

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Gardens of Belden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 5005 Higbee Avenue NW Canton, OH 44718	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442</p> <p>Based on observation, interview, facility repair invoice and facility policy, the facility failed to ensure repairs were completed timely following identified concerns. This affected three residents (#48, #59 and #69) of seven (#7, #16, #48, #59, #69, #84 and #137) reviewed for environmental concerns requiring repairs. The facility census was 87.</p> <p>Findings include:</p> <p>1. Observations on 10/28/24 at 9:46 A.M. with [NAME] President (VP) of Plant Operations #933 and Maintenance Director (MD) #864 revealed Resident #59's room had six ceiling tiles in the first row running perpendicular to the entrance door with dried water stains, three tiles above the dresser were water stained, a hole was cut in the back wall of the bathroom drywall which revealed an exposed pipe. Rust stains were observed on the floor behind and around the toilet. The linoleum flooring was noted to be curled up from the back wall where rust-colored stains were observed. The ceiling tile above the toilet was broken into two pieces</p> <p>Further observations on 10/28/24 at 9:50 A.M. with VP of Plant Operations #933 and MD #864 revealed Resident #48's room had one missing ceiling tile in the row next to the window and four ceiling tiles in the same row with obvious dried water stains.</p> <p>Interviews on 10/28/24 at 10:00 A.M. with VP of Plant Operations #933 and MD #864 confirmed the above findings.</p> <p>Interview on 10/29/24 at 10:43 A.M. with MD #864 revealed the original water leak stemmed from rooms [ROOM NUMBERS] related to water pooling around the base of the toilet which caused leaks in multiple rooms on the first floor due to water traveling. MD #864 attempted to replace the toilet flange but this did not work and caused damage to Resident #59's room. MD #864 stated when he removed the ceiling tiles in Resident #59's bathroom, it required a third-party contractor. MD #864 confirmed the repairs were completed by the contractor on 10/08/24 and the replacement tiles were received on 10/16/24 but the ceiling tiles had not been replaced in the resident rooms prior to the observation.</p> <p>Interview on 10/30/24 at 7:53 A.M. with VP of Plant Operations #933 confirmed the toilet had not leaked since repairs were completed on 10/08/24 so the toilet was not replaced. VP of Plant Operations #933 also confirmed following the contractor repairs, the facility had not completed the tile replacements or gotten quotes for the floor replacement for Resident #59's room.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/31/24 at 10:24 A.M. with the Administrator confirmed he was aware of the leak in the ceiling and had a plumber come out for repairs which required additional parts to be ordered. The Administrator confirmed the work had been completed since 10/09/24 but the ceiling tiles or floor had not been replaced.</p> <p>Interview on 10/31/24 at 11:14 A.M. with Resident #48 (who exhibited intact cognition) revealed the tile in her room had fallen related to wetness and she wanted the ceiling tiles repaired.</p> <p>Interview was not able to be conducted with Resident #59 due to severe cognitive impairment.</p> <p>Review of the facility contractor invoice dated 10/24/24 revealed a contractor came out for service on 09/25/24 and ordered material. On 10/09/24 repairs were completed for the pipe and fitting to the vent and drainage system to the second-floor toilet and it was believed the toilet was cracked. Facility maintenance was to install a new toilet to see if it corrected the issue.</p> <p>Review of the April 2010 facility policy Work Order, Maintenance revealed maintenance orders were to be completed in order to establish a priority of maintenance service. No specifics were listed as to time frame for repairs to be completed.</p> <p>36650</p> <p>2. Interview on 10/29/24 at 10:31 A.M. with Resident #69 and her daughters revealed the sink in the bathroom had been plugged and at times the sink was full of dirty water. Maintenance was notified of the backed up sink and nothing was being done about it.</p> <p>Observation of Resident #69's bathroom sink on 10/29/24 at 10:35 A.M. revealed the sink was half full of standing dirty water.</p> <p>Interview on 10/29/24 at 11:00 A.M. with Regional Director of Clinical Service #930 verified the sink was plugged and that the resident and family were not happy the room.</p> <p>The deficiency represents non-compliance investigated under Complaint Number OH00158304.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on observation, record review, facility policy review and interview, the facility failed to ensure effective measures/systems were in place to prevent resident falls with injury. The facility failed to ensure Resident #38 was transferred appropriately using a gait belt and failed to ensure Resident #48's bed U-bar side rail was maintained in good repair. This affected two residents (#38 and #48) of four residents reviewed for accidents and hazards.