Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky River Gardens Rehab and Nursing Ctr	4102 Rocky River Dr Cleveland, OH 44135

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on interview, review of video footage with audio and review of the facility's Resident Rights policy, the facility failed to ensure residents were treated with respect and dignity. This affected one of three residents observed for dignity during care, Resident #101. The facility census was 99. Findings include: Review of the closed medical records for Resident #101 revealed an admitted [DATE] and a discharge and deceased date of [DATE]. Diagnoses included, right leg amputation, diabetes, chronic kidney disease and congestive heart failure. Review of the care plan dated [DATE] revealed Resident #101 required one person assist with bed mobility, toileting, transfers and personal hygiene. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #101 had intact cognition and required substantial/maximal assistance with toileting and was dependent with rolling, bathing and personal hygiene. Review of current physician orders for [DATE] revealed Resident #101 was ordered two persons with all care. (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER Rocky River Gardens Rehab and Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Rocky River Dr Cleveland, OH 44135	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of video footage with audio provided by Resident #101's daughter, dated [DATE] timed 7:03 P.M., revealed Resident #101 lying naked on her right side at the edge of her bed as STNA #400, who was standing behind Resident #101, was placing a fitted sheet on the bed. Resident #101 asked STNA #400 are you going to pull me back, and STNA #400 responded Honey, I'm trying to fix your bed today as she continued to place the fitted sheet on the bed. Resident #101 then stated, Well I'm about to fall on the floor and then yelled out I'm falling as she fell from the bed face down. As Resident #101 was lying face down on the floor with her left leg resting on the side of the bed, STNA #400 walked around the bed, pushed the bed away from the resident causing Resident #101's left leg to drop to the floor with a thud. STNA #400 exclaimed damn (name of resident) and exited the room without speaking to Resident #101. Resident #101 was heard crying and yelling out help me, help me . is anybody going to get me up? Video footage timed 7:06 P.M. revealed STNA #400 re-entered Resident #101's room with three additional staff members and . Resident #101 yelled out help me and she let me fall on the floor. Resident #101's daughter was heard asking the staff how this occurred and STNA #400 stated I was putting the sheet on the bed and instead of her holding on to the bed, she was digging in her nose. Resident #101 stated I was holding on to the bed, and STNA #400 began to argue stating No you weren't . you were digging in your nose. Resident #101 stated STNA #400 was lying and STNA #400 stated Girl bye. Video footage timed 7:14 P.M. revealed Resident #101 stated I can't believe she let me hit the floor. Staff members present in the room did not respond to Resident #101's comment. Review of the facility policy Resident Rights revised [DATE], revealed resident had the right to be treated with respect, kindness and dignity. This deficiency represents non-compliance investigated under Complaint Number OH00155612, OH0055552 and OH00155548.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on closed medical record review, video footage with audio review, emergency medical services (EMS) run sheet review, hospital record review, interviews, and review of the facility's Change in a Residents' Condition or Status policy and procedure and Abuse, Neglect, Exploitation and Misappropriation policy and procedure, the facility failed to provide adequate and necessary care and services to prevent neglect involving Resident #101. This resulted in Immediate Jeopardy, including actual harm and subsequent death beginning on [DATE] at 7:03 P.M. when an incident of neglect occurred when the facility failed to prevent a fall with injury (rib fracture), to ensure timely and appropriate treatment was provided immediately post fall, to timely identify an acute change in condition and obtain immediate medical care. Review of video footage with audio dated [DATE] timed 7:03 P.M. revealed Resident #101, who was dependent on staff for personal care including bed mobility, was lying naked on her right side at the edge of her bed which was in high position as one State