STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365355	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens of Mayfield Village	6757 Mayfield Rd Mayfield Heights, OH 44124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 44808 Based on observation, resident interview, and staff interview, the facility failed to have survey results readily accessible to residents. This had the potential to affect all 71 residents residing in the facility. Findings include: On 07/31/24 at 8:46 A.M., an interview with Resident #25 stated he wanted to see the survey results for the facility, and he did not know where they were located or if the facility would even allow him to see the survey results. On 07/31/24 at 11:36 A.M., an observation of the facility lobby revealed there was a binder of survey results on the table. The most recent survey results in the binder were from October 2023. The survey results from the four most recent surveys, completed April 2024 through July 2024, were not included in the survey results binder. This was verified by Regional Director of Operations (RDO) #309 at the time of observation. On 07/31/24 at 12:34 P.M., an interview with RDO #309 stated there was another survey binder with the results of recent surveys at the first-floor nurse's station. Observation at the time of interview revealed there was a survey results binder behind the nurse's station at the bottom of a stack of patient care binders, which was not readily accessible by residents. RDO #309 verified this survey results binder was not readily accessible by residents. This deficiency was an incidental finding identified during the complaint investigation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, staff interview, and review of the facility policy, the facility failed to complete care conferences in a timely manner for Resident #25, #35, #40, and #63. This affected four residents (#25, #35, #40, and #63) of four residents reviewed for care conferences. The facility census was 71. Findings include: 1. Review of the medical record for Resident #25 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, morbid obesity, hypertension, and non-pressure chronic ulcer of the left foot. Review of the care conference assessment, dated 01/25/24, revealed a care conference was held with the former social worker, a representative from the activities department, a representative from therapy services, and Resident #25. The assessment form had the social services and resident/family sections completed and the nursing summary, dietary summary, recreation summary, pharmacy summary, therapy and restorative summary, and physician summary sections were either blank or marked not applicable (N/A). The assessment was signed and locked on 04/12/24. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/02/24, revealed Resident #25 was cognitively intact. Review of the comprehensive care plan revealed it was reviewed on 05/07/24 and 08/05/24. Further review of the medical record for Resident #25 revealed no evidence of a care conference completed between May 2024 and July 2024. 2. Review of the medical record for Resident #35 revealed an admitted [DATE] and readmitted [DATE]. Diagnoses included type two diabetes mellitus, morbid obesity, hemiplegia and hemiparesis affecting the left side, bipolar disorder, and altered mental status. Review of the care conference assessment, dated 04/09/24, revealed a care conference was held with the former social worker, a representative from therapy services, a representative from the business office, and Resident #35. The assessment form had the social services and resident/family sections completed and the nursing summary, dietary summary, recreation summary, pharmacy summary, therapy and restorative summary, and physician summary sections were either blank or marked not applicable (N/A). Review of the care conference assessment, dated 06/10/24, revealed the form was incomplete and all fields were blank. Review of the quarterly MDS assessment, dated 07/22/24, revealed Resident #35 had moderate cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive care plan revealed it was reviewed on 07/24/24. Further review of the medical record for Resident #35 revealed no evidence of a care conference completed between May 2024 and July 2024. 3. Review of the medical record for Resident #40 revealed an admitted [DATE] and readmitted [DATE]. Diagnoses included congestive heart failure, severe protein calorie malnutrition, atrial fibrillation, and adult failure to thrive. Review of the care conference assessment, dated 04/10/24, revealed a care conference was held with the former social worker, Resident #40, and Resident #40's family. The assessment form had the social services and resident/family sections completed and the nursing summary, dietary summary, recreation summary, pharmacy summary, therapy and restorative summary, and physician summary sections were either blank or marked not applicable (N/A). Review of the quarterly MDS assessment, dated 06/08/24, revealed Resident #40 had moderate cognitive impairment. Review of the comprehensive care plan revealed it was reviewed on 07/03/24. Further review of the medical record for Resident #40 revealed no evidence of a care conference completed between May 2024 and July 2024. 4. Review of the medical record for Resident #63 revealed an admitted [DATE] and readmitted [DATE]. Diagnoses included paraplegia, moderate protein calorie malnutrition, hemiplegia and hemiparesis affecting the left side, epilepsy, and adult failure to thrive. Review of the care conference assessment, dated 04/12/24, revealed a care conference was held with the former social worker and Resident #63. The assessment form had the social services and resident/family sections completed and the nursing summary, dietary summary, recreation summary, pharmacy summary, therapy and restorative summary, and physician summary sections were either blank or marked not applicable (N/A). Review of the quarterly MDS assessment, dated 07/10/24, revealed Resident #63 had moderate cognitive impairment. Review of the comprehensive care plan revealed it was reviewed on 07/24/24. Further review of the medical record for Resident #63 revealed no evidence of a care conference completed between May 2024 and July 2024. On 08/06/24 at 3:00 P.M., an interview with Regional Director of Operations (RDO) #309 confirmed she was unable to locate care conferences for Residents #25, #35, #40, and #63 that were completed within the last three months. She stated that the facility does not complete care conferences every three months or at the same time as the MDS assessments. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Care Planning - Interdisciplinary Team, dated September 2013, revealed the facility's care planning interdisciplinary team was responsible for the development of an individualized care plan, a comprehensive care plan would be developed within seven days of completion of the resident MDS assessment, the resident or representative would be encouraged to participate in the development of and revisions to the care plan, and every effort would be made to schedule care plan meetings at the best time of day for the resident and/or representative. This deficiency was an incidental finding identified during the complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review and facility policy review, the facility failed to initiate and provide adequate individualized wound care and administer medications as ordered by the physician. This affected two residents (#36 and #40) of two residents reviewed for wound care and four residents (#18, #25, #30 and #63) of seven residents reviewed for medication administration. The facility census was 71. Findings include: 1. Review of the medical record for Resident #36 revealed an admitted [DATE]. Diagnoses included diabetes mellitus (DM) type II with diabetic neuropathy, peripheral angiopathy and chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, acquired absence of left foot, non-pressure chronic ulcer of other part of left foot, and peripheral vascular disease. The quarterly Minimum Data Set (MDS) assessment completed 06/08/24 indicated moderate cognitive impairment. Interview on 07/31/24 at 9:41 A.M. with Resident #36 complained her left foot wound treatments were sometimes skipped and not changed every day. Review of the weekly wound observation tool dated 06/24/24 revealed Resident #36 had a left plantar foot diabetic ulcer acquired on 06/08/24 which measured 1.1 cm (centimeters) length by 1.0 cm width by 0.4 cm depth with no tunneling and it was improving. This was verified with a corresponding wound nurse practitioner (WNP) progress note dated 06/24/24. Review of Resident #36's physician orders effective 07/01/24 indicated a left plantar foot ulcer treatment to cleanse with normal saline, apply Medihoney (a dressing to support the removal of necrotic tissue and aid in wound healing), calcium alginate to the wound bed (a dressing to treat exudating wounds), an abdominal dressing followed by gauze wrap daily and as needed. Review of the treatment administration record (TAR) for July 2024 revealed Resident #36 did not receive the daily wound treatment as ordered on 07/05/08. There was no weekly wound observation tool completed for Resident #36's left plantar foot ulcer on 07/01/24. A progress note dated 07/01/24 specified Resident #36 was not seen by the wound nurse due to being at an appointment. There was no evidence of a WNP progress note for 07/01/24. Review of the weekly wound observation tool dated 07/08/24 revealed Resident #36's left plantar foot ulcer had declined. It measured 1.0 cm length by 0.8 cm width by 0.7 cm depth with tunneling between nine and three o'clock for a maximum of 0.8 cm. Review of Resident #36's physician orders for July 2024 revealed the left plantar foot ulcer treatment was changed on 07/08/24 to cleanse with normal saline, apply silver alginate (a dressing to absorb exudate and add antimicrobial effects), an abdominal dressing followed by gauze wrap daily and as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the TAR for July 2024 revealed Resident #36 did not receive the daily wound treatment as ordered on 07/11/08, 07/12/24, 07/13/24, 07/14/24, 07/17/24, and 07/18/24. Review of the weekly wound observation tool dated 07/19/24 revealed Resident #36's left plantar foot ulcer remained as declined. It measured 1.7 cm length by 1.4 cm width by no documented depth or tunneling. This was verified with a corresponding WNP progress note dated 07/19/24 which indicated the depth was indeterminable due to the presence of slough (dead tissue) at the wound base and no signs or symptoms of infection were present. Review of Resident #36's physician orders for July 2024 revealed the left plantar foot ulcer treatment was changed on 07/19/24 to cleanse with normal saline, apply silver alginate, gentamycin ointment (used to kill bacteria that causes infections), an abdominal dressing followed by gauze wrap daily and as needed. Review of the weekly wound observation tool dated 07/22/24 revealed Resident #36's left plantar foot ulcer had no measurement change but the wound progress was improving. This was verified with a corresponding WNP progress note dated 07/22/24 which indicated there was less slough present and no signs or symptoms of infection were present. Review of the weekly wound observation tool dated 07/29/24 revealed Resident #36's left plantar foot ulcer continued to improve. It measured 1.7 cm length by 1.5 cm width by 0.7 cm depth with no documented depth or tunneling. This was verified with a corresponding WNP progress note dated 07/29/24 which indicated there was minimal slough present and no signs or symptoms of infection were present. Review of the TAR for July 2024 revealed Resident #36 did not receive the daily wound treatment as ordered on 07/30/24. Observation on 07/31/24 at 9:46 A.M. of wound care for Resident #36 with Unit Manager (UM) #305 revealed the left foot dressing was dated 07/31/24 prior to