</p> <p>Actual harm occurred on 09/25/24 at 9:40 A.M. to Resident #38, when Certified Nursing Assistant (CNA) #831 attempted to transfer Resident #38 from a bedside commode to the wheelchair without using a gait belt as care planned. Resident #38 and STNA #831 fell to the floor. Resident #38 sustained a fractured hip which required surgical repair and had chronic pain post surgical repair.</p> <p>Actual harm occurred on 06/08/24 at 3:47 P.M. when during resident care, Resident #48 grabbed the multi-function side rail (U-bar) attached to her bed to pull herself over, the side rail gave way and Resident #48 rolled off the side bed landing on the floor face down sustaining a fracture to the left fibula fracture.</p> <p>Findings include:</p> <p>1. Review of Resident #38's medical record revealed the resident was admitted on [DATE] with diagnoses including a displaced intertrochanteric fracture of the left femur, vascular dementia and diabetes.</p> <p>Review of Resident #38's care plans revealed an intervention dated 05/03/24 indicating staff education to use gait for transfers while toileting resident.</p> <p>Review of Resident #38's Minimum Data Set 3.0 comprehensive assessment dated [DATE] revealed the resident exhibited intact cognition.</p> <p>Review of Resident #38's progress note dated 09/25/24 timed 9:40 A.M. authored by Licensed Practical Nurse (LPN) #906 revealed LPN #906 was alerted to Resident #38's room by CNA #831 who stated she had to lower the resident to the floor because she was not able to get the resident's wheelchair behind him fast enough and the resident was unable to keep himself up. The resident stated he could not hold himself up anymore. Resident #38 was lowered to the floor by CNA #831 and a pillow was placed behind the resident's head. The floor was dry with no clutter and the resident was wearing tennis shoes that were tied and fit properly. Resident #38 complained of pain in the left leg and was transferred to the emergency room for evaluation.</p> <p>Review of the Fall Scene Investigation Report dated 09/25/24 revealed the gait assist at the time of the fall areas were left blank. There was no information the care planned gait belt was in place at the time of the fall. The form indicated the resident lost his balance and could not stay up. The investigation indicated the resident would be changed to a two-staff assist (following the incident).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated fall witness statement authored by CNA #831 revealed she transferred Resident #38 back to his chair (from the bedside commode) when they began to fall to the ground in slow motion. No cracking sounds or popping sounds were heard, he did not fall hard, and the floor was not wet. Resident #38 partially fell on CNA #831 while switching back from the resident's commode to the electric scooter approximately ten seconds after standing from the commode.</p> <p>Review of Resident #38's hospital documentation dated 09/25/24 revealed Resident #38 sustained a closed intertrochanteric fracture of left hip and had surgery for a intramedullary nail to the left intertrochanteric hip fracture.</p> <p>Review of Resident #38's hospital Discharge Summary form dated 09/27/24 revealed Resident #38 had a closed intertrochanteric fracture of the left hip, a closed displaced intertrochanteric fracture of the left femur and operations during the hospitalization included a intramedullary nail to the left intertrochanteric hip fracture.</p> <p>Review of Resident #38's progress note dated 09/27/24 at 2:55 P.M. authored by Registered Nurse (RN) #882 revealed the resident was readmitted to the facility with dressings to the hip which were intact.</p> <p>Review of the physician progress note dated 10/21/24 revealed the visit was a follow up for chronic pain of the left femur fracture and to continue medications, plan of care, physical therapy, occupational therapy and to monitor laboratory results.</p> <p>Interview on 10/30/24 at 9:12 A.M. with LPN #906 revealed she was called to Resident #38's room when CNA #831 lowered Resident #38 to the floor. LPN #906 revealed Resident #38 required assistance to transfer with one to two persons at the time of the incident.</p> <p>Observations on 10/30/24 at 10:15 A.M. revealed two CNAs coming out of Resident #38's room. The resident was in a wheelchair with a Hoyer (mechanical lift) pad underneath him. Interview on 10/30/24 at 10:18 A.M. with Resident #38 revealed the resident had recollection of the incident when CNA #831 transferred him from the bedside commode to a wheelchair and he was dropped to the floor. Resident #38 denied CNA #831 had used a gait belt during the transfer.</p> <p>Interview on 10/30/24 at 10:38 A.M. with Regional Director of Clinical Services #930 confirmed Resident #38's care plan indicated staff were required to transfer the resident using a gait belt and the fall investigation did not have evidence a gait belt was used.