

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER Kirtland Rehabilitation & Care		STREET ADDRESS, CITY, STATE, ZIP CODE 9685 Chillicothe Rd Kirtland, OH 44094	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097</p> <p>Based on interview and record review the facility failed to prevent resident to resident abuse. This affected two resident (#41 and #104) of three residents reviewed for abuse (#41, #57 and #104). The facility census was 103.</p> <p>Findings Include:</p> <p>Review of the closed medical record for the Former Resident #104 revealed an admitted [DATE]. The resident was discharged to the hospital on 06/27/24. Diagnoses included Alzheimer's disease, diabetes, and dementia with agitation. The resident was at the facility for a respite stay.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment, dated 06/20/24, revealed the resident had severely impaired cognition. The resident's hearing and vision were adequate without devices. Behaviors included physical behavioral symptoms directed at others, verbal behavioral symptoms directed at others, other behavioral symptoms not directed at others, and rejection of care.</p> <p>Review of physician orders for June 2024 revealed orders for:</p> <p>Haloperidol Oral Tablet 1 MG by mouth every three hours as needed for Behaviors. 06/27/24 at 10:15 A.M.</p> <p>Alprazolam Oral Tablet (Xanax) 0.5 MG. every four hours as needed for Agitation/Anxiety. 06/25/24 4:15</p> <p>Alprazolam Oral Tablet (Xanax) 0.5 MG. every eight hours as needed for anxiety. 06/13/24 to 06/25/2024</p> <p>Sertraline HCl Oral Tablet 100 MG. by mouth in the morning for depression. 06/14/24 at 6:00 A.M.</p> <p>Risperidone Oral Tablet 0.25 MG. by mouth at bedtime for behaviors 06/13/24.</p> <p>Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 MG. by mouth two times a day. 06/13/24.</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the plan of care dated 06/21/24 revealed Resident #104 had potential for delirium or an acute confusional episode related to Alzheimer diagnosis, change in environment, use/side effects of psychotropic medication. Interventions included: Engage the resident in simple, structured activities that avoid overly demanding tasks. Monitor for/address environmental factors recent change in environment, environmental noise and commotion. Provide medications to alleviate agitation as ordered by MD. Monitor/document side effects and effectiveness. Redirect and provide gentle reality orientation as required. Reorient to person, place, time, situation as required.</p> <p>Review of the plan of care dated 06/17/24 revealed Resident #104 exhibited verbal and physical behaviors related to diagnosis of dementia. He can become combative with hands on care. Interventions included: administer medications as ordered. Monitor for effectiveness. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from the situation and take to an alternate location as needed.</p> <p>Review of the plan of care dated 06/17/24 revealed Resident #104 was an elopement risk/wanderer. Wanders in and out of other's rooms. 06/17/24. Interventions included: Gently redirect away from exit doors.</p> <p>Review of the nurse progress note dated 06/22/24 at 6:43 AM nurses note documented combativeness with care and redirection. Xanax 0.5 MG every 8 hours was effective</p> <p>Review of the nurse progress note dated 06/23/24 at 7:15 P.N revealed resident restless walking around touching other residents. PRN Xanax 0.5 MG every 8 hours was effective.</p> <p>Review of the nurse progress note dated 06/25/24 at 12:15 AM revealed the resident was highly agitated, constantly getting out of bed.</p> <p>Review of the nurse progress note dated 06/25/24 revealed nurse contacted hospice to notify them the resident was highly agitated after dinnertime. The resident was very difficult to redirect even after evening meds and PRN Xanax. Resident #104 was constantly getting up, touching other residents, and going into their rooms.</p> <p>Review of the nurse progress note dated 06/25/24 hospice nurse contacted doctor and increased resident's Alprazolam (Xanax) 0.5 MG to every four hours as needed for agitation/anxiety.</p> <p>Review of the behavior note dated 06/25/24 at 9:00 P.M. STNA stated Resident #104 was constantly getting up out of the wheelchair touching other residents and touching anything in site.</p> <p>Review of the behavior note dated 6/26/24 at 9:30 PM resident has high anxiety and very agitated with care.</p> <p>Review of the nurse progress note dated 06/26/24 at 10:00 PM revealed Resident #104 was constantly moving out of chair, was very agitated, had high anxiety, was touching other residents, and going in their rooms. On 06/27/24 at 1:02 A.M. revealed Xanax was noted as ineffective.</p> <p>Review of the nurse progress note dated 06/27/24 at 10:06 P.M. revealed Xanax given to Resident #104 for increased anxiety</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nurse's progress note dated 06/27/24 at 10:16 A.M. revealed a new order for Haldol 1 mg. was put to pharmacy.</p> <p>Review of the nurse's progress note dated 06/27/24 at 11:55 revealed Xanax 0.5 MG every four hours administration had been effective.</p> <p>Review of the Incident note on 06/27/24 at 8:30 P.M. revealed an STNA observed Resident #104 being physically aggressive with Resident #41 Resident #104 was seen hitting Resident #41 in her room. When the STNA attempted to remove resident #104 from the room he became combative. The STNA notified the nurse. The residents were assessed, no injuries were noted. The nurse was instructed by the Unit Manager to send Resident #104 out to the hospital for evaluation. Resident #104 was placed on one-to-one observation until he left for the hospital.