

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE 4360 Brecksville Rd Richfield, OH 44286	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation of camera footage, interview, record review and review of facility policy the facility failed to ensure Resident #21 was treated with dignity and respect. This affected one resident (Resident #21) out of three residents reviewed for dignity. The facility census was 40.</p> <p>Findings include:</p> <p>Review of Resident #21's medical record revealed an admitted [DATE] and diagnoses included Parkinson's Disease without dyskinesia, without mention of fluctuations, chronic obstructive pulmonary disease, follicular lymphoma, unspecified, lymph nodes of head, face, and neck, dementia, severe, with other behavioral disturbance and schizophrenia.</p> <p>Review of Resident #21's care plan initiated 06/11/18 included Resident #21 had bowel and bladder incontinence, was fixated on bladder urge, and was followed by urology. Resident #21 had a history of neurogenic bladder and took diuretics as needed. Resident #21 sometimes voiced the need for toileting after she was incontinent. Staff placed Resident #21 on toilet dated 01/13/23 with some spontaneous continent episodes noted. Resident #21, dated 03/15/23, was status post left nephrectomy. Interventions included to monitor for incontinence on rounds and as needed. Wash, rinse and dry perineum; change clothing as needed after incontinence episodes: staff might place Resident #21 on the toilet on routine rounds using a stand-up lift, Resident #21 was experiencing occasional spontaneous continent episodes when placed on the toilet.</p> <p>Review of Resident #21's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #21 had severe cognitive impairment. Resident #21 was dependent on staff for toileting.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Resident #21's camera footage dated 05/26/24 at 5:33 A.M. revealed Resident #21 was lying on her bed naked, and did not have clothing, bed sheets, or blankets covering her. Resident #21 was wearing only black socks on both her feet. Resident #21's mattress did not have the fitted sheet covering the edges of the mattress and the bare mattress could be seen. State tested Nursing Assistant (STNA) #243 walked to the bed with a towel in her hands, placed the towel on the bare mattress, picked up the towel, and used it to wipe Resident #21's skin in the area of her perineum, then placed the soiled towel back on the bare mattress. STNA #243 turned Resident #21 on her right side, tucked the fitted sheet underneath her, picked up the towel off of the bare mattress, and wiped Resident #21's left hip and buttock with the towel. After wiping Resident #21's hip and buttocks STNA #243 placed the soiled towel back on the bare mattress. STNA #243 turned Resident #21 on her left side, pulled the fitted sheet from under her, did not change her gloves, and with her soiled gloved left hand picked up Resident #21's stuffed animal off the bed and moved it towards the bottom of the bed.</p> <p>Observation of Resident #21's camera footage dated 05/26/24 at 5:35 A.M. revealed STNA #243 with disposable gloves on her hands picked up Resident #21's stuffed animals, pillows and a plaid blanket off the bed and placed them on a chair. STNA #243 picked up the soiled sheets and linens off of Resident #21's bed and threw them on the floor, but left the towel she used to wipe Resident #21's perineum and buttocks on the bare mattress. Observation revealed Resident #21 was lying on a bare mattress with no clothes on and STNA #243 picked up the soiled towel and wiped Resident #21's perineal area with the towel before throwing it on top of the other sheets and linens she had previously thrown on the floor.</p> <p>Observation of Resident #21's camera footage dated 05/26/24 at 5:37 A.M. revealed Resident #21 was lying naked on the bare mattress. STNA #243 walked to the side of Resident #21's bed carrying a towel. STNA #243 had Resident #21 roll onto her right side and wiped her buttocks and upper thighs with the towel and threw the soiled towel on the pile of soiled linens on the floor when she was finished and removed her gloves. While Resident #21 was naked and lying on the bare mattress STNA #243 had Resident #21 roll back onto her back, raised the head of the bed to about 60 degrees, Resident #21's arms were observed crossed and covering her breasts and the rest of her body was uncovered and exposed.</p> <p>Observation of Resident #21's camera footage dated 05/26/24 at 5:40 A.M. revealed Resident #21 was sitting on the side of the bed, naked, and the mattress was bare and did not have any sheets, or linens on it. STNA #243 was observed assisting Resident #21 to put her shirt on, and once the shirt was on STNA #243 pulled the shirt over Resident #21's breasts, but left her abdomen exposed. STNA #243 then assisted Resident #21 to put her pants on, and once the pants were on STNA #243 pulled Resident #21's pants up to a little above her knees, leaving her perineum exposed. STNA #243 told Resident #21 to lay back, and Resident #21 laid back on the bed from the sitting position until her head was resting against the wall, her head was tilted to the right in an awkward manner, and her legs were dangling off the side of the bed. Resident #21's bare abdomen and perineum could be seen while she was lying back. STNA #243 picked up the soiled sheets and linens off the floor, left Resident #21 in the laid back position, legs dangling off the side of the bed, her abdomen and perineum exposed and left the room. It did not appear STNA #243 closed the door to Resident #21's room when she left the room, but it was unable to be determined for sure if the door was open or closed from the camera footage.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of camera footage dated 05/26/24 at 5:43 A.M. through 5:45 A.M. revealed Resident #21 was lying back on the bare mattress with her abdomen and perineum exposed, her head resting against the wall at an awkward angle and her legs dangling off the edge of the bed. Resident #21's call light was observed laying on the floor and not in Resident #21's reach.</p> <p>Observation of camera footage on 05/26/24 at 5:48 A.M. revealed Resident #21 was lying back on the bare mattress with her abdomen and perineum exposed, her head resting against the wall at an awkward angle and her legs dangling off the edge of the bed. Resident #21's call light was observed laying on the floor and not in Resident #21's reach. STNA #243 returned to Resident #21's room with a second unidentified STNA, did not appear to close the door to the room, the two STNA's assisted Resident #21 off the bare mattress to use the sit-to-stand mechanical lift and was helped into the bathroom.</p> <p>Review of Self-Reported Incident (SRI) number 248114 dated 05/30/24 and the allegation type was physical abuse and neglect. On 05/30/24 at approximately 9:00 A.M. the Administrator was notified of the incident via email sent by Resident #21's sister who was also her Guardian. Interview with Resident #21's Responsible Party (Guardian) revealed concerns with the amount of time it took STNA #243 to obtain a second person to operate the standing lift to assist Resident #21 with toileting. Resident #21's Responsible Party (Guardian) expressed concerns with Resident #21's positioning while waiting on STNA #243 to return. Resident #21's Responsible Party stated Resident #21 did not express signs of harm or distress. STNA #255 was interviewed as a witness because she provided assistance to STNA #243 on 05/26/24 when Resident #21 was assisted to use the sit-to-stand mechanical lift for transportation into the bathroom. STNA #255 confirmed she observed how Resident #21 was left in the room, but Resident #21 did not express signs of distress at the time. Interview on 05/30/24 with STNA #243 revealed she was caring for Resident #21 on the morning of 05/26/24, she was changing her clothing and left the room to get another aide to assist. STNA #243 stated it took longer than usual to find another STNA. STNA #243 stated the bedding was not on the bed when she was performing care because the bedding was soiled. STNA #243 stated she was not fully aware how she left Resident #21 and how long it took her to find another STNA to assist her.</p> <p>Review of a Witness Statement dated 05/30/24 revealed on 05/26/24 STNA #243 was caring for Resident #21, and I was in the process of changing her clothes to get another aide. In the process of that STNA #243 changed Resident #21's bed because of soil.</p> <p>Review of STNA #243's Disciplinary Action Form dated 05/30/24 for an incident on 05/26/24 included STNA #243 was given a second written warning for customer service and violation of company policy (peri care). A previous warning was given on 04/25/23 for unacceptable work performance related to operating a lift without assistance. STNA #243 was suspended on 05/30/24 for an allegation of neglect on 05/27/24 pending investigation.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/01/24 at 4:21 P.M. of Family Member (FM) #262 revealed on 05/29/24 she reviewed Resident #21's camera footage dated 05/26/24 around 5:30 A.M. FM #262 stated Resident #21 was soiled, and STNA #243 rolled Resident #21 over, removed her sheets, then rolled her onto her back onto the soiled mattress which did not have any bed linens on it. FM #262 stated then STNA #243 sat Resident #21 on the edge of the bed while she was naked, assisted to put her shirt on her, but did not pull it down over her breasts, and assisted Resident #21 with her pants but only pulled the pants up to her thighs. STNA #243 told Resident #21 to lay back, Resident #21 laid back, but her head and neck were at an awkward angle against the wall. STNA #243 walked out of the room leaving Resident #21's breasts and vaginal area exposed, with the door open. STNA #243 was gone for about six or seven minutes and returned to the room with a sit-to-stand mechanical lift and a second aide to assist her. FM #262 stated it was very upsetting for her to view the camera footage and see the way Resident #21 was treated.