tested Nursing Assistant (STNA), STNA #400, who was standing behind Resident #101, was placing a fitted sheet on the bed. Resident #101 asked STNA #400 are you going to pull me back, and STNA #400 responded Honey, I'm trying to fix your bed today as she continued to place the fitted sheet on the bed. Resident #101 then stated, Well I'm about to fall on the floor and then yelled out I'm falling as she fell from the bed face down. As Resident #101 was lying face down on the floor with her left leg resting on the side of the bed, STNA #400 walked around the bed, pushed the bed away from the resident causing Resident #101's left leg to drop to the floor with a thud. STNA #400 exclaimed damn (name of resident) and exited the room without speaking to Resident #101. Resident #101 was heard crying and yelling out help me, help me . is anybody going to get me up? Resident #101 was subsequently transferred to the hospital. Resident #101 returned to the facility on [DATE] sometime between 11:00 P.M. and 12:00 A.M. with a diagnosis of a closed rib fracture. After her return to the facility on [DATE] the facility failed to complete neurological (neuro) checks and timely identify an acute change in condition and obtain immediate medical care resulting in an emergent transfer to the hospital on [DATE]. Emergency Medical Services (EMS) were called on [DATE] at 6:31 A.M. The resident was transported to the hospital where she subsequently expired at 7:49 A.M. This affected one resident (#101) of four sampled residents and one of seven residents (Residents #3, #33, #39, #50, #60, #71, and #78) identified as requiring two-person (staff) assistance with care. Facility census was 99. On [DATE] at 4:55 P.M. the Administrator and Regional Nursing Home Administrator were notified Immediate Jeopardy began on [DATE] at 7:03 P.M. when Resident #101 who had diagnoses of right leg amputation, diabetes, chronic kidney disease and congestive heart failure, and required two staff members for all care, was receiving care by one staff member (STNA #400) and fell out of bed landing on the floor face down requiring emergent transport to the hospital where she was diagnosed with a rib fracture. On [DATE] at 2:39 P.M. the Administrator and Regional Director of Clinical Services (RDCS) #401 were notified upon further review of hospital records, additional video footage and follow-up interviews the Immediate Jeopardy encompassed neglect related to failing to prevent the fall with injury, failing to provide timely and appropriate treatment immediately post fall, ensuring timely identification of an acute change in condition, and obtaining immediate medical care which resulted in the death of Resident #101 on [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective action: (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:30 A.M., RDCS #401 met with the Interdisciplinary Team (IDT) team including the Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrator, and Unit Manager (UM) #171 to complete a root cause analysis. The IDT identified a system failure because STNA #400 provided care alone for Resident #101 who required a two person assist and did not follow facility policy for rolling and supervision of resident. The facility also identified Resident #101 was not monitored per protocol, specifically the completion of neuro checks for 72 hours post-fall, upon readmission to facility. On [DATE] from 11:40 A.M. to 12:00 P.M., RDCS #401 educated the Administrator, DON, ADON and UM #171 on post fall monitoring including skilled charting, vital signs every shift for 72 hours, neuro checks for all unwitnessed falls or witnessed falls with head injury per neuro check form for 72 hours, and two-person assist for care. On [DATE] from 12:45 P.M. to 1:15 P.M. a Quality Assurance Performance Improvement (QAPI) meeting was held with the medical director, Administrator, RDCS #401, DON, ADON, UM #171, Human Resources (HR) #252, Business Office Manager (BOM) #110, Dietary Manager (DM) #180, Admissions Director (AD) #152, Housekeeping Supervisor (HS) #199, Medical Records (MR) #232, and Licensed Social Worker (LSW) #134 to review the root cause analysis. All agreed that the root cause was a system failure as STNA #400 provided care alone for Resident #101 who required a two person assist and did not follow facility policy for rolling and supervision of resident. The QAPI team also identified Resident #101 was not monitored per protocol, specifically the completion of neuro checks for 72 hours post-fall, upon readmission to facility. RDCS #401 