</p> <p>Review of the medical record for Resident #41 revealed an admitted [DATE]. Diagnoses included dementia, anxiety disorder, chronic obstructive pulmonary disease (COPD), and bilateral hearing loss</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/06/24, revealed the resident had impaired cognition. Review of behavior revealed wandering.</p> <p>Review of the e-INTERACT SBAR Summary for Providers dated 06/27/24 at 8:30 P.M. revealed a change in condition was reported for Resident #41. There was a change in skin color or condition.</p> <p>Review of the Comprehensive Encounter note 06/28/24 at 1:00 A.M. revealed Resident #41 was seen for a resident associated incident. Resident #41 was alert and oriented to self. Per report, the resident was recently assaulted and hit in the face. At the time of assessment, the resident was sitting in the dining room finishing lunch. She ate the entire meal without difficulty. She appeared to be in no distress, smiling during our interaction. Assessment and palpation of the face revealed no signs or symptoms of discomfort.</p> <p>Review of the Incident note 06/28/24 at 1:17 A.M., Late Entry, revealed the nurse was called to Resident #41's room due to an incident with Resident #104. Per STNA Resident #104 was seen in Resident #41's room hitting her. The STNA separated the residents. Resident #104 was escorted from the room. Resident #41 was assessed for injuries and noted to have a small, reddened area below her left eye. The resident seemed startled and kept stating that a man had hit her on her head. No injuries were noted to her head. Emotional support and comfort was provided. Later, the police officer arrived to interview Resident #41 and she stated that nobody had hit her, no man had hit her in her head. Resident #41 was calm with no behaviors. The resident was resting quietly in bed at this time. Nursing continued to monitor the resident throughout the night for any changes.</p> <p>Review of the Incident Note dated 06/28/24 at 12:20 P.M. revealed Resident #41 had a small pink area noted under her left eye. The area was not raised. The resident denied pain or discomfort. The resident did not remember anything from last evening and was up ambulating with her walker.</p> <p>Review of the social service progress note dated 06/28/24 at 1:15 P.M. Resident #41 was sitting in the dining room eating lunch and in no distress. The resident spoke and was in good spirits. Resident #41 did not seem to recall any events from the night before.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the behavior note dated 06/29/24 at 5:14 A.M. revealed Resident #41 was in bed at onset of this nurse's shift. Roused easily without being startled. Resident was pleasant and cooperative with no behaviors observed/reported. Resident #41 slept throughout the night.</p> <p>Review of the nurse's note dated 06/29/24 at 11:25 A.M. revealed an aide reported to the nurse that Resident #41 had bruising to both hands. The nurse reviewed the areas and noticed the scant bruising. The resident did not report any pain at the time.</p> <p>Review of the social service note dated 06/29/24 at 12:32 P.M. revealed Resident #41 was sitting in the dining room with a few of her friends talking and waiting for lunch. The resident was behaving fine and did not realize that there had been an incident.</p> <p>Review of the SRI and facility investigation dated 06/27/24 revealed on 06/27/24 at approximately 8:30 P.M. staff responded to a commotion in a resident room. Staff entered the room to find Resident #104 standing over Resident #41, who was in bed. Resident #104 was striking Resident #41 in the head. Staff intervened and attempted to remove Resident #104 from the room. Resident #104 then removed a dry erase board from the wall and repeatedly hit staff with it. Resident #104 maneuvered back to Resident #41 and took the pillow and covered Resident #41's head. Staff was able to remove Resident #104 from the room and remained with him. Resident #41 was evaluated for injuries. A red mark was noted on the left eye, no other injuries were noted. The physician was notified and gave order for Resident #104 to be sent to the hospital for further evaluation. The resident departed from facility at approximately 8:50 P.M. Resident #104 was placed on one to one until departure to the hospital. The wife was made aware of the altercations and transfer to the hospital for further evaluation. The police were notified and arrived at the facility to take report of altercation. Follow-up evaluation for Injuries reveal bruising to Resident #41's bilateral wrist/forearm, the resident denied pain. Continued emotional support and psychosocial follow-up was provided to Resident #41. Body audits were completed on like residents with no untoward findings. Abuse audits completed on like residents with no untoward findings Psychosocial follow up completed with no untoward findings.</p> <p>On 06/27/24 four STNAs and two LPNs were interviewed and completed witness statements. The statements confirmed the investigation's findings.</p> <p>Aggressive Resident #104 did not return to the facility.</p> <p>During observations made on 07/17/24, 07/18/24, and 07/22/24 revealed Resident #41 was in good spirits and responded positively to staff and residents. There were no concerns.</p> <p>Interview on 07/24/24 at 3:15 P.M. Unit Manager #428, unit manager for the memory care unit, stated Resident #104 was a fidgeter. He was terminally restless. He would touch everything and everyone around him. It was not in an aggressive way. Unit Manager #428 was shocked when she was called regarding the incident. Resident #104 walked into other resident's rooms but had not done anything physical. The resident had not been violent with staff, just resistant to care. There was only had one regular aide and 3 agency aides the night of the incident. The nurse was also an agency nurse the night of the incident. Unit Manager #428 verified the incident had occurred.