</p> <p>Interview on 07/02/24 at 9:03 A.M. of Ombudsman #263 revealed Resident #21 was left unattended and unclothed while she was in bed. Resident #21 was told to lay back, she did so and the aide left her half in the bed when she left the room. The facility initiated an SRI regarding the situation.</p> <p>Interview on 07/02/24 at 4:55 P.M. of the Administrator revealed she had concerns on 05/26/24 with STNA #243 and how resident care and peri-care was completed. The Administrator stated she was given camera footage for 05/26/24 from Family Member (FM) #262 who was also Resident #21's Guardian, and the footage revealed STNA #243 came to Resident #21's room, the bed was not made, and Resident #21 was lying across the bed half-dressed. The Administrator stated STNA #243 left Resident #21 in an odd position and went to find help with the stand-lift. The Administrator indicated it took about six minutes for STNA #243 to find another aide and come back to Resident #21's room, and this happened on 05/26/24 at around 5:40 A.M. The Administrator stated she opened a self-reported incident under physical abuse and neglect, and STNA #243 was suspended pending an investigation. The Administrator indicated STNA #243 said she was in the process of changing Resident #21, the bed needed changed because it was soiled, STNA #243 took the bedding off, needed help to put Resident #21 on the lift, and it took longer than expected to return to Resident #21's room. The Administrator stated STNA #243 was educated on proper peri-care, and the best policy was to have everything you need for the care including supplies and a second aide when you enter the room to provide the care. The Administrator confirmed Resident #21 was left half-naked on her bed when STNA #243 left the room to find a second staff member to assist with the sit-to-stand mechanical lift. The Administrator stated STNA #243 should have stayed with Resident #21, activated her call light, and waited for someone to answer the call light and have them assist with the sit-to-stand. The Administrator confirmed Resident #21's shirt was kind of lifted up, and her pants were half-way up. The Administrator stated STNA #243 said she closed Resident #21's door to her room, but it could not be determined from the video. The Administrator stated she was not sure if she still had the video, but she would check. The Administrator stated STNA #243 made the wrong decision, did not follow the peri-care policy, but she did not think it was neglect. The Administrator indicated the video was kind of alarming, Resident #21 did not seem like she was in distress, but she should have been covered and made more comfortable. STNA #243 still worked at the facility.</p> <p>Review of the facility policy titled Resident Rights dated 05/01/22 revealed the facility would make every effort to assist each resident in exercising his or her rights to assure the resident was always treated with kindness, respect and dignity.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154599.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, interview, record review, facility self-reported incident (SRI) review, and review of facility policy the facility failed to ensure Resident #21's Injury of Unknown Origin was reported to the State Agency. This affected one resident (Resident #21) out of three residents reviewed for abuse. The facility census was 40.</p> <p>Findings include:</p> <p>Review of Resident #21's medical record revealed an admitted [DATE] and diagnoses included Parkinson's Disease without dyskinesia, without mention of fluctuations, chronic obstructive pulmonary disease, follicular lymphoma, unspecified, lymph nodes of head, face, and neck, dementia, severe, with other behavioral disturbance and schizophrenia.</p> <p>Review of Resident #21's care plan dated 10/14/19 included Resident #21 had an ADL (Activity of Daily Living) self-care performance deficit related to severe cognitive impairment secondary to dementia, physical limitations, chronic and debilitating health conditions. Resident #21 was nearly dependent for all ADL's. Resident #21 would be clean, dry, appropriately groomed and dressed daily through the review date. Interventions included transfers required extensive assistance of two staff; Resident #21 required mechanical stand-up lift for transfers; Resident #21 did not stand without lift and did not walk; for toileting Resident #21 required two staff and stand-up lift for transfers on and off the toilet.</p> <p>Review of Resident #21's care plan did not reveal a care plan for a DVT (deep vein thrombosis) or anticoagulant medication or interventions related to anticoagulant medication.</p> <p>Review of Resident #21's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #21 had severe cognitive impairment. Resident #21 was dependent on staff for toileting.</p> <p>Review of Resident #21's Treatment Administration Record (TAR) dated 06/23/24 revealed weekly skin check by licensed nurse every day shift every Sunday was documented it was completed.</p> <p>Review of Resident #21's assessments and progress notes from 06/16/24 through 06/30/24 did not reveal a Weekly Head-To-Toe Assessment was completed. Further review did not reveal documentation Resident #21 had bruises on her arms.</p> <p>Review of Resident #21's camera footage dated 06/28/24 from 9:36 P.M. through 9:39 P.M. revealed STNA #238 pushed Resident #21 into her room in what appeared to be a shower chair. STNA #238 assisted Resident #21 out of the shower chair and onto a sit-to-stand mechanical lift without another staff member helping him. STNA #238 transferred Resident #21 to her bed without assistance, helped her sit on the edge of the bed, remove the sling and help Resident #21 lay down in the bed. While STNA #238 was assisting Resident #21 two bruises on her right lower arm near the elbow could be seen, and one long bruise on her left lower arm could be seen.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #21's progress notes dated 06/30/24 at 11:48 A.M. included STNA #252 notified the nurse he noticed some bruising on Resident #21. Upon assessment four areas of bruising were discovered on Resident #21's arms. Resident #21 did not know where she got the bruises from, and did not complain of pain and vital signs were WNL (within normal limits). A complete head-to-toe assessment was completed and the bruises on Resident #21's arms were measured for reference and monitoring. Educated STNA's about the importance of being careful when toileting Resident #21 due to smaller bathroom. The DON, NP, Physician and POA were notified. Physician #269 was not concerned because Resident #21 took blood thinners.</p> <p>Review of Resident #21's Weekly Head-To-Toe Assessment-Licensed Nurses dated 06/30/24 included Resident #21 had a bruise to her left upper arm and the length was measured at two inches, Resident #21 had a bruise on her left lower arm and measurements were length of four and a half inches and a width of one and a half inches. Resident #21 had a bruise to the right lower arm with a length of one inch, and another bruise on her right lower arm which measured a length of one and a half inches. Resident #21 had purple bruising on both arms. Resident #21 did not know the origin of the bruising. The DON, NP and POA were notified.</p> <p>Review of the facility incident log dated 06/30/24 at 7:24 P.M. revealed Resident #21 had an injury of unknown cause.</p> <p>Review of Resident #21's IDT (interdisciplinary team) Post Incident Investigation Summary dated 06/30/24 at 7:24 P.M. included staff notified nurse of bruises to Resident #21's bilateral arms. Upon interviewing staff, Resident #21's arms had been witnessed bumping against door frame when on the mechanical lift and during transfer into the bathroom. Resident #21 recently moved to a new room with a smaller bathroom, narrow doorway. Resident #21 utilized a mechanical lift for transfers. Resident #21 was on anticoagulant therapy (Eliquis), was prone to bruising and Resident #21's physician was notified and there were no changes in orders. Staff was educated on monitoring arms and body positioning while using mechanical lifts to avoid injury. Resident #21's Guardian was contacted and arrangements were made to move Resident #21 back to her previous room due to bathroom was large enough to accommodate the mechanical lift and had enough doorway clearance to transfer Resident #21 safely.</p> <p>Review of Resident #21's IDT (interdisciplinary team) Post Incident Investigation Summary dated 06/30/24 at 7:24 P.M. revealed two Witness Statements. Witness Statement dated 06/30/24 of LPN #226 included an STNA notified her he noticed bruising on Resident #21's arms, she assessed Resident #21 and found four areas of bruising, two on each arm. The Director of Nursing and Assistant Director of Nursing were notified and risk management and a skin assessment were completed. Physician #269 was contacted, was not concerned due to Resident #21 received Eliquis. Resident #21's Guardian was notified and she mentioned she saw bruising the previous night while she observed Resident #21's bedtime routine, but had not mentioned it to anyone at the facility.</p> <p>Further review of Resident #21's IDT (interdisciplinary team) Post Incident Investigation Summary dated 06/30/24 at 7:24 P.M. revealed Witness Statement dated 06/30/24 of STNA #253 included every time STNA #253 helped operated the stand lift to assist Resident #21 into the bathroom it was a very tight squeeze trying to get Resident #21 in the bathroom without bumping her arms. Last time she worked with Resident #21 the aides had a hard time shielding her arms from the doorway.