</p> <p>Telephone interview on 10/30/24 at 12:56 P.M. with CNA #831 revealed Resident #38 fell backwards when she was trying to get him off of the bedside commode to the wheelchair. CNA #831 said she did not use a gait belt when transferring the resident. She stated the facility did not have gait belts for staff use.</p> <p>Review of the Safe Lifting and Movement of Residents policy revised July 2027 revealed safe lifting and movement of residents was part of an overall facility employee health and safety program, which involved employees identifying problem areas and implementing workplace safety and injury-prevention strategies; providing training on safety, ergonomics and proper use of equipment; and continually evaluating the effectiveness of workplace safety and injury-prevention strategies.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>45442</p> <p>2. Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included but were not limited to unspecified fracture of shaft of left fibula (06/12/24), congestive heart failure, type II diabetes mellitus, morbid obesity, hemiplegia and hemiparesis and bipolar disorder.</p> <p>Review of the care plan for Resident #48 dated 03/19/24 revealed self-care deficit related to decreased functional mobility. Interventions were one to two staff assist as required for bed mobility, toileting and transfers.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #48 revealed she was cognitively intact, incontinent of bowel and bladder, and was dependent on staff for activities of daily living.</p> <p>Review of the nursing progress note dated 06/08/24 authored by Licensed Practical Nurse (LPN) #812 timed at 12:54 P.M. revealed Resident #48 was assisted from the floor to the bed with person assist using a mechanical lift. Resident #48 stated she wanted to go to the hospital due to the knot on her left upper forehead.</p> <p>Review of nursing progress revealed clarification dated 06/08/24 timed 3:47 P.M. indicating Resident #48 rolled out of bed during patient care while bed was in low position.</p> <p>Review of the nursing progress note dated 06/09/24 timed at 4:52 A.M. authored by LPN #934 revealed Resident #48 was admitted to the hospital related to increased blood pressure and possible fracture to left ankle.</p> <p>Review of the fall incident report for fall dated 06/08/24 revealed LPN #812 was providing patient care for Resident #48. Resident #48 was using her grab bar (multi-function side rail) to roll over and the grab bar became detached, and Resident #48 fell out of bed onto the floor. Vitals and neurological checks were completed, and Resident #48 was sent to the emergency room for evaluation.</p> <p>Review of the witness statement from LPN #812 dated 06/08/24 revealed at approximately 11:00 A.M. on 06/08/24 she was providing incontinence care for Resident #48 and Resident #48 used her safety grab bar to roll over onto her left side which became detached, and Resident #48 fell face forward onto the floor in a prone position.</p> <p>Review of the witness statement from CNA #841 revealed she was not present when the fall occurred but assisted LPN #812 with the mechanical lift to transfer Resident #48 from the floor to her bed.</p> <p>Review of the witness statement dated 06/08/24 from CNA #841 revealed she did not observe Resident #48's fall but did respond to LPN #812's call for help and assisted her with the mechanical lift to get Resident #48 off the floor back into bed.</p> <p>Review of the hospital admission note for Resident #48 dated 06/09/24 revealed she sustained a left ankle fracture after falling out of bed at the nursing facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the x-ray report dated 06/10/24 for Resident #48 revealed limited exam due to decreased bone mineralization, patient positioning and superimposed artifact. There was questioned cortical irregularity at the lateral margin of the fibula with suspected lucency in the distal tibia, suspicious for nondisplaced fracture. Irregularity at the medial malleolus could be chronic. Degenerative changes were present. Soft tissue edema overlaid the dorsum of the forefoot and anterior ankle.</p> <p>Interview on 10/30/24 at 8:33 A.M. with Regional Director of Clinical Services #930 confirmed Resident #48 rolled out of bed onto the floor during patient care because her grab bar (multi-function side rail) became loose when she was rolling onto her side, and Resident #48 fell face forward onto the floor. Regional Director of Clinical Service #930 revealed Resident #48 required one person assist as she was able to use the grab bar to roll and turn herself.</p> <p>A telephone interview on 10/31/24 at 9:48 A.M. with LPN #812 revealed she was providing incontinence care to Resident #48, who was a one person assist, and when Resident #48 rolled she put all of her weight on the grab bar which pushed it outwards, and the grab bar became detached causing Resident #48 to roll out of the bed onto the floor face first. LPN #812 assessed Resident #48 and then obtained assistance from CNA #841 and using the mechanical lift transferred Resident #48 off the floor back into her bed. Resident #48 was sent to the emergency room .