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/24/24 at 5:23 P.M. LPN #455, the usual day shift nurse on the memory care unit, revealed day shift on 06/27/24 received the order for Haldol from hospice. The hospice nurse came in on 06/27/24 at around 9:30 A.M. The night shift nurse had called hospice the previous evening and left a message that Resident #104 had increased behaviors in the evenings and nursing wanted something in place. However, Resident #104 did not have behaviors that morning or during the day. When LPN #455 left at 7:00 P.M. on 07/27/24 Resident #104 had not exhibited any behaviors of concern and had not needed the new order for Haldol or even Xanax.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155690 and Complaint Number OH00155684.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097</p> <p>Based on record review and interview the facility failed to adequately update the care plan for Resident #63's use of contacts. This affected one resident of four residents (#21, #56, #63, and #68) reviewed for care plan revision. Facility census was 103.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #63 revealed an admitted [DATE]. Diagnoses included aphasia, psychotic disorder with delusions, dementia-severe with delusions, and bipolar disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #63, dated 05/09/24, revealed the resident had severe cognitive impairment. The resident had a behavior of rejection of care.</p> <p>Review of physician orders for Resident #63 revealed an order to give glasses to Resident #63 in the morning and place in cart at bedtime every day and night shift dated 06/10/24.</p> <p>A physician order to encourage removal of contact every evening in the evening for contact removal had been started 4/24/24 and was discontinued on 05/21/24.</p> <p>Review of the nurses note on 05/20/24 at 11:00 A.M. revealed the eye doctor had been able to remove the contact out of Resident #63's right eye.</p> <p>Review of the communication with family note on 05/23/24 at 4:47 P.M. revealed a message was left for Resident #63's husband and son to inform them the resident had the contact lens removed by the eye doctor and it was recommended for the contact lens to stay out.</p> <p>Review of the social services progress note on 05/24/24 at 9:13 A.M. revealed Resident #63's son and spouse were contacted regarding the residents contact recently being removed by the optometrist. The family was educated that future infections might occur if a contact was placed in the resident's eye for any lengthy periods of time. The son stated they would not be bringing in any other contacts and agreed to at least try and see if the resident would utilize eyeglasses.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the plan of care initiated 04/25/24 for Resident #63 revealed the resident was at risk for injury related to infection due to the use of contact lenses and refusing to allow staff to assist with inserting and removing. Resident #63 had an ophthalmology evaluation on 12/4/23, contact removed to the right eye, resident had new glasses that resident does not wear. Ophthalmology recommended that contacts not be worn by the resident. On 5/20/24 the resident 's contact was able to be removed by the optometrist. The Goals were: Resident will have no indication of acute eye problems initiated 04/25/24 and irritation in right eye will resolve without complications initiated on 04/25/24. Interventions included: Document all refusals of resident allowing staff to assist with contact lenses 4/25/24. Extended wear lenses: wear up to 30 days and then throw away. Give your eyes a rest for at least one night. Then put in a new pair. 4/25/24. Family will assist with placement and cleaning of contact lenses 4/25/24. Wash and rinse your hands before touching your lenses. Use only contact lens solution to store or rinse your contacts initiated 05/17/24. Replace your contact lens case every three to six months initiated 5/17/24. Put your contacts in before you use makeup initiated 5/17/24.</p> <p>Random observations from 07/17/24 through 07/23/24 revealed no concerns. Resident #63 was not wearing a contact lens.</p> <p>Interview on 07/24/24 at 3:45 P.M. with the DON and Regional Resource Nurse #509 verified the goals for Resident #63 had changed from ensuring contact care to prevent getting an eye infection to ensuring the resident did not wear contacts lens' anymore. The care plan did not reflect the changes made in Resident #63's care.</p> <p>Review of the Comprehensive Care Plan policy dated 01/13/18 revealed the Care Planning/Interdisciplinary Team is responsible for the review and updating of Care plans when there has been a significant change in the resident's condition, when the desired outcome is not met, and at least quarterly.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526</p> <p>Based on observation, interview, record review, facility policy review, and review of the Food and Drug Administration (FDA) guidelines, the facility failed to properly store refrigerated medications and ensure food items were not stored inside medication carts. This affected four residents (#19, #29, #69 and #89) and had the potential to affect all 103 residents residing in the facility.</p> <p>Findings include:</p> <p>Observation of medication storage on 07/22/24 at 11:32 A.M. with Unit Manager (UM) #447 revealed the east long medication cart had two unopened snack sized packages of cookies in the top drawer. The central medication cart had two unopened snack sized containers of applesauce and two unopened snack sized containers of pudding in the second drawer from the top. The central medication room refrigerator contained no thermometer. Inside were two insulin pens, one Lispro and one Lantus, for Resident #19, and one vial of Lispro insulin for Resident #29. Interview at the time of the observation with UM #447 verified the findings.