</p> <p>Review of the facility SRI history revealed the facility did not submit a SRI for Resident #21's injury of unknown origin on 06/30/24.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 07/02/24 at 9:01 A.M. of State tested Nursing Assistant (STNA) #252 and #254 revealed they used the sit-to-stand mechanical lift to transport Resident #21 from the bathroom to her bed. The sit-to-stand mechanical lift with Resident #21 fit through the doorway of the bathroom without hitting or rubbing Resident #21's arms on the door frame.</p> <p>Interview on 07/02/24 at 4:30 P.M. of STNA #252 revealed on 06/30/24 he noticed Resident #21's bruises on her arms when she rolled her sleeves up. STNA #252 stated he immediately told Licensed Practical Nurse (LPN) #226 about the bruises. STNA #252 indicated he was not assigned to care for Resident #21 on 06/29/24 and 06/30/24 was the first time he saw the bruises.</p> <p>Interview on 07/02/24 at 4:31 P.M. of STNA #254 revealed she did not work on 06/29/24 or 06/30/24, but on 06/28/24 she cared for Resident #21 and she did not have bruises on her arms.</p> <p>Observation on 07/02/24 at 4:35 P.M. of Resident #21 with STNA #254 revealed Resident #21 had a large purple bruise on her lower left arm about six inches long and three inches wide. Resident #21 was unable to roll her sleeve up to show the bruise on her upper left arm. Further observation revealed two purple-green bruises on Resident #21's right forearm by the elbow and they were circular and one to two inches in diameter.</p> <p>Interview on 07/02/24 at 4:41 P.M. of LPN #226 revealed STNA #252 saw bruises on Resident #21's arms after she pulled her sleeves up and he told her about them. LPN #226 stated she completed a full body assessment and lifted Resident #21's sleeves up all the way so she could see her entire arm. Resident #21 had two purple colored bruises on her right lower arm, one bruise on her left upper arm about two inches and circular, and a long purple bruise on her left lower arm. LPN #226 stated she did not work on 06/29/24 and we had no idea how the bruises happened. LPN #226 indicated she called Physician #269, he was not concerned because Resident #21 was taking Eliquis (anticoagulant) and was prone to bruises. LPN #226 stated she notified the DON and Family Member/Guardian #262 about the bruise and Family Member/Guardian #262 stated she saw Resident #21's bruises through the camera on Saturday night. LPN #226 stated the DON made sure she documented the bruises appropriately and there were no additional bruises. LPN #226 stated Resident #21 bruised easily, but the past bruises were small. LPN #226 indicated Resident #21 had a habit of banging her arm against the wall when she was done in the bathroom, but Resident #21 did not know how the bruises happened, and she did not complain of pain.</p> <p>Interview on 07/02/24 at 4:55 P.M. of the Administrator revealed Resident #21 was on Eliquis (anticoagulant), Resident #21 was recently moved to the room she was currently in and the room had a smaller doorway to the bathroom, and was hard to get into using a sit-to-stand mechanical lift. The Administrator indicated Resident #21 was not conscious of her arms, and had a few night where she was banging on the wall. The Administrator stated they were trying to figure out how Resident #21 got the bruises, the aides said it was a tight squeeze going through the door to the bathroom, but did not say Resident #21's arms hit or rubbed the door frame. The Administrator stated Physician #269 was notified of Resident #21's bruises. The Administrator stated a facility incident report was opened, but a Self-Reported Incident (SRI) was not reported to the State Agency.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/03/24 at 8:55 A.M. of Family Member/Guardian #262 revealed Resident #21 was taken to the bathroom using a sit-to-stand mechanical lift. Family Member/Guardian #262 stated the room Resident #21 was now in was set up different than her other room, getting into the bathroom was real tight, and she heard banging while the aides transported Resident #21 to the bathroom using the sit-to-stand mechanical lift. Family Member/Guardian #262 stated she saw Resident #21's arm bruises on the camera footage before it was reported by the staff.</p> <p>Interview on 07/03/24 at 9:49 A.M. of Chief Operating Officer (COO) #270 revealed the facility knew immediately what Resident #21's bruises were caused by and started education immediately. COO #270 stated the STNA's (State tested Nursing Assistant's) saw Resident #21's arms hit the door frame, and that caused the bruises.</p> <p>Interview on 07/03/24 at 11:59 A.M. of Licensed Practical Nurse (LPN) #228 revealed she worked on 06/29/24 and was assigned to the nursing unit Resident #21 resided on and she did not see bruises on Resident #21's arms, and no aides reported bruises on Resident #21's arms. LPN #228 stated when she administered Resident #21's medications she talked to her, asked how she was feeling, and she did not mention she had pain or bruises on her arms.</p> <p>Interview on 07/03/24 at 1:17 P.M. of State tested Nursing Assistant (STNA) #253 revealed she was assigned to care for Resident #21 on 06/29/24 and she did not notice bruises on her arms. STNA #253 indicated Resident #21 used a sit-to-stand lift for transportation into the bathroom, the aides had to block Resident #21's arms from hitting the door frame, and remind her to tuck her elbows in. STNA #253 stated she did not know how Resident #21 got the bruises on her arms, and she did not hurt her arms when STNA #253 transferred her using the sit-to-stand lift.</p> <p>Interview on 07/08/24 at 6:50 A.M. of STNA #238 revealed he was very familiar with Resident #21. STNA #238 stated Resident #21 received her showers in the evening around 8:20 P.M., he gave her a shower last week and did not remember seeing bruises on her arms. STNA #238 stated the sit-to-stand mechanical lift was used to transfer Resident #21 to the toilet, her recliner and her bed. STNA #238 stated two people were needed to use the sit-to-stand mechanical lift, but confirmed sometimes he could not find anyone to help him and transferred Resident #21 by himself. STNA #238 stated Resident #21 did not hit her arms on the door frame, or anything else when he transported her to the bathroom.</p> <p>Interview on 07/08/24 at 7:01 A.M. of STNA #242 revealed she did not remember seeing bruises on Resident #21's arms. STNA #242 stated Resident #21 banged the wall in the middle of the night when she wanted something, and sometimes threw her pillow across the room. STNA #242 stated if she saw bruises on Resident #21's arms she would have documented it and told the nurse. STNA #242 indicated Resident #21 used the sit-to-stand mechanical lift for transfers, there was always two staff members who assisted her with transfers, and Resident #21 tucked her arms in when she went through the doorway of the bathroom. STNA #242 stated the doorway to the bathroom was smaller than the room Resident #21 used to reside in, but Resident #21 could be transported through the doorway without brushing her arms, and the sit-to-stand could be turned in the bathroom without Resident #21 hitting her arms. STNA #242 stated it was not a squeeze, Resident #21 would be told to tuck her arms and she did. STNA #242 stated no aide would push her into the bathroom and let her arms hit the door frame, and if she did hit her arms on the door frame it would probably cause a skin tear because Resident #21 had fragile skin. STNA #242 stated she never saw Resident #21 hit her arms on the doorframe.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/08/24 at 7:18 A.M. of STNA #254 revealed Resident #21 could be transported through the bathroom door, there was plenty of room on either side of her arms, and the aides did not have to worry about Resident #21 hitting her arms on the door frame. STNA #254 stated she did not see Resident #21 hit her arms on the door frame.</p> <p>Interview on 07/08/24 at 11:13 A.M. of STNA #243 revealed she did not assist Resident #21 with her care except when she was a second person when the sit-to-stand mechanical lift was used to transfer her. STNA #243 stated when she assisted with the lift she did not see Resident #21's arms hit the doorframe, or hear her call out because her arms hit the doorframe when she was transported to the bathroom.</p> <p>Review of the facility policy titled Abuse Prevention dated 08/20/21 included it was the facility policy to investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property, including Injuries of Unknown Source, in accordance with this policy. Facility staff should immediately report all such allegations to the Administrator and to the State Department of Health. An injury was classified as an Injury of Unknown Source when the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident AND the injury was suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154653.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, interview, record review and review of facility policy the facility failed to ensure a thorough investigation of Resident #21's Injury of Unknown Origin on her bilateral arms. This affected one resident (Resident #21) out of three residents reviewed for abuse. The facility census was 40.</p> <p>Findings include:</p> <p>Review of Resident #21's medical record revealed an admitted [DATE] and diagnoses included Parkinson's Disease without dyskinesia, without mention of fluctuations, chronic obstructive pulmonary disease, follicular lymphoma, unspecified, lymph nodes of head, face, and neck, dementia, severe, with other behavioral disturbance and schizophrenia.