removal. After removed, the left foot had amputated digits. The wound was plantar and appeared as a small, moderately deep crater, dull in color with minimal slough present at the wound base. UM #305 confirmed the observation. Interview on 08/05/24 at 8:54 A.M. with Resident #36 complained her left foot wound treatments continued to be skipped on some days. Observation of the left foot wound dressing date was 08/04/24. Review of the TAR for August 2024 revealed Resident #36 did not receive the daily wound treatment as ordered on 08/02/24. Interview on 08/05/24 at 2:33 P.M. with UM #305 verified the above findings and confirmed Resident #36's wound treatments were not completed daily as ordered. UM #305 recalled during the wound observation on 07/31/24 of Resident #36's dressing dated as changed on 07/31/24. UM #305 explained she had removed the dressing to look at the wound prior to this surveyor's observation of wound care but could not recall what the date was on the dressing prior to removing it since the dressing was not completed on 07/30/24. UM #305 indicated remembering it was changed on 07/29/24 because she did it but could not confirm it was completed on 07/30/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility policy titled, Wound and Skin Care revealed any alteration in skin integrity will be assessed, communicated to physician, treatment order obtained and initiated. The charge nurse will notify the physician if a treatment cannot be completed as ordered and request an order for alternate treatment. 2. Review of the closed medical record for Resident #40 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included congestive heart failure, severe protein-calorie malnutrition, anemia, dementia and adult failure to thrive. Review of the quarterly MDS assessment completed 06/08/24 indicated moderate cognitive impairment. A death in the facility MDS assessment was completed 07/31/24. Review of a weekly skin assessment dated [DATE] revealed Resident #40 had new skin tears identified on the left buttock, the right buttock, the right trochanter (hip), the left gluteal fold and the right gluteal fold. No assessment or details related to the skin tears were documented, and there were no specified treatments initiated. Review of the progress notes for July 2024 revealed Resident #40 received hospice services. There was no evidence of a treatment initiated or provided, and no indication hospice was made aware of the skin tears identified on 07/29/24. Review of the physician orders and TAR for July 2024 revealed no treatment was initiated or provided for Resident #40's skin tears identified on 07/29/24. Interview on 08/05/24 at 2:49 P.M. with UM #305 verified the above findings and indicated Resident #40 was actively transitioning with death but could not confirm any treatment was initiated or whether the physician or hospice was made aware of the new skin condition. Review of the facility policy, Wound and Skin Care revealed any alteration in skin integrity will be assessed, communicated to physician, treatment order obtained and initiated. The charge nurse will notify the physician if a treatment cannot be completed as ordered and request an order for alternate treatment. 3. Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included dementia, insomnia, anxiety disorder and adult failure to thrive. The quarterly MDS assessment completed 05/11/24 indicated Resident #18 was rarely or never understood. Review of Resident #18's physician orders effective July 2024 revealed an order for Ativan (antianxiety) 0.5 mg (milligrams) three times daily for anxiety. Review of Resident #18's medication administration record (MAR) for July 2024 revealed Ativan was administered at 10:00 P.M. on 07/05/24, 07/06/24, 07/11/24, 07/12/24 and 07/13/24. However, the corresponding controlled substance disposition record for Resident #18's Ativan specified there was no Ativan removed from storage on each of those dates at 10:00 P.M. for administration. Interview on 08/06/24 at 2:41 P.M. with the Acting Director of Nursing (DON), Regional Director of Clinical Services (RDCS) #310 confirmed there was no evidence Resident #18 received Ativan as ordered at 10:00 P.M. on 07/05/24, 07/06/24, 07/11/24, 07/12/24 and 07/13/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Administering Medications, revised December 2012, revealed medications must be administered in accordance with the orders. The individual administering the medication will record in the resident's medical record the date and time the medication was administered, the dosage, the route of administration. Review of the facility policy, Controlled Substances, revised December 2012, revealed the controlled drug substance record must include at least the following: the name of the resident, the name and strength of the medication, the number on hand, the time of administration and the method of administration. 4. Review of the medical record for Resident #25 revealed an admitted [DATE]. Medical diagnoses included DM, chronic atrial fibrillation, essential primary hypertension and age-related cognitive decline. The quarterly MDS assessment completed 05/02/24 indicated no cognitive impairment. Interview on 07/31/24 at 8:46 A.M. with Resident #25 complained there were times when the nurses did not provide all his medications. Review of Resident #25's physician orders effective July 2024 indicated the following medications for administration: Amaryl (anti-diabetic) 4 mg twice daily for DM, atenolol (beta blocker) 50 mg twice daily for increased blood pressure, and omega-3 fatty acids (supplement) two capsules twice daily for joint and muscle pain. Review of Resident #25's medication administration record for July 2024 revealed all three medications, Amaryl, atenolol, and omega-3 fatty acids, were not administered on 07/05/24 at 5:00 P.M. and 07/22/24 at 5:00 P.M. as ordered. Interview on 08/06/24 at 2:26 P.M. with RDCS #310 verified Resident #25 did not receive Amaryl, atenolol, and omega-3 fatty acids as ordered on 07/05/24 and 07/22/24. Review of the facility policy, Administering Medications, revised December 2012, revealed medications must be administered in accordance with the orders. The individual administering the medication will record in the resident's medical record the date and time the medication was administered, the dosage, and the route of administration. 