</p> <p>Review of the medical record for Resident #19 revealed an admitted [DATE] and a diagnosis of diabetes mellitus type 2 with diabetic peripheral angiopathy. The physician orders showed an order dated 07/18/24 for Lispro insulin injected subcutaneously (SQ) twice daily, and an order dated 07/17/24 for Lantus insulin injected SQ once daily at bedtime.</p> <p>Review of the medical record for Resident #29 revealed an admitted [DATE] and a diagnosis of diabetes mellitus type 2 without complications. The physician orders showed an order initiated 05/10/24 and discontinued on 07/17/24 for Lispro insulin injected SQ three times daily for sliding scale coverage.</p> <p>Observation of medication storage on 07/23/24 at 12:04 P.M. with Licensed Practical Nurse (LPN) #468 revealed the memory care unit medication room refrigerator had a freezing point temperature of 32 degrees Fahrenheit (F). Inside were two Lantus and one Lispro insulin pens for Resident #69, three Lantus and two Humalog insulin pens for Resident #89, and two vials of Tuberculin for intradermal testing used for residents and staff. Interview at the time of the observation with LPN #468 verified the findings.</p> <p>Review of the memory care unit medication room refrigerator log for July 2024 revealed the temperature was checked daily from 07/16/24 to 07/22/24, and maintained a temperature of 35 degrees (F). There was no temperature check recorded for 07/23/24.</p> <p>Review of the medical record for Resident #69 revealed an admitted [DATE] and a diagnosis of diabetes mellitus type 2 with diabetic chronic kidney disease. The physician orders showed an order dated 04/12/24 for Lispro insulin injected SQ three times daily and an order dated 06/11/24 for Lantus insulin injected SQ once daily at bedtime.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the medical record for Resident #89 revealed an admitted [DATE] and a diagnosis of diabetes mellitus with unspecified complications. The physician orders showed an order dated 06/24/24 for Lantus insulin injected once daily at bedtime and an order initiated 05/14/24 and discontinued 07/19/24 for Lispro insulin injected three times daily.</p> <p>Review of the FDA guidelines for information regarding insulin storage last updated on 09/19/17 from https://www.fda.gov/drugs/emergency-preparedness-drugs/information-regarding-insulin-storage-and-switching-between-products-emergency revealed according to the product labels from all three national insulin manufacturers, it was recommended that insulin be stored in a refrigerator at 36 to 46 degrees (F). Some effectiveness of insulin was lost when exposed to extreme temperatures, and the longer the exposure the less effective it becomes. It can result in loss of blood glucose control over time. Insulin was not to be used if frozen.</p> <p>Review of the FDA guidelines for Tuberculin intradermal administration last updated November 2013 from https://www.fda.gov/media/74862/download revealed the storage of the product was 36 to 46 degrees (F) and was not to be frozen.</p> <p>Review of the facility policy Storage of Medications, revised November 2020 revealed drugs and biologicals used in the facility were stored under proper temperatures.</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097</p> <p>Based on observation, interview, and record review the facility failed to provide food in the correct form to two residents (#10 and #11) when the wrong trays were given to them by nursing. This had the potential to affect all 48 residents on the 300 unit.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #10 revealed an admitted [DATE]. Diagnoses included myocardial infarction, chronic bronchitis, and protein-calorie malnutrition.</p> <p>Review of the Modification of Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed the resident was cognitively intact.</p> <p>Review of physician orders for Resident #10 revealed the resident was on a Cardiac diet, regular texture, thin Liquids consistency.</p> <p>Review of nursing note on 07/22/24 at 5:00 P.M. revealed Resident #10 received the wrong diet for lunchtime. The resident did not have any issues eating the meal. The emergency contact was notified that resident received wrong tray/meal.</p> <p>Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included Alzheimer's, unspecified psychosis, aphasia, and dementia with other behavioral symptoms.</p> <p>Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed the resident was cognitively impaired.</p> <p>Review of physician orders for Resident #11 revealed the resident was on a mechanical soft texture, thin consistency diet with extra gravy on side for mechanical soft meat. A grilled cheese sandwich was added with lunch and dinner.</p> <p>Review of physician orders for Resident #11 revealed adaptive equipment was ordered for meals. Drinks were served in a bilateral weighted sip cup, weighted utensils, and a scoop dish.</p> <p>Review of physician orders for Resident #11 revealed a STAT chest x-ray to rule out aspiration, one time only for rule out aspiration for 1 Day on 07/22/24.</p> <p>Review of nursing note on 07/22/24 at 5:03 P.M. revealed Resident #11 received and consumed the wrong diet/consistency tray for lunch. There were no issues with Resident#11 while consuming the meal. The physician was made aware and ordered a STAT chest x-ray. The nurses were to check lung sounds every shift and notify the physician of any changes. The guardian was notified the resident received wrong tray/meal and of the new physician orders</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 07/22/24 at 12:51 P.M. revealed Resident #10 complained she was not served a lunch tray. STNA #488 stated Resident #10's tray was not on the cart, then went to Resident #11's room and Resident #11 was served Resident #10's tray. STNA #488 she returned to the cart, obtained Resident #11's food tray, removed the banana and vanilla shake, handed those to another nurse aide who took the items to Resident #11 and then delivered Resident #11's tray to Resident #10. STNA #488 stated the two diets were the same so there was no issue. Resident #11's tray had large-handed utensils and a scoop plate, but the STNA indicated it was not a problem and gave those items to Resident #10 with the extra grilled cheese ordered for Resident #11.