provided education to team including post fall monitoring including skilled charting and vital signs every shift for 72 hours and neuro checks for all unwitnessed falls or witnessed falls with head injury per neuro check form for 72 hours, two person assist for care, and checking binder at nurse's station for number of persons required to assist with resident care at the start of nursing shift. On [DATE] between 2:30 P.M. and 5:30 P.M. the Administrator, DON, ADON, UM #171, DM #180, HS #199, and BOM #110 educated all facility staff on post fall monitoring including skilled charting, vital signs every shift for 72 hour, neuro checks for all unwitnessed falls or witnessed falls with head injury per neuro check form for 72 hours, two person assist for care, and checking the binder at nurse's station for two person assist for resident care at the start of nursing shift. Staff hired after [DATE] would be educated on the above information during new hire orientation. On [DATE] at 6:00 P.M., UM #171 reviewed fall investigations for past 30 days to ensure interventions, including but not limited to fall mats, enabler bars, proper positioning, visual reminders, therapy evaluations, and assistive devices were in place and appropriate care plans were in place for all residents. No additional issues were identified. On [DATE] at 7:00 P.M. the DON and Minimum Data Set (MDS) Nurse #251 audited care plans, Kardex (brand name for system that staff use to quickly reference resident information and care plans) and physician orders for all residents to ensure all assistance orders were in place and care planned appropriately. On [DATE] at 7:00 P.M. the ADON and UM #171 created a binder for each nurse's station that contained the number of persons required to provide resident care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:15 P.M. the Regional Director of Operations (RDO) met with the IDT including the DON, ADON, Administrator, and UM #171 to complete an additional root cause analysis. The IDT identified a system failure as Licensed Practical Nurse (LPN) #150 failed to identify Resident #101's change in condition and provide timely intervention. LPN #150 failed to assess Resident #101 and identify a change in condition of mental status and did not obtain any vital signs or blood sugar checks. On [DATE] between 3:40 P.M. and 4:00 P.M. a QAPI meeting was held with the Medical Director, Administrator, DON, ADON, UM #171, BOM #110, DM #180, AD #152, HS #199, MR #232, Social Service Designee (SSD) #202, and Central Supply #107 to review the root cause analysis. All agreed that the root cause was a system failure as LPN #150 failed to identify resident change in condition and provide timely intervention. The RDO provided education to the team on abuse and neglect policy and acute change in condition policy to include changes in mental status, vital signs or blood sugar. On [DATE] Between 4:00 P.M. and 4:45 P.M. Maintenance Director (MD)#104, HS #199, BOM #110, DM #180, MR #232 and SSD #202 interviewed residents with a Brief Interview of Mental Status (BIMS) score of 13 or greater (BIMS score of 13 and above indicates cognition is intact) to ensure no further instances of neglect or change in condition without identification/intervention with no negative findings. On [DATE] between 4:00 P.M. and 7:00 P.M. the RDO provided education to the IDT team on abuse and neglect policy and acute change in condition policy to include changes in mental status, vital signs or blood sugar. The Administrator, DON, ADON, UM #171, DM #180, HS #199, and BOM #110 then educated all facility staff on the facility abuse and neglect policy and acute change in condition policy. Staff hired after [DATE] would be educated on the above information during new hire orientation. On [DATE] at 4:30 P.M., UM #171 assessed residents with a BIMS score of 12 or lower (moderate to severe cognitive impairment) to ensure further instances of neglect or change in condition without identification/intervention. No negative findings. On [DATE] at 4:30 P.M. the DON reviewed the 72- hour report to ensure there were no residents with identified change in condition without appropriate follow-up. No negative findings were noted. On [DATE] at 4:45 P.M. the DON reviewed change of condition assessments from [DATE] to present to ensure appropriate interventions. No negative findings were noted. On [DATE], LPN #150 was suspending pending an investigation for resident neglect. On [DATE] at 8:44 P.M. the RDO submitted a Self-Reported Incident (SRI) for neglect related to