</p> <p>Interview on 10/31/24 at 10:24 A.M. with the Administrator revealed the facility completed an annual check of the facility equipment, including side rails and staff were encouraged to report any observed concerns related to facility equipment to the maintenance department.</p> <p>Interview on 10/31/24 at 11:14 A.M. with Resident #48 revealed LPN #812 was providing incontinence care for her, Resident #48 stated she used the grab bar on her bed to assist her to roll over and when she bore her weight on it, the grab bar broke off and she fell out of bed onto the floor face first. LPN #812 assessed her, and another nurse assisted her with the mechanical lift back into bed and then she was sent to the hospital for treatment.</p> <p>Review of manufacturer's information for the expandable deck bariatric low bed with multi-function side rails, which was the type bed Resident #48 was on at the time of the fall, revealed the bed weight capacity was 600 pounds and was able to meet most patient needs with multi-function side rails that swung up and locked for patient assistance.</p> <p>Review of the April 2010 revised facility policy called; Work Order, Maintenance provided no specific information regarding the frequency which the facility was to complete maintenance checks to ensure bed rails were functioning properly and attached per manufacturer requirements.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158638.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49774</p> <p>Based on interview, record review, and facility policy review the facility failed to ensure monitoring prior to and following dialysis treatments for Resident #13. This affected one resident (#13) of one reviewed for dialysis. The facility census was 87.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included end stage renal disease, dependence on renal dialysis, chronic obstructive pulmonary disease, type II diabetes mellitus, acute and chronic respiratory failure with hypoxia, and heart failure.</p> <p>Review of the physician's orders for Resident #13 revealed an order dated 06/19/24 for dialysis treatment at an off site dialysis center which began at 6:30 A.M. on Monday, Wednesday, and Friday. Resident #13 also had a physician order dated 12/05/23 for Resident #13's dialysis site be checked for signs and symptoms of infection every shift.</p> <p>Review of the pre and post dialysis assessments for Resident #13 in the electronic medical record revealed a no pre dialysis evaluations were completed from January 2024 through October 2024 and no post dialysis evaluations from December 2023 through October 2024. Upon request, no further evidence was provided pre-dialysis and post dialysis assessments were completed during this time.</p> <p>Review of the vitals documentation for Resident #13 from June to October 2024 revealed blood pressure, pulse, blood oxygen, and temperature monitoring only occurred after dialysis treatment.</p> <p>Review of nursing progress notes from July to 10/22/24 did not reveal any additional documentation on Resident #13's status prior to or post dialysis treatments.</p> <p>Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for October 2024 for Resident #13 did not reveal any documentation the bruit or thrill of Resident #13's dialysis shunt was assessed.</p> <p>Review of the care plan for Resident #13 revised 10/23/24 revealed Resident #13 received dialysis. Interventions included checking the arteriovenous fistula every shift for thrill/bruit for signs and symptoms of infection or bleeding, monitoring and documenting signs or symptoms of renal insufficiency, and coordinating care with dialysis.</p> <p>Interview on 10/31/24 at 12:00 P.M. with Registered nurse (RN) #885 revealed pre and post dialysis vitals were checked at the dialysis center. Upon her return, Resident #13 provided the nurse with a paper from dialysis that documented her vitals. RN #885 reported she reviewed the vitals and entered them into the electronic medical record and then discarded the paper.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated facility policy called; Hemodialysis Access Care revised September 2010 revealed care immediately following dialysis included palpating the site to feel the thrill or use a stethoscope to hear the whoosh or bruit of blood flow through the access. The policy did not include a pre-dialysis evaluation be completed. The Policy also indicated that the general medical nurse should document the location of the catheter, condition of dressing, if dialysis was done during shift, any part of report from dialysis nurse post-dialysis given, and observations post-dialysis.