5. Review of the medical record for Resident #30 revealed an admitted [DATE]. Medical diagnoses included DM with diabetic nephropathy. The admission MDS assessment completed 06/20/24 indicated no cognitive impairment. Interview on 07/31/24 at 8:42 A.M. with Resident #30 complained there were times when the nurses did not provide all her medications. Review of Resident #30's physician orders effective July 2024 indicated the following medications for administration: insulin glargine 100 U (units) per ml (milliliter) give 40 U subcutaneously (SQ) daily at bedtime for DM, insulin lispro 100 U per ml SQ twice daily per sliding scale for DM, and oxybutynin (bladder relaxant) 5 mg three times daily for overactive bladder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #30's MAR for July 2024 revealed on 07/11/24 and 07/12/24 both insulin glargine and insulin lispro by sliding scale were not administered at bedtime, and on 07/21/24 oxybutynin was not administered in the evening as ordered. Interview on 08/06/24 at 2:30 P.M. with RDCS #310 verified Resident #30 did not receive insulin glargine and insulin lispro by sliding scale on 07/11/24 and 07/12/24, and oxybutynin on 07/21/24 as ordered. Review of the facility policy, Administering Medications, revised December 2012, revealed medications must be administered in accordance with the orders. The individual administering the medication will record in the resident's medical record the date and time the medication was administered, the dosage, and the route of administration. 6. Review of the medical record for Resident #63 revealed an admitted [DATE]. Medical diagnoses paraplegia, flaccid hemiplegia affecting left nondominant side, major depressive disorder, cardiomyopathy, essential primary hypertension, acquired absence of kidney, vascular dementia, and hyperlipidemia (HLD). The quarterly MDS assessment completed 07/10/24 indicated moderate cognitive impairment. Review of Resident #63's physician orders effective July 2024 indicated the following medications for administration: mirtazapine 7.5 mg daily at bedtime to stimulate appetite, rosuvastatin 20 mg daily at bedtime for HLD, metoprolol 37.5 mg twice daily for hypertension, and sodium bicarbonate 650 mg three times daily for minerals/electrolytes. Review of Resident #63's MAR for July 2024 revealed on 07/16/24 both mirtazapine and rosuvastatin were not administered at bedtime, and both metoprolol and sodium bicarbonate were not administered at 9:00 P. M. as ordered. Interview on 08/06/24 at 2:34 P.M. with RDCS #310 verified Resident #63 did not receive mirtazapine, rosuvastatin, metoprolol and sodium bicarbonate on 07/16/24 as ordered. Review of the facility policy, Administering Medications, revised December 2012, revealed medications must be administered in accordance with the orders. The individual administering the medication will record in the resident's medical record the date and time the medication was administered, the dosage, and the route of administration. This deficiency represents non-compliance investigated under Master Complaint Number OH00155849 and Complaint Numbers OH00155843 and OH00155844. This deficiency is an example of continued noncompliance to the surveys completed 06/05/24 and 07/02/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on medical record review, review of the facility's fall investigations and incident reports, staff interview, and review of the facility's fall policy, the facility failed to conduct a thorough investigation after falls occurred and failed to implement appropriate interventions after a fall. This affected three residents (#31, #40, and #66) of three residents reviewed for falls. The facility census was 71. Findings include: 1. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis affecting the right side, morbid obesity, muscle weakness, hypertension, and a history of falling. Review of the fall risk care plan, revised 09/22/23, revealed no new interventions were added since 09/22/23. Review of the fall risk assessment dated [DATE] revealed Resident #31 was high risk for falls. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/13/24, revealed Resident #31 was dependent on staff for activities of daily living (ADL). Review of the facility's fall investigation dated 07/23/24 revealed Resident #31 was found lying on the floor next to his bed. Resident #31 stated he fell on to the floor, and the immediate action taken was a skin assessment, and vital signs were checked. The investigation did not include any new interventions, and there were no statements or interviews from staff regarding the fall. The incident report included with the fall investigation revealed there was no fall risk assessment completed after the fall. 2. Review of the medical record for Resident #40 revealed an admitted [DATE] and readmitted [DATE]. Diagnoses included congestive heart failure, severe protein calorie malnutrition, atrial fibrillation, and adult failure to thrive. Review of the quarterly MDS assessment, dated 06/08/24, revealed Resident #40 was dependent on staff for ADL and had experienced one fall with no injury. Review of the progress note dated 07/14/24 at 6:53 P.M. revealed Resident #40 was found lying on her back on the floor and holding the left side of her neck. Resident #40 was unable to state how she ended up on the floor or how long she had been on the floor. Resident #40 complained of pain to the right side of her body and a headache, reporting a pain level of seven out of ten. Hospice was notified and instructed the facility not to send Resident #40 to the hospital. Review of the progress note dated 07/14/24 at 7:52 P.M. revealed