</p> <p>Observation on 07/22/24 at 1:06 P.M. of Resident #11 revealed the tray in front of resident in bed, with a ticket printed on the tray for Resident #10. Most of the hamburger on bun was eaten, white rice on side with corn on side not pureed were untouched. The resident was in the process of drinking the vanilla shake, had drank all the juice and ate the banana. The resident complained of not having the grilled cheese he liked.</p> <p>Observation on 07/22/24 at 1:08 P.M. revealed Resident #10 had a tray in front of her, sitting on edge of bed. The grilled cheese was half eaten, the pureed corn was on the scoop plate with a mixture of meat, shredded lettuce, refried beans and cheese next to Spanish rice. Resident #10 complained the tray was not hers but the aide left it there. Resident #10 complained she could not use the utensils they were too fat and heavy and complained of having the grilled cheese and the taco salad with cheese. The resident stated this was not her meal, that she was on a cardiac diet.</p> <p>Interview on 07/22/24 at 1:17 P.M. with Food Service Director #429 revealed the menu for lunch was taco salad (refried beans, shredded lettuce, ground meat and cheese), Spanish rice, and corn. Mechanical soft diets were allowed to have taco salad with Spanish rice and pureed corn. Cardiac diets couldn't have the taco salad, so they got hamburger, with lettuce tomato, corn and white rice not Spanish. Food Service Director #429 confirmed Resident #11 should have received pureed corn and Resident #10 a hamburger due to cardiac diet.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526</p> <p>Based on observation, interview and record review, the facility failed to accurately document fall interventions for Resident #62 and make vaccination documentation readily accessible in the medical record for Residents #97 and #102. This affected three residents (#62, #97 and #102) of 23 medical records reviewed. The facility census was 103.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #62 revealed an admitted [DATE]. Diagnoses included muscle weakness and repeated falls. The Quarterly MDS (Minimum Data Set) assessment completed 06/19/24 indicated moderately impaired cognition and receipt of hospice services. A physician order initiated 12/01/23 and effective July 2024 indicated a floor mat to the left bedside while in bed.</p> <p>Observation on 07/17/24 at 11:50 A.M. revealed Resident #62 in bed with no fall mat to the left bedside as ordered. Interview at the time of the observation with State tested Nursing Assistant (STNA) #470 confirmed there was no mat in place next to the bed, but indicated it was not on the Kardex (a quick reference for resident information).</p> <p>Review of Resident #62's Kardex effective 07/17/24 did not indicate a floor mat was required at the bedside.</p> <p>Review of Resident #62's care plan effective 07/17/24 indicated the fall intervention for a floor mat to the left bedside was discontinued on 06/24/24.</p> <p>Interview on 07/17/24 at 12:21 P.M. with Unit Manager (UM) #447 verified Resident #62 no longer required a left bedside floor mat as a fall intervention and it was to be discontinued on 06/24/24. UM #447 indicated the active physician order for the floor mat was an error, and not discontinued on 06/24/24 when required.</p> <p>37097</p> <p>2. Resident #97 was admitted to the facility on [DATE] with diagnosis including paroxysmal atrial fibrillation, dementia, and anxiety disorder.</p> <p>Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #97 was cognitively impaired.</p> <p>Review of the immunization status for Resident #97 revealed only the First step of tuberculosis testing was recorded and Pneumococcal 20 had been refused.</p> <p>Interview on 07/23/24 at 11:32 A.M. with Unit Manager #447 revealed not all the immunizations had been put into the immunization tab. They had been done. Tuberculosis testing first step was done</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>07/03/24. The second step had been done 07/11/24 and read on 07/14/24 but recorded in different places.</p> <p>3. Resident #102 was admitted to the facility on [DATE] with diagnosis including fracture of 5th lumbar vertebra, adult failure to thrive, Parkinson's disease, and chronic pain syndrome.</p> <p>Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #102 was cognitively intact.</p> <p>Review of the immunization status for Resident #102 revealed the resident had tuberculosis testing upon admission and had received Pneumovax 23 historically, but there was no information on the status of influenza immunization status.</p> <p>Interview on 07/23/24 at 11:32 A.M. with Unit Manager #447 revealed the facility looked for information on influenza immunization and were able to find it but it had not been entered in the correct location.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41526</p> <p>Based on observation, interview and facility policy review, the facility failed to appropriately dispose of biohazardous materials and handle clean and soiled linen to prevent the spread of infection. This affected eight residents (#1, #8, #13, #24, #40, #58, #73 and #77) and had the potential to affect all 103 residents residing in the facility.