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442</p> <p>Based on observation, interview and record review the facility failed to ensure the kitchen was maintained in a sanitary manner, foods were dated, labeled, and discarded when expired, and ensure the ware washing was completed appropriately to ensure sanitation. This affected all 87 residents receiving meals from the kitchen. The facility indicated there were no residents who received nothing by mouth. The facility census was 87.</p> <p>Findings include:</p> <p>Observation on [DATE] at 9:30 A.M. during the initial kitchen tour with Regional Culinary Director #932 revealed the following concerns.</p> <ul style="list-style-type: none"> - The front of reach in refrigerator had visible caked on soiling on the front of the refrigerator and the handle. - An undated, open package of shredded cheddar cheese was found in the reach in refrigerator. - An unlabeled, undated roast beef sandwich was found in the reach in refrigerator - The reach in refrigerator was soiled with multiple spills and had various food particles spread across the bottom of it. - The steam table was visibly soiled in the front with dried spilled food items. - The three compartment sink was not functional with a plugged drain. - The high temperature dish machine met the initial wash temperature of 153 degrees Fahrenheit (F), but the wash cycle did not get above 156 F to meet the required 180 F. <p>Interview on [DATE] at 9:48 A.M. with Regional Culinary Director #932 confirmed the above findings and stated she was informed this morning the three-compartment sink was not working and confirmed the observation of the dish machine not getting up to the appropriate temperature. Regional Culinary Director #932 was not aware of the three-compartment sink was plugged until this morning.</p> <p>Interview on [DATE] at 9:55 A.M. with [NAME] #869 revealed when they realized the dish machine was not working on the morning of [DATE], they washed and rinsed the dishes in the two-compartment sink but did not sanitize them. [NAME] #869 stated they notified the Administrator the dish machine and the three compartment sink was not working.</p> <p>Interview on [DATE] at 10:19 A.M. with Maintenance Director #864 revealed the three-compartment sink was not working when he started over five weeks ago. Maintenance Director #864 stated a repairman was out last week and stated he had previously been out to diagnose the issue and stated he was unable to fix it. Maintenance Director #864 stated he found out about the dish machine about 10:00 A.M. this morning and had called the company to have a repairman out today.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on [DATE] at 10:22 A.M. with Regional Culinary Director #932 revealed upon finding out the dishwasher was not functioning properly as well as the three compartment sink drain being plugged, the facility obtained Styrofoam containers and plastic silverware to serve the residents until the dish machine was fixed.</p> <p>Interview on [DATE] at 8:52 A.M. with Dietary Aide (DA) #900 stated in regard to three compartment, it had not been functioning for the past two to three weeks and was told by the maintenance director not to use it. During that period all of the dish items were being run through the dish machine. On [DATE] there was an issue with the dish machine not getting up to temperature and the maintenance director was notified and fixed the issue the same afternoon. On the morning of [DATE] around 8:30 A.M. DA #900 and DA #850 realized the dish machine was again not getting up to correct temperature. They shut the machine off, and they got out three large containers; one was dish soap and water; one was with an unmeasured amount of bleach in the water and the third was just hot water for rinse. After they washed the first cart which held 14 resident trays, they replaced each of the hot water and detergents in the three large containers before starting each consecutive cart until all six carts were washed. DA #900 confirmed he had not tested the chemical level of the bleach to ensure the sanitation level.</p> <p>Interview on [DATE] at 9:03 A.M. with Regional Culinary Director #932 confirmed with the dish machine not working and the three compartment sink being plugged, employees should have tested the dish water to ensure the proper sanitation level was achieved.</p> <p>Observation of the unit refrigerators for resident use on [DATE] at 9:05 A.M. with Regional Culinary Director #932 revealed the following concerns in the second floor 200 hall refrigerator.</p> <ul style="list-style-type: none"> - Two containers of ,d+[DATE] cup undated unlabeled coleslaw - One package of 12 ounce sausage with no visible expiration date but had a distinct spoiled odor and was visibly discolored. - Four containers of ,d+[DATE] cup med pass apple sauce that were dated [DATE]. - 28-ounce open, undated container of five layer dip with an expiration date of [DATE]. <p>Interview on [DATE] at 9:10 A.M. with Regional Culinary Director #932 confirmed the above observations of resident floor refrigerators.