hospice assessed Resident #40, called Resident #40's representative, and decided to send Resident #40 to the hospital for evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's fall investigation dated 07/14/24 indicated Resident #40 had an unwitnessed fall, was found on the floor, she was unable to state how she ended up on the floor or how long she had been there, she complained of pain and rated it seven out of ten, and the immediate action taken was Resident #40 was assisted back to bed with the assistance of four staff. The assessment indicated Resident #40 was not sent to the hospital. The investigation did not include any new interventions, and there were no statements or interviews from staff regarding the fall. The incident report included with the fall investigation revealed there was no fall risk assessment completed after the fall. Review of the fall risk care plan revealed a new intervention was not added until 07/22/24, eight days after the fall occurred. 3. Review of the medical record for Resident #66 revealed an admitted [DATE] with diagnoses including epilepsy, muscle weakness, personal history of transient ischemic attack (stroke), and a history of falling. Review of the quarterly MDS assessment, dated 05/21/24, revealed Resident #66 had severe cognitive impairment and required substantial or maximum assistance for ADL. Review of the facility's fall investigation dated 07/11/24 revealed Resident #66 rolled out of bed while an unnamed State tested Nurse Aide (STNA) was providing resident care. The investigation did not specify how Resident #66 rolled out of bed while care was being provided. The new intervention was to keep the bed low at all times while the resident was in bed, which did not address how to prevent future falls during resident care. The investigation indicated there were no witnesses of the fall despite the fall occurring while an STNA was providing care. There were no statements or interviews from staff regarding the fall. On 08/06/24 at 3:00 P.M., an interview with the acting Director of Nursing (DON), Regional Director of Clinical Services (RDCS) #310, verified thorough fall investigations were not completed, and no appropriate interventions were implemented timely for Residents #31, #40, and #66. They also verified there was no fall risk assessment completed after Residents #31 and #40's falls. Review of the facility's policy titled Falls and Fall Risk, Managing, dated December 2007, revealed facility staff would identify underlying causes of falls, identify appropriate interventions to reduce the risk of falls, monitor and document the resident's response to interventions, re-evaluate the situation and determine if interventions should be continued or changed, and try to minimize complications from falling. This deficiency represents non-compliance investigated under Complaint Number OH00155756 and is an example of continued noncompliance to the survey completed 05/09/24.

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	365355	A. Building B. Wing	08/08/2024

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Gardens of Mayfield Village	6757 Mayfield Rd Mayfield Heights, OH 44124

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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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, resident interview, and staff interview, the facility failed to ensure residents were seen by a general physician or nurse practitioner at least once every 60 days. This affected two residents (#16 and #51) of three residents reviewed for physician visits. The facility census was 71. Findings include: 1. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including legal blindness, anxiety disorder, and hypertension. Review of the practitioner's progress notes revealed the last general practitioner note was written on 02/29/24. There was no evidence of a general practitioner visit for Resident #16 after 02/29/24. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/29/24, revealed Resident #16 was cognitively intact. On 07/31/24 at 11:58 A.M., an interview with Resident #16 stated he had not seen the general practice physician or nurse practitioner in a very long time. 2. Review of the medical record for Resident #51 revealed an admitted [DATE] and readmitted [DATE]. Diagnoses included congestive heart failure, type two diabetes, morbid obesity, lymphedema, atrial fibrillation, anxiety disorder, major depressive disorder, peripheral vascular disease, and anemia. Review of the practitioner's progress notes revealed the last general practitioner note was written on 02/29/24. There was no evidence of a general practitioner visit for Resident #51 after 02/29/24. Review of the quarterly MDS assessment, dated 07/10/24, revealed Resident #51 was cognitively intact. On 08/06/24 at 3:40 P.M., an interview with the Acting Director of Nursing, Regional Director of Clinical Services #310, confirmed she was unable to find any physician's notes for visits after February 2024 for Residents #16 and #51. This deficiency represents non-compliance investigated under Complaint Number OH00155844.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review, facility policy review, review of manufacturer instructions, and review of the Food and Drug Administration (FDA) database of licensed biological products, the facility failed to be free of a five percent or greater medication error rate. This affected one resident (#2) of five residents (#1, #2, #22, #32 and #46) observed for medication administration. This had the potential to affect 15 residents (#1, #2, #9, #15, #21, #27, #29, #30, #31, #34, #35, #36, #38, #54 and #57) who received insulin, and all 60 residents (#1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #19, #21, #22, #24, #25, #26, #27, #28, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #42, #43, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #59, #60, #62, #63, #64, #66, #67, #68, #69, #70 and #71) who resided on the facility's second floor. The facility