</p> <p>Findings include:</p> <p>Observation on 07/22/24 at 8:53 A.M. the adjoining bathroom shared by Residents #8, #13, #58 and #77 revealed a feces soiled pillowcase crumpled on the bathroom floor next to the toilet. Interview at the time of the observation with STNA #488 confirmed the finding.</p> <p>Observation on 07/22/24 at 11:20 A.M. of the laundry room with Housekeeping District Manager (DM) #611 revealed a pile of soiled linens placed on the floor in front of the middle washer which was not functioning and filled with washed linen. There were two wall mounted fans on in the clean laundry area, one blowing air toward the dryers and the other blowing air toward the folded and hanging linens/clothes. Both fans were visibly dirty and had lint, dirt and debris built up on the back and front fan areas. Interview at the time of the observation with DM #611 verified the findings.</p> <p>Observation on 07/23/24 at 9:02 A.M. revealed Laundry Worker (LW) #606 walking through the 300 hallway toward the memory care unit pushing a rolling rack filled with residents' hanging personal clothes and a shelf on the rack bottom just above the wheels with a number of miscellaneous pieces of linen/clothing. Interview at the time of the observation with LW #606 verified the clothing was being delivered to residents and during the interview, bent down and picked up a small thin blue sheet from the bottom shelf and swung it over the clothing then adjusted it to try and cover it. The sheet made contact with the clothes and covered the width of the rack but only covered the upper half portion of the hanging clothes. The lower shelf also remained uncovered. LW #606 explained the sheet was used daily to cover the clothes but she had forgotten to put it back over the clothes during delivery. LW #606 confirmed there was no covered linen/clothing cart available to use for delivering clean laundry.</p> <p>Observations on 07/23/24 at 10:43 during an environment tour with Maintenance Director (MD) #474 revealed Resident #24's bathroom had soiled linen on the floor. The adjoining bathroom shared by Residents #1, #40 and #73 had two large biohazardous red bags stored inside. One red bag was not closed and contained a large amount of soiled linen. On top of the other red bag there was a crumpled soiled disposable gown so it could not be determined if the bag was opened or closed or what was inside the red colored bag. Interview at the time of the observation with MD #474 verified the findings.</p> <p>Review of the facility policy, Laundry and Bedding, Soiled, revised September 2022 revealed soiled laundry and bedding was handled, transported and processed according to best practices for infection prevention and control. Clean linen was protected from dust and soiling during transport and storage to ensure cleanliness.</p>		

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<p>F 0910</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure resident rooms meet each resident's needs.</p> <p>41526</p> <p>Based on observation and interview, the facility failed to provide an adequate bathroom door for privacy. This affected one resident (#25) of 103 residents whose rooms were observed for privacy. The facility census was 103.</p> <p>Findings include:</p> <p>Observations on 07/23/24 at 10:43 A.M. during a facility tour with Maintenance Director (MD) #474 revealed Resident #25's room had a bathroom entrance with a full length curtain installed to cover the doorway in lieu of a door. The curtain was placed on a rod which extended approximately two to three inches away from the wall/door opening so when the curtain was drawn completely closed, it left a wide gap on both sides leaving ample opening to see inside the bathroom. With Resident #25's bedroom door opened and the bathroom curtain closed, the inside bathroom remained visible through the left bathroom curtain gap from the facility hallway outside of the bedroom. Interview at the time of the observation with MD #474 verified the findings.</p>		

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<p>F 0917</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space.</p> <p>41526</p> <p>Based on observation and interview, the facility failed to provide private closet space separate from roommates' clothing. This affected 46 residents (#1, #2, #4, #6, #7, #8, #11, #13, #16, #20, #22, #23, #27, #31, #34, #35, #41, #42, #44, #47, #50, #51, #58, #59, #61, #64, #69, #73, #77, #78, #79, #80, #81, #82, #83, #84, #86, #88, #92, #93, #94, #97, #98, #100, #102 and #103) out of 103 resident rooms reviewed for closet space. The facility census was 103.</p> <p>Findings include:</p> <p>Observations on 07/23/24 at 10:43 A.M. during a facility tour with Maintenance Director (MD) #474 revealed the following residents were roommates and had one closet shared by both residents that did not separate the roommates' clothing:</p> <ul style="list-style-type: none"> - Residents #78 and #80 - Residents #100 and #16 - Residents #77 and #13 - Residents #84 and #44 - Residents #58 and #8 - Residents #31 and #47 - Residents #93 and #35 - Residents #98 and #61 - Residents #20 and #64 - Residents #50 and #11 - Residents #4 and #94 - Residents #82 and #59 - Residents #23 and #102 - Residents #73 and #1 - Residents #27 and #79 <p>(continued on next page)</p>