</p> <p>Review of Resident #21's care plan dated 10/14/19 included Resident #21 had an ADL (Activity of Daily Living) self-care performance deficit related to severe cognitive impairment secondary to dementia, physical limitations, chronic and debilitating health conditions. Resident #21 was nearly dependent for all ADL's. Resident #21 would be clean, dry, appropriately groomed and dressed daily through the review date. Interventions included transfers required extensive assistance of two staff; Resident #21 required mechanical stand-up lift for transfers; Resident #21 did not stand without lift and did not walk; for toileting Resident #21 required two staff and stand-up lift for transfers on and off the toilet.</p> <p>Review of Resident #21's care plan did not reveal a care plan for a DVT (deep vein thrombosis) or anticoagulant medication or interventions related to anticoagulant medication.</p> <p>Review of Resident #21's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #21 had severe cognitive impairment. Resident #21 was dependent on staff for toileting.</p> <p>Review of Resident #21's Treatment Administration Record (TAR) dated 06/23/24 revealed weekly skin check by licensed nurse every day shift every Sunday was documented it was completed.</p> <p>Review of Resident #21's assessments and progress notes from 06/16/24 through 06/30/24 did not reveal a Weekly Head-To-Toe Assessment was completed. Further review did not reveal documentation Resident #21 had bruises on her arms.</p> <p>Review of Resident #21's camera footage dated 06/28/24 from 9:36 P.M. through 9:39 P.M. revealed STNA #238 pushed Resident #21 into her room in what appeared to be a shower chair. STNA #238 assisted Resident #21 out of the shower chair and onto a sit-to-stand mechanical lift without another staff member helping him. STNA #238 transferred Resident #21 to her bed without assistance, helped her sit on the edge of the bed, remove the sling and help Resident #21 lay down in the bed. While STNA #238 was assisting Resident #21 two bruises on her right lower arm near the elbow could be seen, and one long bruise on her left lower arm could be seen.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #21's progress notes dated 06/30/24 at 11:48 A.M. included STNA #252 notified the nurse he noticed some bruising on Resident #21. Upon assessment four areas of bruising were discovered on Resident #21's arms. Resident #21 did not know where she got the bruises from, and did not complain of pain and vital signs were WNL (within normal limits). A complete head-to-toe assessment was completed and the bruises on Resident #21's arms were measured for reference and monitoring. Educated STNA's about the importance of being careful when toileting Resident #21 due to smaller bathroom. The DON, NP, Physician and POA were notified. Physician #269 was not concerned because Resident #21 took blood thinners.</p> <p>Review of Resident #21's Weekly Head-To-Toe Assessment-Licensed Nurses dated 06/30/24 included Resident #21 had a bruise to her left upper arm and the length was measured at two inches, Resident #21 had a bruise on her left lower arm and measurements were length of four and a half inches and a width of one and a half inches. Resident #21 had a bruise to the right lower arm with a length of one inch, and another bruise on her right lower arm which measured a length of one and a half inches. Resident #21 had purple bruising on both arms. Resident #21 did not know the origin of the bruising. The DON, NP and POA were notified.</p> <p>Review of the facility incident log dated 06/30/24 at 7:24 P.M. revealed Resident #21 had an injury of unknown cause.</p> <p>Review of Resident #21's IDT (interdisciplinary team) Post Incident Investigation Summary dated 06/30/24 at 7:24 P.M. included staff notified nurse of bruises to Resident #21's bilateral arms. Upon interviewing staff, Resident #21's arms had been witnessed bumping against door frame when on the mechanical lift and during transfer into the bathroom. Resident #21 recently moved to a new room with a smaller bathroom, narrow doorway. Resident #21 utilized a mechanical lift for transfers. Resident #21 was on anticoagulant therapy (Eliquis), was prone to bruising and Resident #21's physician was notified and there were no changes in orders. Staff was educated on monitoring arms and body positioning while using mechanical lifts to avoid injury. Resident #21's Guardian was contacted and arrangements were made to move Resident #21 back to her previous room due to bathroom was large enough to accommodate the mechanical lift and had enough doorway clearance to transfer Resident #21 safely.</p> <p>Review of Resident #21's IDT (interdisciplinary team) Post Incident Investigation Summary dated 06/30/24 at 7:24 P.M. revealed two Witness Statements. Witness Statement dated 06/30/24 of LPN #226 included an STNA notified her he noticed bruising on Resident #21's arms, she assessed Resident #21 and found four areas of bruising, two on each arm. The Director of Nursing and Assistant Director of Nursing were notified and risk management and a skin assessment were completed. Physician #269 was contacted, was not concerned due to Resident #21 received Eliquis. Resident #21's Guardian was notified and she mentioned she saw bruising the previous night while she observed Resident #21's bedtime routine, but had not mentioned it to anyone at the facility.</p> <p>Further review of Resident #21's IDT (interdisciplinary team) Post Incident Investigation Summary dated 06/30/24 at 7:24 P.M. revealed Witness Statement dated 06/30/24 of STNA #253 included every time STNA #253 helped operated the stand lift to assist Resident #21 into the bathroom it was a very tight squeeze trying to get Resident #21 in the bathroom without bumping her arms. Last time she worked with Resident #21 the aides had a hard time shielding her arms from the doorway.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 07/02/24 at 9:01 A.M. of State tested Nursing Assistant (STNA) #252 and #254 revealed they used the sit-to-stand mechanical lift to transport Resident #21 from the bathroom to her bed. The sit-to-stand mechanical lift with Resident #21 fit through the doorway of the bathroom without hitting or rubbing Resident #21's arms on the door frame.</p> <p>Interview on 07/02/24 at 4:30 P.M. of STNA #252 revealed on 06/30/24 he noticed Resident #21's bruises on her arms when she rolled her sleeves up. STNA #252 stated he immediately told Licensed Practical Nurse (LPN) #226 about the bruises. STNA #252 indicated he was not assigned to care for Resident #21 on 06/29/24 and 06/30/24 was the first time he saw the bruises.</p> <p>Interview on 07/02/24 at 4:31 P.M. of STNA #254 revealed she did not work on 06/29/24 or 06/30/24, but on 06/28/24 she cared for Resident #21 and she did not have bruises on her arms.</p> <p>Observation on 07/02/24 at 4:35 P.M. of Resident #21 with STNA #254 revealed Resident #21 had a large purple bruise on her lower left arm about six inches long and three inches wide. Resident #21 was unable to roll her sleeve up to show the bruise on her upper left arm. Further observation revealed two purple-green bruises on Resident #21's right forearm by the elbow and they were circular and one to two inches in diameter.</p> <p>Interview on 07/02/24 at 4:41 P.M. of LPN #226 revealed STNA #252 saw bruises on Resident #21's arms after she pulled her sleeves up and he told her about them. LPN #226 stated she completed a full body assessment and lifted Resident #21's sleeves up all the way so she could see her entire arm. Resident #21 had two purple colored bruises on her right lower arm, one bruise on her left upper arm about two inches and circular, and a long purple bruise on her left lower arm. LPN #226 stated she did not work on 06/9/24 and we had no idea how the bruises happened. LPN #226 indicated she called Physician #269, he was not concerned because Resident #21 was taking Eliquis (anticoagulant) and was prone to bruises. LPN #226 stated she notified the DON and Family Member/Guardian #262 about the bruise and Family Member/Guardian #262 stated she saw Resident #21's bruises through the camera on Saturday night. LPN #226 stated the DON made sure she documented the bruises appropriately and there were no additional bruises. LPN #226 stated Resident #21 bruised easily, but the past bruises were small. LPN #226 indicated Resident #21 had a habit of banging her arm against the wall when she was done in the bathroom, but Resident #21 did not know how the bruises happened, and she did not complain of pain.</p> <p>Interview on 07/02/24 at 4:55 P.M. of the Administrator revealed Resident #21 was on Eliquis (anticoagulant), Resident #21 was recently moved to the room she was currently in and the room had a smaller doorway to the bathroom, and was hard to get into using a sit-to-stand mechanical lift. The Administrator indicated Resident #21 was not conscious of her arms, and had a few night where she was banging on the wall. The Administrator stated they were trying to figure out how Resident #21 got the bruises, the aides said it was a tight squeeze going through the door to the bathroom, but did not say Resident #21's arms hit or rubbed the door frame. The Administrator stated Physician #269 was notified of Resident #21's bruises. The Administrator stated a facility incident report was opened, but a Self-Reported Incident (SRI) was not reported to the State Agency.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/03/24 at 8:55 A.M. of Family Member/Guardian #262 revealed Resident #21 was taken to the bathroom using a sit-to-stand mechanical lift. Family Member/Guardian #262 stated the room Resident #21 was now in was set up different than her other room, getting into the bathroom was real tight, and she heard banging while the aides transported Resident #21 to the bathroom using the sit-to-stand mechanical lift. Family Member/Guardian #262 stated she saw Resident #21's arm bruises on the camera footage before it was reported by the staff.