Resident #101. The facility implemented a plan for audits to be completed by the DON/designee for every fall occurrence to ensure appropriate post fall monitoring including skilled charting, vital signs, and neuro checks as indicated for eight weeks beginning [DATE] and ending [DATE]. The facility implemented a plan for audits to be completed to ensure the appropriate number of staff were providing care per identified needs would be completed by DON/designee on five random residents throughout all units five times weekly for eight weeks beginning [DATE] and ending [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility implemented a plan for audits to be completed to ensure the person assist binders were accurate and up to date would be completed by DON/designee five times weekly for eight weeks beginning [DATE] and ending [DATE]. The DON/designee would complete random staff interviews on all shifts to ensure binders were reviewed at start of shift. Two staff members to be interviewed five times weekly for eight weeks beginning [DATE] and ending [DATE]. All new physician orders related to transfer status would be audited by DON/designee five times a weekly for eight weeks beginning [DATE] and ending [DATE]. The DON/designee would observe 10 random residents a day five times a week for four weeks, then 10 random residents a week for four weeks, and randomly thereafter to ensure no change in condition without assessment and intervention and no signs of abuse or neglect beginning [DATE] and ending [DATE]. The DON/designee would interview five random residents a day five times a week four weeks, then five random residents a week for four weeks to ensure no allegations of abuse or neglect beginning [DATE] and ending [DATE]. The DON/designee would randomly review charting five times a week for four weeks to ensure no change in condition without assessment and intervention beginning [DATE] and ending [DATE]. All audits would be reviewed during monthly QAPI meetings, and any identified concerns addressed immediately by QAPI committee. Review of in-service sign-in sheets confirmed most facility staff received the training/education. Staff who did not attend would receive the training/education at the start of their next shift. Although the Immediate Jeopardy was removed on [DATE] the deficiency remained at Severity Level II (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as staff in-servicing and auditing to ensure continued compliance was still in process. Findings include: Review of the closed medical records for Resident #101 revealed an admitted [DATE] and a discharge and deceased date of [DATE]. Resident #101 had diagnoses including right leg amputation, diabetes, chronic kidney disease and congestive heart failure. Review of the care plan dated [DATE] revealed Resident #101 required one person assist with bed mobility, toileting, transfers and personal hygiene. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #101 had intact cognition, required substantial/maximal assistance from staff for toileting and was dependent with rolling, bathing and personal hygiene. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of current physician orders for [DATE] revealed Resident #101 was ordered two persons with all care. Resident #101 was ordered Plavix (antiplatelet) 75 milligram once daily with a start date of [DATE]. Review of the progress note dated [DATE] timed 9:57 P.M. authored by LPN #205 revealed a STNA reported Resident #101 was on the floor. Upon entering Resident #101's room the resident was observed lying face down on the floor. Resident #101 was assisted back into bed via a Hoyer (mechanical) lift and assessed. Resident #101 stated she hit her head, and a small amount of emesis was observed on Resident #101's face and on the floor. Resident #101's vital signs were stable. EMS was called and transferred Resident #101 to the hospital. Resident #101's daughter was notified via a Bluetooth device in the resident's room. The DON was also notified. Review of the progress note dated [DATE] timed 11:45 P.M. authored by LPN #214 revealed Resident #101 was returned from the hospital. The note indicated the resident was negative for any abnormalities. The note also indicated Resident #101 was non-compliant with obtaining a head-to-toe assessment and vital signs. Review of the progress note dated [DATE] timed 12:09 P.M. authored by LPN #208 revealed Resident #101 was alert and oriented and able to make her needs known, vital signs and neuro checks were within normal limits. The progress note did not