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<ul style="list-style-type: none"> - Residents #7 and #92 - Residents #81 and #6 - Residents #42 and #88 - Residents #41 and #86 - Residents #22 and #69 - Residents #2 and #103 - Residents #97 and #34 - Residents #83 and #51 <p>Interview at the time of the observations with MD #474 confirmed the above findings.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>41526</p> <p>Based on observation, interview and facility policy review, the facility failed to provide a safe, sanitary and homelike environment. This affected 48 residents (#3, #6, #7, #8, #13, #15, #16, #17, #19, #21, #23, #24, #27, #31, #32, #34, #35, #37, #38, #39, #42, #44, #46, #47, #49, #51, #55, #58, #59, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #88, #89, #92, #93, #95, #97, #100 and #102) and had the potential to affect all 103 residents residing in the facility.</p> <p>Findings include:</p> <p>Observation on 07/17/24 at 10:49 A.M. of the adjoining bathroom shared by Residents #8, #13, #58 and #77 revealed a sticky floor and a toilet paper roll placed on the back of the toilet in lieu of a toilet paper holder, which was not secured tightly to the wall. The toilet water was low inside the commode with a large amount of soiled toilet paper, black/brown in color piled inside, and black/brown soilage dried around the inner commode walls. Residents #13 and #77's shared bedroom closet was missing a handle to functionally open/close the door with only a pointed screw protruding from it, and the floor was sticky in the area from the sink to the bathroom entrance. Resident #24's room had no closet door/cover and the bathroom had a toilet paper roll placed on the back of the toilet in lieu of a toilet paper holder.</p> <p>Interview on 07/17/24 at 11:00 A.M. with State tested Nursing Assistant (STNA) #440 verified the findings in the rooms for Residents #8, #13, #24, #58 and #77.</p> <p>Observation on 07/17/24 at 11:26 A.M. of Resident #34 and #97's room revealed no curtain covering the window. Interview at the time of the observation with Licensed Practical Nurse (LPN) #434 confirmed there was no window covering and indicated Resident #97 complained of bright light at night while trying to sleep.</p> <p>Observation on 07/17/24 at 11:35 A.M. of Resident #74's bathroom revealed a toilet paper roll placed on the back of the toilet in lieu of a toilet paper holder.</p> <p>Observation on 07/17/24 at 11:37 A.M. of Resident #21's bathroom revealed a toilet paper roll placed over the attached toilet faucet/sprayer used for cleaning excrement in lieu of a toilet paper holder.</p> <p>Interview on 07/17/24 at 11:38 A.M. with Housekeeper #602 confirmed the observations of Residents #21 and #74's rooms, and indicated there were broken toilet paper holders so toilet paper was placed wherever possible.</p> <p>Observation on 07/17/24 at 11:42 A.M. of the memory care unit revealed a missing baseboard around the walls of the shower room and the area across the hall from the shower room. The hallways throughout the unit had numerous spackled or patched areas.</p> <p>Interview on 07/17/24 at 1:33 P.M. with Administrator verified the memory care unit painting and baseboard repair was planned although it had been that way since May 2024.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 07/22/24 at 8:53 A.M. the adjoining bathroom shared by Residents #8, #13, #58 and #77 revealed dried feces smeared on the bathroom door frame toward Resident #13 and #77's bedroom, a feces soiled pillowcase crumpled on the bathroom floor next to the toilet, and visible dried feces on the toilet paper roll and holder which was not fully secured to the wall and hanging down. Dried feces was smeared over a significant portion of the toilet seat. Inside the toilet had a low water level and piles of feces soiled toilet paper piled inside it with dried feces covering most of the inner toilet walls. Interview at the time of the observation with STNA #488 verified the findings. On the floor blocking Resident #13 and #77's bedroom entrance was a large pile of debris including a medication cup with a dried pink substance inside, pieces of paper, food, dust and dirt. A floor duster handle missing a duster head was left leaning against the wall outside the left entrance door.</p> <p>Interview on 07/22/24 at 8:59 A.M. with Housekeeper #609 verified the pile of swept debris was left in its place blocking Resident #13 and #77's bedroom entrance because a new floor duster head was being retrieved.</p> <p>Observation on 07/22/24 at 11:20 A.M. of the laundry room with Housekeeping District Manager (DM) #611 revealed a gray colored blanket stuffed between the dryers closest to the door and the next dryer. The blanket was covered with lint, dirt and debris. DM #611 indicated it was placed there due to staff being concerned with critters coming through from behind the dryers but confirmed it did not belong there. After blanket removal, there was a large amount of dirt, debris and lint visible between the dryers.</p> <p>Observations on 07/23/24 at 10:43 A.M. during an environment tour with Maintenance Director (MD) #474 revealed the following findings:</p> <p>Resident #19's bathroom had a protruding screw point from the wall into the toilet paper holder area where toilet paper was retrieved. The bedroom wall mounted light fixture had no light shade leaving a light bulb fully uncovered.</p> <p>Resident #95's bathroom had a burned out light bulb. The bathroom paper towel dispenser was secured to the wall in such a way to block the light switch making it difficult to access for use.</p> <p>The 300 hall activity and puzzle room had one large and four small water stains on the ceiling tiles. MD #474 indicated a painted covering was used over the large stain but the replacement tiles had not yet been obtained for replacement.</p> <p>Resident #78 and #80's bedroom had one shared closet with a folding door which did not function properly being off track, and the closet door knob was loose and spinning. The lower bathroom wall opposite the toilet had a piece of tile broken off on the floor and a missing tile above the broken tile.</p> <p>Resident #17's bedroom closet floor contained numerous dead insects in scattered small and larger piles. The closet floor carpet had a large unsightly dark stain. The folding door of the closet did not function properly, being off track. MD #474 indicated the bedroom closet area was sprayed for insects and it was not cleaned up afterward. (Review of the pest control treatment and inspection records indicated Resident #17's bedroom was treated for swarmer ants on 06/14/24 and 06/24/24.)