</p> <p>Review of the [DATE] revised facility policy called; Sanitization revealed manual washing and sanitizing would employ a three-step process for washing, rinsing, and sanitizing.</p> <ol style="list-style-type: none"> a. Scrape food particles and wash using hot water and detergent, b. rinse with hot water to remove soap residue and c. sanitize with hot water or chemical sanitizing solution. Chemical sanitizing solutions could consist of: <ol style="list-style-type: none"> 1. Chlorine 50 parts per million (ppm) for 10 seconds. <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Gardens of Belden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 5005 Higbee Avenue NW Canton, OH 44718	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. Iodine 12.5 ppm for 30 seconds or</p> <p>3. Quaternary ammonium compound ,d+[DATE] ppm for time designated by the manufacture.</p> <p>Review of the undated facility policy; Food Brought in By Visitors revealed all perishable food in resident's rooms were to be in tightly closed containers, labeled and dated well. No specific dating timeframes were listing on the policy.</p>		

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on observation, record review and interview, the facility failed to ensure the appropriate use of personal protective equipment. This had the potential to affect 47 residents who resided on the second floor including Residents #1, #4, #6, #9, #11, #12, #13, #16, #19, #20, #22, #24, #27, #28, #29, #30, #34, #36, #38, #39, #40, #41, #42, #44, #51, #52, #55, #56, #57, #58, #61, #65, #70, #71, #74, #75, #76, #77, #78, #79, #80, #81, #84, #137, #187, #189 and #190. The facility census was 87.</p> <p>Findings include:</p> <p>1. Review of Resident #18's medical record revealed the resident was admitted on [DATE] with diagnoses including COVID-19, chronic diastolic congestive heart failure and major depressive disorder.</p> <p>Review of Resident #18's physician orders revealed an order dated 10/28/24 for droplet isolation for COVID-19 for ten days (to be discontinued 11/07/24).</p> <p>Observation on 10/28/24 at 10:25 A.M. revealed Housekeeping #842 coming out of Resident #18's room. Housekeeping #842 had on a blue surgical gown, gloves and a blue surgical mask at the time of the observation. Signage on the resident's door indicated the resident was COVID-19 positive.</p> <p>Interview on 10/28/24 at 10:30 A.M. with Housekeeping #842 confirmed she did not use the N95 respiratory mask and eye protection when cleaning Resident #18's room and she confirmed the resident's door had signage that he was COVID-19 positive. Housekeeping #842 confirmed she cleaned resident rooms and common areas on the second floor.</p> <p>Review of the facility Coronavirus (COVID-19) Policy and Procedure dated 09/23/24 revealed staff were to don personal protective equipment (PPE) for Droplet precautions including N95 mask, face shield or goggles, gown and gloves prior to entering COVID positive resident rooms per the Centers for Disease Control (CDC) donning process and when exiting the room, staff were to follow the CDC guidance for doffing PPE.</p> <p>36650</p> <p>2. Review of Resident #82's medical record revealed the resident was admitted on [DATE] with diagnoses including COVID-19, osteomyelitis of right ankle and foot and type two diabetes.</p> <p>Review of Resident #82's physician orders revealed an order dated 10/25/24 for droplet isolation for COVID-19 for ten days (to be discontinued 11/04/24).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Gardens of Belden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 5005 Higbee Avenue NW Canton, OH 44718	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 10/30/24 at 12:25 P.M. revealed Register Nurse (RN) #906 donning personal protective equipment (PPE) prior to going into Resident #82's room. RN #82 donned a gown, gloves and N-95 mask prior to entering Resident #82's room. RN #82 did not apply eye protection until after entering the resident's room and being asked if eye protection was required. RN #906 stated I thought my glasses were good enough, I have goggles if I need to wear them. Upon completing her tasks and exiting Resident #82's room, RN #906 removed her gown and gloves used hand sanitizer and proceeded down the hall to the vending machine. RN #906 spoke to multiple residents and staff, and upon returning to Resident #82's room to give him the pop she purchased at the vending machine she confirmed she had not doffed the N95 or eye protection after being in Resident #82's room.</p> <p>Review of the facility Coronavirus (COVID-19) Policy and Procedure dated 09/23/24 revealed staff were to don personal protective equipment (PPE) for Droplet precautions including N95 mask, face shield or goggles, gown and gloves prior to entering COVID positive resident rooms per the Centers for Disease Control (CDC) donning process and when exiting the room, staff were to follow the CDC guidance for doffing PPE.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157894.</p>		