census was 71. Findings include: Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included dementia, diabetes mellitus (DM) type 2, and vitamin deficiency. Review of Resident #2's physician orders effective July 2024 included Humalog (insulin lispro) 100 U (units) per ml (milliliter) pen injector give 12 U SQ (subcutaneously) three times daily for DM, Humalog (insulin lispro) per sliding scale SQ three times daily with meals, Lantus (insulin glargine) 100 U per ml pen injector give 38 U SQ in the morning for DM, and vitamin B-12 5000 mcg (micrograms) sublingual daily in the morning for vitamin deficiency. Observation on 07/31/24 at 11:53 A.M. with Unit Manager (UM) #305 of medication administration for Resident #2 revealed a blood glucose test was completed to indicate an additional 4 U of insulin lispro was required per sliding scale with the routine 12 U as ordered. UM #305 prepared the insulin lispro pen injector by looking at the insulin pen's chamber, attached a disposable needle, and dialed 16 U for administration. UM #305 did not prime the needle to remove air after being attached. UM #305 then entered Resident #2's room and administered the 16 U of insulin lispro SQ into the left upper extremity. Interview at the time of the observation with UM #305 confirmed the insulin lispro pen injector was not primed after needle attachment and indicated it was not necessary because there was no visible air bubbles in the insulin pen's chamber. Interview on 07/31/24 at 12:16 P.M. with the acting Director of Nursing, Regional Director of Clinical Services (RDCS) #310 indicated priming of insulin pens after needle attachment was not required if the insulin pen's chamber was checked for air bubbles. Review of the medication information package insert for Humalog (lispro) insulin pen instructions revised July 2023 and retrieved from https://uspl.lilly.com/humalog/humalog.html#ppi0 revealed to prime the insulin pen before each injection. Priming meant to remove air from the needle and cartridge that collected during normal use and ensured it worked correctly. If priming was not completed, too much or too little insulin may be administered. Insulin pen priming included to turn the dose knob to 2 U, hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, and while holding the pen pointing upward push the dose knob until it stopped and zero was seen in the dose window. Insulin would be seen at the top of the needle. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/01/24 at 8:12 A.M. with Licensed Practical Nurse (LPN) #239 revealed one vitamin B-12 1000 mcg tablet was removed from an over-the-counter medication bottle and placed into a medication administration cup. LPN #239 then entered Resident #2's room and administered the vitamin B-12 orally. A blood glucose test was completed to indicate an additional 2 U of insulin lispro was required per sliding scale with the routine 12 U as ordered. LPN #239 prepared the insulin lispro pen injector and dialed 14 U for administration. LPN #239 was unable to find the Lantus (insulin glargine) pen injector in the medication cart then went to the medication room and obtained Basaglar (insulin glargine) from the starter medications. LPN #239 prepared the Basaglar insulin pen injector and dialed 38 U for administration. Then LPN #239 entered Resident #2's room and administered both the insulin lispro and Basaglar insulin SQ into the right lower abdomen area. Interview at the time of the observation with LPN #239 confirmed giving the Basaglar insulin in lieu of the ordered Lantus because they were both long acting insulins and were both insulin glargine. Interview on 08/01/24 at 9:47 A.M. with Pharmacist #311 verified Basaglar insulin and Lantus insulin were not approved by the FDA as being interchangeable because although having the similar ingredient of insulin glargine, the products were not identical. Pharmacist #311 explained for Basaglar insulin to be interchanged with Lantus insulin, the physician would need to provide an order of approval and confirm its dosage and frequency. Interview on 08/01/24 at 10:07 A.M. with UM #305 verified there were no physician standing orders or list of interchangeable medications approved by the physician. Interview on 08/01/24 at 11:14 A.M. with LPN #239 confirmed Resident #2 was administered vitamin B-12 at the incorrect dose of 1000 mcg in lieu of the ordered 5000 mcg and by the wrong route given orally in lieu of the ordered route of sublingually. Review of the FDA database of licensed biological products obtained on 08/01/24 at https://purplebooksearch.fda.gov/results?query=insulin%20glargine&title=Lantus revealed there was no biosimilar for Lantus (insulin glargine) and no approved interchangeable including Basaglar (insulin glargine). Observations from 07/31/24 to 08/01/24 of medication administration revealed 29 medications observed for five residents (#1, #2, #22, #32 and #46), administered by three nurses, UM #305 and LPNs #209 and #239, with three medication errors as referenced above. This resulted in a medication error rate of 9.67 percent. Review of facility policy, Administering Medications, revised December 2012 revealed medications must be administered in accordance with the orders. The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. This deficiency was an incidental finding identified during the complaint investigation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review, facility policy review, review of manufacturer instructions, and review of the Food and Drug Administration (FDA) database of licensed biological products, the facility failed to prevent a significant medication error for Resident #2 when insulin was inappropriately administered, and a medication was administered using the wrong dose and route. This affected one resident (#2) of five residents observed for medication administration. This had the potential to affect 15 residents (#1, #2, #9, #15, #21, #27, #29, #30, #31, #34, #35, #36, #38, #54 and #57) who received insulin, and all 60 