</p> <p>Interview on 07/03/24 at 9:49 A.M. of Chief Operating Officer (COO) #270 revealed the facility knew immediately what Resident #21's bruises were caused by and started education immediately. COO #270 stated the STNA's (State tested Nursing Assistant's) saw Resident #21's arms hit the door frame, and that caused the bruises.</p> <p>Interview on 07/03/24 at 11:59 A.M. of Licensed Practical Nurse (LPN) #228 revealed she worked on 06/29/24 and was assigned to the nursing unit Resident #21 resided on and she did not see bruises on Resident #21's arms, and no aides reported bruises on Resident #21's arms. LPN #228 stated when she administered Resident #21's medications she talked to her, asked how she was feeling, and she did not mention she had pain or bruises on her arms.</p> <p>Interview on 07/03/24 at 1:17 P.M. of State tested Nursing Assistant (STNA) #253 revealed she was assigned to care for Resident #21 on 06/29/24 and she did not notice bruises on her arms. STNA #253 indicated Resident #21 used a sit-to-stand lift for transportation into the bathroom, the aides had to block Resident #21's arms from hitting the door frame, and remind her to tuck her elbows in. STNA #253 stated she did not know how Resident #21 got the bruises on her arms, and she did not hurt her arms when STNA #253 transferred her using the sit-to-stand lift.</p> <p>Interview on 07/08/24 at 6:50 A.M. of STNA #238 revealed he was very familiar with Resident #21. STNA #238 stated Resident #21 received her showers in the evening around 8:20 P.M., he gave her a shower last week and did not remember seeing bruises on her arms. STNA #238 stated the sit-to-stand mechanical lift was used to transfer Resident #21 to the toilet, her recliner and her bed. STNA #238 stated two people were needed to use the sit-to-stand mechanical lift, but confirmed sometimes he could not find anyone to help him and transferred Resident #21 by himself. STNA #238 stated Resident #21 did not hit her arms on the door frame, or anything else when he transported her to the bathroom.</p> <p>Interview on 07/08/24 at 7:01 A.M. of STNA #242 revealed she did not remember seeing bruises on Resident #21's arms. STNA #242 stated Resident #21 banged the wall in the middle of the night when she wanted something, and sometimes threw her pillow across the room. STNA #242 stated if she saw bruises on Resident #21's arms she would have documented it and told the nurse. STNA #242 indicated Resident #21 used the sit-to-stand mechanical lift for transfers, there was always two staff members who assisted her with transfers, and Resident #21 tucked her arms in when she went through the doorway of the bathroom. STNA #242 stated the doorway to the bathroom was smaller than the room Resident #21 used to reside in, but Resident #21 could be transported through the doorway without brushing her arms, and the sit-to-stand could be turned in the bathroom without Resident #21 hitting her arms. STNA #242 stated it was not a squeeze, Resident #21 would be told to tuck her arms and she did. STNA #242 stated no aide would push her into the bathroom and let her arms hit the door frame, and if she did hit her arms on the door frame it would probably cause a skin tear because Resident #21 had fragile skin. STNA #242 stated she never saw Resident #21 hit her arms on the doorframe.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/08/24 at 7:18 A.M. of STNA #254 revealed Resident #21 could be transported through the bathroom door, there was plenty of room on either side of her arms, and the aides did not have to worry about Resident #21 hitting her arms on the door frame. STNA #254 stated she did not see Resident #21 hit her arms on the door frame.</p> <p>Interview on 07/08/24 at 11:13 A.M. of STNA #243 revealed she did not assist Resident #21 with her care except when she was a second person when the sit-to-stand mechanical lift was used to transfer her. STNA #243 stated when she assisted with the lift she did not see Resident #21's arms hit the doorframe, or hear her call out because her arms hit the doorframe when she was transported to the bathroom.</p> <p>Interview on 07/08/24 at 11:08 A.M. of the Director of Nursing (DON) confirmed Resident #21 did not have an anticoagulant care plan and Resident #21's Weekly Head-To-Toe Assessment due on 06/23/24 was not completed.</p> <p>Review of the facility policy titled Abuse Prevention dated 08/20/21 included it was the facility policy to investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property, including Injuries of Unknown Source, in accordance with this policy. Facility staff should immediately report all such allegations to the Administrator and to the State Department of Health. An injury was classified as an Injury of Unknown Source when the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident AND the injury was suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154653.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, interview, record review and review of facility policy the facility failed to ensure Resident #18 and #21's incontinence care was completed timely, and followed appropriate standards of care. This affected two residents (Resident's #18 and #21) out of three residents reviewed for incontinence care. The facility census was 40.</p> <p>Findings include:</p> <p>1. Review of Resident #18's medical record revealed an admitted [DATE] and diagnoses included unspecified dementia, unspecified severity with agitation, psychotic disorder with delusions due to known physiological condition, and Alzheimer's Disease.</p> <p>Review of Resident #18's care plan dated 11/03/22 included Resident #18 had an ADL (activity of daily living) self-care performance deficit related to Alzheimer's Disease, dementia. Resident #18 would maintain his current level of function in ADL's through the review date of 06/03/24. Interventions included Resident #18 required assistance with incontinence care when incontinent. Resident #18 had episodes of bladder incontinence and was at risk for bowel incontinence related to cognitive impairment. Resident #18 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included to check on routine rounds and as needed for incontinence. Wash, rinse and dry perineum and change clothing as needed after incontinence episodes; monitor for nonverbal indicators of toileting needs (restlessness, pacing, pulling, tugging at perineal or buttock areas) and if toileting needs suspected attempt to take Resident #18 to the restroom.</p> <p>Review of Resident #18's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18 had severe cognitive impairment. Resident #18 required partial to moderate assistance with toileting and was always incontinent of urine and bowel.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 07/03/24 at 8:38 A.M. of Resident #18 revealed he was walking in the hall of the secured memory care unit and was wearing only an incontinence brief. Further observation revealed the incontinence brief was extremely full and the weight of the brief from being soaked with urine was causing it to hang down toward the floor. State tested Nursing Assistant (STNA) #239 walked quickly out of the common area and immediately assisted Resident #18 into the shower room. STNA #239 stated she arrived to work at 7:00 A.M. , Resident #18 was sleeping, she did not wake him up for breakfast, and she had not checked him for incontinence. STNA #239 stated as soon as she arrived she had to start getting residents ready for the breakfast meal which usually arrived around 7:30 A.M. and she also had to assist with passing the meal trays. STNA #239 stated she just finished picking up the last breakfast tray after the residents finished eating when she saw Resident #18 walking in the hall without any clothes on except an incontinence brief. Observation revealed Resident #18's incontinence brief was so saturated with urine and a moderate amount of feces that urine was dripping out of the side of the brief onto the floor. STNA #239 removed Resident #18's incontinence brief, it was soaked and as she held the brief urine drained out of the brief onto the floor. STNA #239 had to soak the urine up with a towel. STNA #239 stated the night shift aides should have changed Resident #18's incontinence brief and there was no way they changed him before they left. STNA #239 stated Resident #18's incontinence brief would not have been in that condition if he was changed on last rounds around 5:00 A.M., and obviously his brief had been that way for awhile. STNA #239 indicated Resident #18 was always sweet and did not refuse care. Resident #18 did not have redness or open areas on his buttocks.</p> <p>Review of the facility policy titled Resident ADL care dated 07/01/23 included the facility believed in supporting and encouraging the autonomy and independence of all residents in activities of daily living to the fullest extent possible given the limitations of their debility and disease. Residents would be expected to maintain reasonable standards of hygiene and grooming during their stay at the facility. When autonomy and independence were no longer possible or feasible, the facility resident care staff would provide the necessary support in all ADL functioning. The procedure was to maintain infection control, maintain personal hygiene and grooming standards acceptable to communal living, maintain maximal functioning in ADL's and to promote the highest quality of life. Assistance and, or supervision would be provided as necessary with toileting and feeding.</p> <p>2. Review of Resident #21's medical record revealed an admitted [DATE] and diagnoses included Parkinson's Disease without dyskinesia, without mention of fluctuations, chronic obstructive pulmonary disease, follicular lymphoma, unspecified, lymph nodes of head, face, and neck, dementia, severe, with other behavioral disturbance and schizophrenia.