</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #16 and #100's bedroom had one shared closet with a folding door. The closet door knob was loose and spinning.</p> <p>Resident #13 and #77's bedroom had a large wall area to the right of the window with removed paint exposing wallpaper from underneath, a missing floor tile underneath the sink, and an unsecured toilet paper holder in the adjoining bathroom shared with Resident #8 and #58.</p> <p>Resident #44 and #84's bedroom had one shared closet with a folding door. The closet door knob was not attached leaving a visible protruding pointed screw.</p> <p>Resident #8 and #58's bedroom had one shared closet with a folding door not functioning properly being off track. A broken unused wall mounted plastic bracket was protruding from the wall next to Resident #58's bed.</p> <p>Resident #31 and #47's bedroom had a missing piece of floor tile in the center of the room.</p> <p>Resident #35 and #93's bedroom had a window with vertical blinds. There were two missing slats from the vertical blinds. The one shared closet had a folding door not functioning properly being off its track.</p> <p>Resident #3's bathroom had a broken toilet paper holder.</p> <p>Resident #75's bathroom mirror had multiple areas of dark discoloration making the mirror unusable.</p> <p>Resident #59 and #82's bathroom had a combined light and fan which made a loud clanging noise when in use.</p> <p>Resident #23, #38 and #102's adjoining bathroom had a toilet paper roll placed over the attached toilet faucet/sprayer used for cleaning excrement in lieu of a toilet paper holder.</p> <p>Resident #32's bathroom had dried feces smeared on the toilet riser seat and the left bathroom wall and floor had multiple areas with dried feces.</p> <p>Resident #39 and #55's inside bedroom door had exposed metal corner bead for drywall over approximately ten inches of the lower door frame.</p> <p>Resident #15, #39 and #55's adjoining bathroom had dried smeared feces on the toilet riser. The bathroom door handle used to exit from the bathroom into Resident #15's room had a child safety doorknob cover in place which prevented its use.</p> <p>Resident #27, #79 and #89's adjoining bathroom had a toilet riser with multiple rusted and peeled away coated areas.</p> <p>Resident #89's bedroom window had vertical blinds with three missing slats.</p> <p>Resident #37's bathroom had a toilet paper roll placed over the attached toilet faucet/sprayer used for cleaning excrement in lieu of a toilet paper holder.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER Kirtland Rehabilitation & Care		STREET ADDRESS, CITY, STATE, ZIP CODE 9685 Chillicothe Rd Kirtland, OH 44094	

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #6, #7, #81 and #92's adjoining bathroom had a toilet riser with multiple rusted and peeled away coated areas. There was a toilet paper roll placed on the back of toilet in lieu of a toilet paper holder.</p> <p>Resident #6 and #81's bedroom had one shared closet with a folding door. The closet door had a missing handle leaving a protruding pointed screw.</p> <p>Resident #7 and #92's bedroom had a non-functioning paper towel dispenser.</p> <p>Resident #49's bedroom window had vertical blinds with one missing slat. The left folding closet door had a broken plastic handle with sharp edges remaining.</p> <p>Resident #21's bedroom had two folding closet doors with broken plastic handles leaving sharp edges remaining.</p> <p>Resident #46's bedroom had a folding closet door not properly functioning being off track, and the door was inappropriately sized, not covering the entire closet space.</p> <p>Residents #42, #76 and #88's adjoining bathroom had dried feces smeared on the toilet seat. There was a cracked and partially missing bathroom tile piece next to the bathroom door leading toward Resident #76's bedroom. The damaged tile had rough edges exposed.</p> <p>Resident #34, #51, #83 and #97's adjoining bathroom a clump of hair hanging from the toilet riser. The toilet paper roll was placed over the attached toilet faucet/sprayer used for cleaning excrement in lieu of a toilet paper holder.</p> <p>Interview at the time of the observation with MD #474 verified the above findings.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>41526</p> <p>Based on record review and interview, the facility failed to provide dementia management training for three nurse aides on or after hire. This had the potential to affect all 103 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the personnel file for State tested Nursing Assistant (STNA) #485 revealed a hire date of 06/12/24. There was no evidence any dementia management training was completed on or after hire.</p> <p>Review of the personnel file for STNA #496 revealed a hire date of 06/26/24. There was no evidence any dementia management training was completed on or after hire.</p> <p>Review of the personnel file for STNA #503 revealed a hire date of 07/10/24. There was no evidence any dementia management training was completed on or after hire.</p> <p>Interview on 07/18/24 at 11:48 A.M. with Human Resource Director #510 verified dementia management training was not provided to STNA #485, #496 and #503 as required.</p> <p>Review of the Facility Assessment effective January 2024 through December 2024 revealed the facility accepted neurological and psychiatric mood disorders, and provided special treatments including behavioral health needs, and care for behavioral symptoms, cognitive loss and dementia. Staff training or education for nurse aides required dementia management training.</p>