both handle grips and a soiled footboard. Interview on 06/17/24 at 3:15 P.M. with Registered Nurse (RN) #326 confirmed the [NAME] 3000 sit to stand devices in the East-2 hallway needed to be cleaned. RN #326 said equipment should be cleaned on night shift or when visibly soiled or after use with any resident in isolation. Interviews conducted on 06/18/24 between 1:16 P.M. and 1:25 P.M. with STNA #359 and STNA #353 confirmed night staff were responsible for cleaning wheelchairs and mechanical lift equipment. Review of the facility example housekeeping checklist and procedure for room and bathroom cleaning from the Environmental Operations Manual revealed Housekeepers were to tour their assigned sections to identify any immediate issues and communicate Deep Cleans within the first thirty minutes of their shift. The procedure further revealed all vertical surfaces were to be spot cleaned with a cloth and disinfectant. The procedure did not address window cleaning. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This deficiency represents non-compliance investigated under Complaint Number OH00153775. This deficiency is an example of continued noncompliance from the survey dated 05/02/24.