</p> <p>Review of Resident #21's care plan initiated 06/11/18 included Resident #21 had bowel and bladder incontinence, was fixated on bladder urge, and was followed by urology. Resident #21 had a history of neurogenic bladder and took diuretics as needed. Resident #21 sometimes voiced the need for toileting after she was incontinent. Staff placed Resident #21 on toilet dated 01/13/23 with some spontaneous continent episodes noted. Resident #21, dated 03/15/23, was status post left nephrectomy. Interventions included to monitor for incontinence on rounds and as needed. Wash, rinse and dry perineum; change clothing as needed after incontinence episodes: staff might place Resident #21 on the toilet on routine rounds using a stand-up lift, Resident #21 was experiencing occasional spontaneous continent episodes when placed on the toilet.</p> <p>Review of Resident #21's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #21 had severe cognitive impairment. Resident #21 was dependent on staff for toileting.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Resident #21's camera footage dated 05/26/24 at 5:33 A.M. revealed Resident #21 was lying on her bed naked, and did not have clothing, bed sheets, or blankets covering her. Resident #21 was wearing only black socks on both her feet. Resident #21's mattress did not have the fitted sheet covering the edges of the mattress and the bare mattress could be seen. State tested Nursing Assistant (STNA) #243 walked to the bed with a towel in her hands, placed the towel on the bare mattress, picked up the towel, and used it to wipe Resident #21's skin in the area of her perineum, then placed the soiled towel back on the bare mattress. STNA #243 turned Resident #21 on her right side, tucked the fitted sheet underneath her, picked up the towel off of the bare mattress, and wiped Resident #21's left hip and buttock with the towel. After wiping Resident #21's hip and buttocks STNA #243 placed the soiled towel back on the bare mattress. STNA #243 turned Resident #21 on her left side, pulled the fitted sheet from under her, did not change her gloves, and with her soiled gloved left hand picked up Resident #21's stuffed animal off the bed and moved it towards the bottom of the bed.</p> <p>Observation of Resident #21's camera footage dated 05/26/24 at 5:35 A.M. revealed STNA #243 with disposable gloves on her hands picked up Resident #21's stuffed animals, pillows and a plaid blanket off the bed and placed them on a chair. STNA #243 picked up the soiled sheets and linens off of Resident #21's bed and threw them on the floor, but left the towel she used to wipe Resident #21's perineum and buttocks on the bare mattress. Observation revealed Resident #21 was lying on a bare mattress with no clothes on and STNA #243 picked up the soiled towel and wiped Resident #21's perineal area with the towel before throwing it on top of the other sheets and linens she had previously thrown on the floor.</p> <p>Observation of Resident #21's camera footage dated 05/26/24 at 5:37 A.M. revealed Resident #21 was lying naked on the bare mattress. STNA #243 walked to the side of Resident #21's bed carrying a towel. STNA #243 had Resident #21 roll onto her right side and wiped her buttocks and upper thighs with the towel and threw the soiled towel on the pile of soiled linens on the floor when she was finished and removed her gloves. While Resident #21 was naked and lying on the bare mattress STNA #243 had Resident #21 roll back onto her back, raised the head of the bed to about 60 degrees, Resident #21's arms were observed crossed and covering her breasts and the rest of her body was uncovered and exposed.</p> <p>Observation of Resident #21's camera footage dated 05/26/24 at 5:40 A.M. revealed Resident #21 was sitting on the side of the bed, naked, and the mattress was bare and did not have any sheets, or linens on it. STNA #243 was observed assisting Resident #21 to put her shirt on, and once the shirt was on STNA #243 pulled the shirt over Resident #21's breasts, but left her abdomen exposed. STNA #243 then assisted Resident #21 to put her pants on, and once the pants were on STNA #243 pulled Resident #21's pants up to a little above her knees, leaving her perineum exposed. STNA #243 told Resident #21 to lay back, and Resident #21 laid back on the bed from the sitting position until her head was resting against the wall, her head was tilted to the right in an awkward manner, and her legs were dangling off the side of the bed. Resident #21's bare abdomen and perineum could be seen while she was lying back. STNA #243 picked up the soiled sheets and linens off the floor, left Resident #21 in the laid back position, legs dangling off the side of the bed, her abdomen and perineum exposed and left the room. It did not appear STNA #243 closed the door to Resident #21's room when she left the room, but it was unable to be determined for sure if the door was open or closed from the camera footage.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of camera footage dated 05/26/24 at 5:43 A.M. through 5:45 A.M. of Resident #21's camera footage revealed she was lying back on the bare mattress with her abdomen and perineum exposed, her head resting against the wall at an awkward angle and her legs dangling off the edge of the bed. Resident #21's call light was observed laying on the floor and not in Resident #21's reach.</p> <p>Observation of camera footage dated 05/26/24 at 5:48 A.M. of Resident #21's camera footage revealed she was lying back on the bare mattress with her abdomen and perineum exposed, her head resting against the wall at an awkward angle and her legs dangling off the edge of the bed. Resident #21's call light was observed laying on the floor and not in Resident #21's reach. STNA #243 returned to Resident #21's room with a second unidentified STNA, did not appear to close the door to the room, the two STNA's assisted Resident #21 off the bare mattress to use the sit-to-stand mechanical lift and was helped into the bathroom.</p> <p>Interview on 07/01/24 at 4:21 P.M. of Family Member (FM) #262 revealed on 05/26/24 around 5:30 A.M. she viewed Resident #21's camera footage. FM #262 stated Resident #21 was soiled (her incontinence brief was soiled), and STNA #243 rolled Resident #21 over, removed her sheets, then rolled her onto her back onto the soiled mattress which did not have any bed linens on it. FM #262 stated then STNA #243 sat Resident #21 on the edge of the bed while she was naked, assisted to put her shirt on her, but did not pull it down over her breasts, and assisted Resident #21 with her pants but only pulled the pants up to her thighs. STNA #243 told Resident #21 to lay back, Resident #21 laid back, but her head and neck were at an awkward angle against the wall. STNA #243 walked out of the room leaving Resident #21's breasts and vaginal area exposed, with the door open. STNA #243 was gone for about six or seven minutes and returned to the room with a sit-to-stand mechanical lift and a second aide to assist her. FM #262 stated it was very upsetting for her to view the camera footage and see the way Resident #21 was treated.</p> <p>Interview on 07/02/24 at 9:03 A.M. of Ombudsman #263 revealed Resident #21 was left unattended and unclothed while she was in bed. Resident #21 was told to lay back, she did so and the aide left her half in the bed when she left the room. The facility initiated a self-reported incident regarding the situation.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/02/24 at 4:55 P.M. of the Administrator revealed she had concerns on 05/26/24 with STNA #243 and how resident care and peri-care was completed. The Administrator stated she was given camera footage for 05/26/24 from Family Member (FM) #262 and the footage revealed STNA #243 came to Resident #21's room, the bed was not made, and Resident #21 was lying across the bed half-dressed. The Administrator stated STNA #243 left Resident #21 in an odd position and went to find help with the stand-lift. The Administrator indicated it took about six minutes for STNA #243 to find another aide and come back to Resident #21's room, and this happened on 05/26/24 at around 5:40 A.M. The Administrator stated she opened a self-reported incident under physical abuse and neglect, and STNA #243 was suspended pending an investigation. The Administrator indicated STNA #243 said she was in the process of changing Resident #21, the bed needed changed because it was soiled, STNA #243 took the bedding off, needed help to put Resident #21 on the lift, and it took longer than expected to return to Resident #21's room. The Administrator stated STNA #243 was educated on proper peri-care, and the best policy was to have everything you need for the care including supplies and a second aide when you enter the room to provide the care. The Administrator confirmed Resident #21 was left half-naked on her bed when STNA #243 left the room to find a second staff member to assist with the sit-to-stand mechanical lift. The Administrator stated STNA #243 should have stayed with Resident #21, activated her call light, and waited for someone to answer the call light and have them assist with the sit-to-stand. The Administrator confirmed Resident #21's shirt was kind of lifted up, and her pants were half-way up. The Administrator stated STNA #243 said she closed Resident #21's door to her room, but it could not be determined from the video. The Administrator stated she was not sure if she still had the video, but she would check. The Administrator stated STNA #243 made the wrong decision, did not follow the peri-care policy, but she did not think it was neglect. The Administrator indicated the video was kind of alarming, Resident #21 did not seem like she was in distress, but she should have been covered and made more comfortable. STNA #243 still worked at the facility.