residents (#1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #19, #21, #22, #24, #25, #26, #27, #28, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #42, #43, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #59, #60, #62, #63, #64, #66, #67, #68, #69, #70 and #71) who resided on the facility's second floor. The facility census was 71. Findings include: Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included dementia, diabetes mellitus (DM) type 2, and vitamin deficiency. Review of Resident #2's physician orders effective July 2024 included Humalog (insulin lispro) 100 U (units) per ml (milliliter) pen injector give 12 U SQ (subcutaneously) three times daily for DM, Humalog (insulin lispro) per sliding scale SQ three times daily with meals, Lantus (insulin glargine) 100 U per ml pen injector give 38 U SQ in the morning for DM, and vitamin B-12 5000 mcg (micrograms) sublingual daily in the morning for vitamin deficiency. Observation on 07/31/24 at 11:53 A.M. with Unit Manager (UM) #305 of medication administration for Resident #2 revealed a blood glucose test was completed to indicate an additional 4 U of insulin lispro was required per sliding scale with the routine 12 U as ordered. UM #305 prepared the insulin lispro pen injector by looking at the insulin pen's chamber, attached a disposable needle, and dialed 16 U for administration. UM #305 did not prime the needle to remove air after being attached. UM #305 then entered Resident #2's room and administered the 16 U of insulin lispro SQ into the left upper extremity. Interview at the time of the observation with UM #305 confirmed the insulin lispro pen injector was not primed after needle attachment and indicated it was not necessary because there were no visible air bubbles in the insulin pen's chamber. Interview on 07/31/24 at 12:16 P.M. with the Acting Director of Nursing, Regional Director of Clinical Services (RDCS) #310 indicated priming of insulin pens after needle attachment was not required if the insulin pen's chamber was checked for air bubbles. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medication information package insert for Humalog (lispro) insulin pen instructions revised July 2023 and retrieved from https://uspl.lilly.com/humalog/humalog.html#ppi0 revealed to prime the insulin pen before each injection. Priming meant to remove air from the needle and cartridge that collected during normal use and ensured it worked correctly. If priming was not completed, too much or too little insulin may be administered. Insulin pen priming included to turn the dose knob to 2 U, hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, and while holding the pen pointing upward push the dose knob until it stopped and zero was seen in the dose window. Insulin would be seen at the top of the needle. Observation on 08/01/24 at 8:12 A.M. with Licensed Practical Nurse (LPN) #239 revealed one vitamin B-12 1000 mcg tablet was removed from an over-the-counter medication bottle and placed into a medication administration cup. LPN #239 then entered Resident #2's room and administered the vitamin B-12 orally. A blood glucose test was completed to indicate an additional 2 U of insulin lispro was required per sliding scale with the routine 12 U as ordered. LPN #239 prepared the insulin lispro pen injector and dialed 14 U for administration. LPN #239 was unable to find the Lantus (insulin glargine) pen injector in the medication cart then went to the medication room and obtained Basaglar (insulin glargine) from the starter medications. LPN #239 prepared the Basaglar insulin pen injector and dialed 38 U for administration. Then LPN #239 entered Resident #2's room and administered both the insulin lispro and Basaglar insulin SQ into the right lower abdomen area. Interview at the time of the observation with LPN #239 confirmed giving the Basaglar insulin in lieu of the ordered Lantus because they were both long-acting insulins and were both insulin glargine. Interview on 08/01/24 at 9:47 A.M. with Pharmacist #311 verified Basaglar insulin and Lantus insulin were not approved by the FDA as being interchangeable because although having the similar ingredient of insulin glargine, the products were not identical. Pharmacist #311 explained for Basaglar insulin to be interchanged with Lantus insulin, the physician would need to provide an order of approval and confirm its dosage and frequency. Interview on 08/01/24 at 10:07 A.M. with UM #305 verified there were no physician standing orders or list of interchangeable medications approved by the physician. Interview on 08/01/24 at 11:14 A.M. with LPN #239 confirmed Resident #2 was administered vitamin B-12 at the incorrect dose of 1000 mcg in lieu of the ordered 5000 mcg and by the wrong route given orally in lieu of the ordered route of sublingually. Review of the FDA database of licensed biological products obtained on 08/01/24 at https://purplebooksearch.fda.gov/results?query=insulin%20glargine&title=Lantus revealed there was no biosimilar for Lantus (insulin glargine) and no approved interchangeable including Basaglar (insulin glargine). Review of the facility policy, Administering Medications, revised December 2012, revealed medications must be administered in accordance with the orders. The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. This deficiency is an incidental finding identified during the complaint investigation and is an example of continued noncompliance to the survey completed 06/05/24.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on interview and record review, the facility failed to accurately document medication administration for Resident #18, enteral feedings for Resident #69, and make available for review controlled medication disposition records for Residents #18, #22 and #43. This affected four residents (#18, #22, #43 and #69) out of 19 medical records reviewed and had the potential to affect all 71 residents residing in the facility. There were 16 residents who received controlled medications (#1, #7, #12, #18, #22, #28, #38, #40, #41, #43, #44, #51, #56, #58, #60 and #61) and four residents who received enteral feedings (#13, #22, #41 and #69). Findings include: 1. Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included dementia, insomnia, anxiety disorder and adult failure to thrive. The Quarterly MDS (Minimum Data Set) assessment completed 05/11/24 indicated Resident #18 was rarely or never understood. Review of Resident #18's physician orders effective July 2024 revealed the following controlled medication orders: tramadol 50 mg (milligrams) every six hours as needed for pain dated 01/30/23, and ativan 0.5 mg every eight hours as needed for anxiety dated 06/06/24. Resident #18's controlled medication disposition records for tramadol from June 2024 to July 2024 were requested for review and not provided. Interview on 08/06/24 at 8:15 A.M. with Regional Director of Operations (RDO) #309 confirmed there were no controlled medication disposition records for Resident #18's tramadol from June 2024 to July 2024 available for review. Review of Resident #18's controlled medication disposition records for ativan from June 2024 to July 2024 revealed on 06/23/24 at 6:00 A.M. a dose of ativan was removed for medication administration. Resident #18's medication administration record (MAR) for June 2024 had no documentation the ativan was administered on 06/23/24 at 6:00 A.M. Interview on 08/06/24 at 2:41 P.M. with the acting Director of Nursing, Regional Director of Clinical Services #310 verified there was no documentation on Resident #18's MAR of the ativan dose being administered on 06/23/24 at 6:00 A.M. 2. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included congestive heart failure, chronic obstructive pulmonary disease and idiopathic gout. The Significant Change MDS assessment completed 07/03/24 indicated Resident #43 had moderate cognitive impairment. Review of Resident #22's physician orders effective July 2024 revealed the following controlled medication orders: morphine sulfate 20 mg per ml (milliliter) give 0.5 ml every two hours as needed for pain dated 07/03/24, and ativan 0.5 mg every four hours as needed for anxiety dated 07/03/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #22's controlled medication disposition records for morphine sulfate and ativan for July 2024 were requested for review and not provided. Interview on 08/06/24 at 8:15 A.M. with RDO #309 confirmed there were no controlled medication disposition records for Resident #22's morphine sulfate and ativan for July 2024 available for review. 3. Review of the medical record for Resident #43 revealed an admitted [DATE]. Diagnoses included multiple sclerosis and a history of a healed traumatic fracture. The Quarterly MDS assessment completed 07/17/24 indicated Resident #43 had no cognitive impairment. Review of Resident #43's physician orders effective July 2024 revealed a controlled medication order for tramadol 50 mg every six hours as needed for pain dated 01/10/22. Resident #43's controlled medication disposition records for tramadol from June 2024 to July 2024 were requested for review and not provided. Interview on 08/06/24 at 8:15 A.M. with RDO #309 confirmed there were no controlled medication disposition records for Resident #43's tramadol from June 2024 to July 2024 available for review. 44808 4. Review of the medical record for Resident #69 revealed an admitted [DATE] with diagnoses including amyotrophic lateral sclerosis (ALS), moderate protein calorie malnutrition, type two diabetes mellitus, a history of transient ischemic attack (stroke), and dysphagia. Review of the physician's orders for July 2024 identified orders for enteral feed one time daily at 6:00 A.M. (discontinued on 07/31/24) and Isosource 1.5 at 50 milliliters (ml) per hour until 1200 ml had infused (discontinued on 07/31/24). A new order was added on 07/31/24 to hold the tube feed if resident consumed less than 50% of meal tray. Review of the medication administration record for July 2024 for Resident #69 revealed the following: - On 07/02/24, enteral feed one time daily at 6:00 A.M. was marked as refused and continuous enteral feeding of Isosource 1.5 at 50 milliliters (ml) per hour was marked as administered. - On 07/06/24, enteral feed one time daily at 6:00 A.M. was marked as refused and continuous enteral feeding of Isosource 1.5 at 50 milliliters (ml) per hour was marked as administered. - On 07/09/24, enteral feed one time daily at 6:00 A.M. was marked as refused and continuous enteral feeding of Isosource 1.5 at 50 milliliters (ml) per hour was marked as administered. - On 07/14/24, continuous enteral feeding of Isosource 1.5 at 50 milliliters (ml) per hour was marked as refused and enteral feed one time daily at 6:00 A.M. was marked as administered. - On 07/23/24, enteral feed one time daily at 6:00 A.M. was marked as refused and continuous enteral feeding of Isosource 1.5 at 50 milliliters (ml) per hour was marked as administered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 07/28/24, continuous enteral feeding of Isosource 1.5 at 50 milliliters (ml) per hour was marked as refused and enteral feed one time daily at 6:00 A.M. was marked as administered. - On 07/29/24, continuous enteral feeding of Isosource 1.5 at 50 milliliters (ml) per hour was marked as refused and enteral feed one time daily at 6:00 A.M. was marked as administered. On 08/05/24 at 10:18 A.M., an interview with Unit Manager Licensed Practical Nurse (LPN) #305 confirmed the order to hold the tube feed was incorrect because it should have been greater than 50% of the meal tray and not less than 50% of the meal tray. On 08/06/24 at 3:00 P.M., an interview with the acting Director of Nursing, Regional Director of Clinical Services #310, verified the documentation for administration of enteral feedings was inaccurate for Resident #69. This deficiency was an incidental finding identified during the complaint investigation and is an example of continued noncompliance to the complaint survey completed 04/04/24.