</p> <p>Observation on 07/03/24 at 9:46 A.M. of STNA #252 revealed he was assisting Resident #21 off the toilet. Observation of Resident #21's buttocks revealed they were dark purple and red in color. Resident #21's buttocks blanched when her skin was pressed. STNA #252 stated this was how Resident #21's buttocks typically looked.</p> <p>Review of the facility policy titled Peri Care dated 05/01/22 included the policy was to provide cleanliness and comfort to the resident, prevent infections and skin irritation and observe the resident's skin condition. The procedure included to gather necessary equipment for the procedure, provide privacy, place equipment on clean surface within easy reach, provide hand hygiene and apply gloves. Assist with position of the resident into a safe, comfortable position, avoid overexposing the resident's body. Use a clean area of cloth for each area cleansed. Use multiple cloths, if necessary, to maintain infection control practices. Place the call light within easy reach of the resident.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154599.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, interview, record review the facility failed to complete Resident #20's Speech Therapy evaluation was ordered to ensure safe eating and adequate nutrition. This affected one resident (Resident #20) out of three residents reviewed for nutrition. The facility census was 40.</p> <p>Findings include:</p> <p>Review of Resident #20's medical record revealed an admitted [DATE] and diagnoses included Alzheimer's Disease, dementia without behavioral, psychotic disturbance, mood disturbance and anxiety, atherosclerotic heart disease, and major depressive disorder. Resident #20 resided in the secured unit for dementia.</p> <p>Review of Resident #20's care plan revised 01/02/22 included Resident #20 had an ADL (Activity of Daily Living) self-care performance deficit related to Alzheimer's Disease, dementia and other diagnoses. Resident #20 would maintain her current level of function with ADL's and mobility through the review date. Interventions include Resident #20 was independent, supervised, cued with eating. Resident #20 had a nutritional problem or potential nutritional problem related to disease process and had a history of difficulty chewing and dysphagia. Resident #20 would maintain weight plus or minus five percent. Interventions included to monitor, document, report as needed signs and symptoms of dysphagia such as coughing, choking, several attempts at swallowing, appearing concerned during meals.</p> <p>Review of Resident #20's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had severe cognitive impairment. Resident #20 required supervision or touching assistance with eating.</p> <p>Review of Resident #20's physician progress notes dated 04/17/24 and written by Certified Nurse Practitioner (CNP) #264 included nursing noticed Resident #20 coughing during meals and after medications were given. Resident #20's current diet was regular, puree texture, thin liquids. Resident #20 ate her meals very slowly. Resident #20 stated she had a hard time swallowing and had to cough a lot. Resident #20 had a history of swallowing difficulties and had a modified barium swallow and esophagram completed in 2022. Referral would be made to speech therapy for evaluation and treatment.</p> <p>Review of Resident #20's physician orders dated 04/17/24 revealed Speech Therapy screen and, or evaluation or treatment.</p> <p>Review of Resident #20's medical record including physician progress notes, progress notes and assessments from 04/17/24 through 07/02/24 did not reveal evidence Resident #20's Speech Therapy screen or evaluation was completed.</p> <p>Observation on 07/02/24 at 8:31 A.M. of Resident #20 with Licensed Practical Nurse (LPN) #232 revealed Resident #20 was sitting on the side of her bed with her breakfast meal (pureed food) in front of her on a bedside table, and she was eating her breakfast. There was no staff in the room while Resident #20 was eating. Observation revealed while LPN #232 was administering Resident #20's medications, Resident #20 started coughing and clearing her throat repeatedly. LPN #232 stated Resident #20 often did that when she had medications administered and while she was eating.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/03/24 at 11:08 A.M. of the Administrator, Director of Nursing and Director of Rehab (DOR) #271 revealed the facility changed systems on 05/01/24 and DOR #271 did not have access to the previous system. DOR #271 stated Resident #20 did not have a Speech Therapy evaluation or treatment from 05/01/24 through 07/02/24, but she would check with the corporate office to see if they could find if Resident #20 had a Speech Therapy and Evaluation from 04/17/24 through 05/01/24.</p> <p>Interview on 07/08/24 at 8:09 A.M. of State tested Nursing Assistant's (STNA)'s #239 and #240 revealed Resident #20 did not like to eat in the dining room and preferred to eat her meals in her room. STNA #239 stated the aides helped set her food up and Resident #20 let them know if she needed help. STNA's 239 and #240 stated Resident #20 did have something with her throat and they had seen her cough and kind of gag, while eating, but mostly she did it with her medications.</p> <p>Interview on 07/08/24 at 10:10 A.M. of Chief Operating Officer (COO) #270 revealed Resident #20 did not have a Speech Therapy Evaluation or treatment completed from 04/17/24 through 07/02/24.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154653.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on interview, record review and review of the facility policy the facility failed to ensure Resident #21 was free from significant medication error and medications were administered per physician orders. This affected one resident (Resident #21) out of three residents reviewed for medications administered per physician orders. The facility census was 40.</p> <p>Findings include:</p> <p>Review of Resident #21's medical record revealed an admitted [DATE] and diagnoses included Parkinson's Disease without dyskinesia, without mention of fluctuations, chronic obstructive pulmonary disease, follicular lymphoma, unspecified, lymph nodes of head, face, and neck, dementia, severe, with other behavioral disturbance and schizophrenia.</p> <p>Review of Resident #21's care plan initiated 06/11/18 included Resident #21 received psychoactive medications (antipsychotic, anxiolytic) to treat mental illness. Resident #21 would receive the lowest possible dosage of the prescribed psychotropic drugs to ensure maximum functional ability both mentally and physically through the next review date. Interventions included to administer medication as prescribed by the physician and implement behavior interventions; notify physician of side effects, decline in function or worsening of symptoms.</p> <p>Review of Resident #21's physician orders dated 03/01/23 revealed CBC (complete blood count) with diff now and every four weeks while on clozaril, every shift starting on the second and ending on the second every month.</p> <p>Review of Resident #21's physician orders dated 01/26/24 revealed Clozaril (antipsychotic medication) oral tablet 100 mg, give 100 mg by mouth two times a day related to Parkinson's Disease.</p> <p>Review of Resident #21's physician orders dated 01/26/24 revealed Clozaril oral tablet 50 mg, give one tablet by mouth at bedtime related to Parkinson's Disease, administer with 100 mg tablet to equal 150 mg.</p> <p>Review of Resident #21's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #21 had severe cognitive impairment. Resident #21 was taking an antipsychotic medication.</p> <p>Review of Resident #21's Treatment Administration Record (TAR) dated 06/02/24 revealed CBC with diff now and every four weeks while on Clozaril was documented as completed.</p> <p>Review of Resident #21's TAR dated 06/11/24 revealed CBC, Thyroid panel, BMP (base metabolic panel), B12, lipid panel, full thyroid panel with T3, TFree T4, ANC (measures neutrophils in the blood), and Clozaril levels every three weeks was documented as completed.</p> <p>Review of Resident #21's progress notes dated 06/18/24 at 10:40 P.M. revealed pharmacy phoned for update on Clozapine (Clozaril). The Tech (pharmacy tech) stated medication would not be delivered because labs were not sent. Labs from 05/06/24 were printed and faxed to the pharmacy. Tech unsure if new prescription was needed and would update the facility.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #21's progress notes dated 06/19/24 at 11:56 A.M. revealed Clozaril oral tablet 100 mg, give 100 mg two times a day related to Parkinson's Disease was on order.</p> <p>Review of Resident #21's physician progress notes dated 06/19/24 written by Certified Nurse Practitioner (CNP) #264 included Resident #21 took Clozaril (antipsychotic) twice a day. Nursing stated pharmacy needed a new prescription. Nursing notified Resident #21's psychiatrist. Required labs were ordered for tomorrow morning. Labs would be faxed to the Psychiatrist's office once they resulted for prescription.</p> <p>Review of Resident #21's physician orders dated 06/19/24 revealed CBCWD (complete blood count with differential), thyroid panel, BMP, B12, lipid panel, T3, FT4, ANC, clozaril level was ordered for 06/20/24.</p> <p>Review of Resident #21's Medication Administration Record (MAR) revealed Clozaril oral tablet 50 mg (Clozapine), give one tablet by mouth at bedtime related to Parkinson's Disease, administer with 100 mg tablet to equal 150 mg was documented it was administered on 06/19/24 at 9:00 P.M. (although it was not available to administer). Further review on 06/20/24 at 9:00 P.M. revealed documentation Clozaril was not administered.</p> <p>Review of Resident #21's MAR revealed Clozaril oral tablet 100 mg (Clozapine), give 100 mg by mouth two times a day related to Parkinson's Disease revealed on 06/19/24 at 9:00 A.M. Clozaril was not administered. Further review on 06/19/24 at 9:00 P.M. revealed documentation Clozaril was administered (although was not available to administer). On 06/20/24 at 9:00 A.M. Clozaril was documented it was administered (although was not available to administer) and on 06/20/24 at 9:00 P.M. Clozaril was documented it was not administered.</p> <p>Review of Resident #21's progress notes dated 06/20/24 at 8:56 P.M. revealed Clozaril oral tablet 100 mg, give 100 mg by mouth two times a day related to Parkinson's Disease, labs faxed to pharmacy.</p> <p>Review of Resident #21's progress notes dated 06/20/24 at 8:57 P.M. revealed Clozaril oral tablet 50 mg, give one tablet by mouth at bedtime related to Parkinson's Disease, administer with 100 mg tablet to equal 150 mg. Labs faxed to pharmacy.</p> <p>Review of Resident #21's progress notes dated 06/20/24 at 11:24 P.M. revealed STAT (immediately) labs faxed to pharmacy. Clozaril would be in tonight's tote.</p> <p>In addition to Resident #21 not receiving Clozaril as ordered, review of Resident #21's physician orders and MAR dated 06/18/24, 06/23/24, 06/24/24, 06/25/24, 06/26/24 and 06/28/24 did not reveal evidence Resident #21's Carbidopa-Levodopa oral tablet 25-100 mg, give one tablet by mouth in the evening related to Parkinson's Disease was administered at 6:00 P.M. as ordered.</p> <p>Review of Resident #21's MAR dated 06/18/24, 06/23/24, 06/24/24, 06/25/24, 06/26/24 and 06/28/24 did not reveal evidence Resident #21 also did not receive Ipratropium-Albuterol Solution 0.5-2.5 mg per three milliliters, one dose inhale orally two times a day for increased SOB (shortness of breath) and secretions as ordered at 6:00 P.M.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/01/24 at 4:21 P.M. of Family Member (FM)/Guardian #262 revealed the facility ran out of Resident #21's antipsychotic medication, Clozaril, and she was not sure how long Resident #21 did not receive the Clozaril.</p> <p>Interview on 07/02/24 at 3:49 P.M. of the Director of Nursing (DON) revealed Resident #21 had labwork drawn every three weeks, which was set up on Emed lab to be done every three weeks, and once the results come back Clozaril levels were sent to the pharmacy and to Resident #21's Psychiatry Nurse Practitioner (PNP) #265. PNP #265 would update the profile and that gave the pharmacy the ability to refill Resident #21's Clozaril. The DON stated Resident #21's labwork was placed in Emed to queue every three weeks, but it could only be queued for so many months, and after the specified time the lab would fall off the queue and need to be reordered. The DON stated the labwork to be drawn in 05/2024 was missed because the lab fell off, she was not aware the lab fell off, and Resident #21's labwork was not sent to PNP #265 or the pharmacy. The DON indicated when the facility realized Resident #21 was out of Clozaril, it was looked into and they found out Resident #21's labs had not been completed and her Clozaril could not be sent. The DON stated Resident #21's labs were drawn, including a neutrophil level which was included in the CBC. The DON indicated when Resident #21's CBC results came back, including the neutrophil level, pharmacy was able to drop ship her Clozaril. The DON stated Resident #21 missed four doses of Clozaril, two on 06/19/24 and two on 06/20/24. The DON stated Resident #21 had tremors when her Clozaril was not available to be administered and she was administered as needed medications for pain and anxiety to help with her symptoms.</p> <p>Interview on 07/03/24 at 1:11 P.M. of the DON confirmed Resident #21 did not receive Clozaril on 06/19/24 or 06/20/24. The DON stated the nurse's signed off the Clozaril was given on 06/19/24 at 9:00 P.M. and on 06/20/24 at 9:00 A.M. but we did not have it to give and the documentation on Resident #21's MAR was incorrect.</p> <p>Interview on 07/08/24 at 11:32 A.M. of the DON confirmed Resident #21's TAR had documentation her bloodwork was drawn on 06/02/24 and 06/11/24 but it was not drawn on those dates. The DON stated the nurse was supposed to double check the draw list for residents receiving labwork, and the requisitions with each residents TAR to make sure all residents who were supposed to have labwork collected had their labs completed. Resident #21 was not on the draw list and did not have a requisition, and the nurse did not double check her TAR to make sure she had her blood drawn. The nurse signed off Resident #21's TAR but did not check the draw list. The DON confirmed Resident #21's TAR had days where there was no documentation her Sinemet (Carbidopa-Levodopa) was given, but it was given and the nurse forgot to sign off she gave it because it was close to shift change. The DON stated Resident #21 got breathing treatments twice a day, and confirmed there were days when she did not receive her evening treatment. The DON stated the nurses were educated on the importance of Resident #21's breathing treatments and now she received the treatments as ordered.</p> <p>Review of the facility policy titled Medication Administration dated 05/01/22 included medications should be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. 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. As required or indicated for a medication, the individual administering the medication would record in the resident's medical record, including the date and time the medication was administered, the dosage, the route of administration and the signature and title of the person administering the drug.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE 4360 Brecksville Rd Richfield, OH 44286	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00154599.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
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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>42013</p> <p>Based on observation, interview, record review and review of the facility policy the facility failed to ensure a safe environment, and equipment was functioning and available for preparation of resident food. This had the potential to affect all residents served food from the kitchen. The facility census was 40.</p> <p>Findings include:</p> <p>Observation on 07/02/24 at 11:00 A.M. of the facility kitchen revealed staff were very busy, moving about the kitchen hurriedly and were preparing the lunch meal.</p> <p>Interview on 07/02/24 at 11:00 A.M. of Cook/Dietary Aide #266 revealed the kitchen staff were behind preparing the lunch meal because they had a mandatory meeting today and the meeting had just finished. Cook/Dietary Aide #266 stated the lunch meal would be about a half hour behind because of the meeting.</p> <p>Observation on 07/02/24 at 11:05 A.M. of the kitchen with Cook/Dietary Aide #266 revealed a Steamer sitting on the counter that was not being used. Cook/Dietary Aide #266 stated the Steamer did not work and had not worked for quite a while. Further observation of the kitchen floor revealed tiles were missing on the floor, and the area where the tiles were missing created a trip hazard because the floor was uneven.</p> <p>Interview on 07/02/24 at 11:43 A.M. of Dietary Supervisor (DS) #267 revealed the Steamer did not work, and had not worked since she started working at the facility about two months ago. DS #267 stated she told Maintenance Supervisor (MS) #219 and the Administrator about the Steamer not working. DS #267 stated Regional Dietary Manager (RDM) #268 talked to MS #219 about the Steamer. DS #267 stated the kitchen staff were using metal pans without handles designed for the oven, to cook food on top of the stove, because the Steamer was not working.</p> <p>Interview on 07/02/24 at 12:53 P.M. of MS #219 revealed he started working as the Maintenance Supervisor about a month ago, and before that he worked in housekeeping. MS #219 stated the Steamer had been broken since he started working at the facility. MS #219 stated a former kitchen staff employee asked him if he could fix the Steamer when he became the Maintenance Supervisor, and he found a company that could do it but they wanted to be paid up front because the facility owed them money. MS #219 indicated he was told to submit an invoice for the work, but the company would not come to the facility to give an estimate on how much it would cost to fix the Steamer until they were paid. MS #219 stated a new food management company took over, he was not sure who was responsible to fix the Steamer, but thought the new food management company would make sure the Steamer was fixed. MS #219 stated he had been very busy since becoming the Maintenance Supervisor and fixing the Steamer fell between the cracks. MS #219 stated the Administrator told him to get invoices when he needed to have things fixed.</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>Interview on 07/02/24 at 2:37 P.M of the Administrator revealed she did not know the Steamer was broken before today. The Administrator stated before the current food company managed the kitchen the facility managed the kitchen and the Steamer not working never came up. The Administrator stated DS #267 did not mention the Steamer was not working, and MS #219 did not tell her the Steamer was not working. The Administrator stated she did not get food complaints because the Steamer did not work. The Administrator confirmed she knew about the broken floor tiles in the kitchen, but did not address it. The Administrator confirmed the old owners of the facility did not pay some of their bills, the new owners did not want to pay bills from old owners, vendors refused to come until they were paid, and it took awhile to get everything sorted out.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154653.</p>		