include the vital signs. Review of the progress note dated [DATE] timed 2:01 P.M. authored by Social Services (SS) #134 revealed Resident #101 had a camera in her room and the fall had been recorded on video. SS #134 placed a call to Resident #101's daughter requesting a copy of the video for review and was awaiting receipt of video. The progress note indicated Resident #101's daughter requested half rails be placed on Resident #101's bed. The progress note also indicated the DON would interview the staff member that had been present at the time of the fall and all STNAs would be educated on proper positioning and a new bed with rails had been provided. Review of the progress note dated [DATE] timed 4:49 P.M. authored by LPN #404 revealed Resident #101's vital signs were blood pressure ,d+[DATE], heart rate 82, and oxygen saturation was 94% (normal , d+[DATE]%). Review of a progress note dated [DATE] timed 9:43 P.M. and authored by LPN #150 documented Resident #101 was arousable to verbal stimuli, resident sleeping, and medications were held. There was no additional information as to why the resident's medications were held at this time. Review of a progress note dated [DATE] timed 12:10 A.M. and authored by LPN #150 documented Resident #101 remained asleep, no distress. Review of a progress note dated [DATE] timed 3:55 A.M. and authored by LPN #150 documented Resident #101 continued to rest with no distress noted. Review of the progress note dated [DATE] timed 5:30 A.M. authored by LPN #150 revealed Resident #101 was arousable to verbal stimuli and pain, dressing was changed without incidence with no distress noted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the progress note dated [DATE] timed 7:35 A.M. authored by LPN #150 revealed Resident #101 had a change in condition with altered mental status. Blood pressure was ,d+[DATE], heart rate 76, and oxygen saturation was 97% on room air. Review of the progress note dated [DATE] time 8:03 A.M. authored by LPN #150 revealed Resident #101 was noted to have increased drowsiness throughout the evening with a change in mental status as Resident #101 was not at her baseline. Resident #101 responded to pain but was not answering questions appropriately. Resident #101's vital signs were fluctuating. Emergency Services were called, and Resident #101 was transported out of the facility. The ADON was notified. Review of the EMS run report dated [DATE] revealed a call was received at 6:31 A.M. and EMS were in route at 6:35 A.M., on scene at 6:38 A.M. and at Resident #101 at 6:39 A.M. The report indicated Resident #101 was unresponsive with altered mental status for two days. Blood pressure taken at 6:53 A.M. was , d+[DATE], heart rate was 86 and weak, oxygen was 96% on room air and blood sugar was 40 (normal ,d+[DATE]), skin was cool and pale. Upon arrival Resident #101 was in a reclining chair and was slow to respond only responding to painful stimuli. The EMS report indicated Resident #101 was last seen normal yesterday ([DATE]) and normal mental status was alert and oriented. Review of hospital documentation dated [DATE] revealed Resident #101 presented with altered mental status along with low blood pressure and low blood sugar. Resident #101 was last known well sometime yesterday ([DATE]). Resident #101 was declared deceased on [DATE] at 7:49 A.M. Review of Resident #101's recorded vital signs revealed on [DATE] at 9:18 P.M. staff documented her blood pressure was ,d+[DATE], on [DATE] at 10:45 A.M. her blood pressure was ,d+[DATE] and on [DATE] at 7:36 A.M. her blood pressure was ,d+[DATE]. Review of Resident #101's closed medical record including the hard/paper chart revealed no documented evidence of any type of neurological checks were completed following the resident's fall. Review of the facility progress note dated [DATE] timed 10:20 A.M. and authored by SS #134 revealed Resident #101 expired on [DATE] at 8:24 A.M. Review of video footage with audio provided by Resident #101's daughter, dated [DATE] timed 7:03 P.M., revealed Resident #101 lying naked on her right side at the edge of her bed which was in high position without siderails as STNA #400, who was standing behind Resident #101, was placing a fitted sheet on the bed. Resident #101 asked STNA #400 are you going to pull me back, and STNA #400 responded Honey, I'm trying to fix your bed today as she continued to place the fitted sheet on the bed. Resident #101 then stated, Well I'm about to fall on the floor and then yelled out I'm falling as she fell from the bed face down. As Resident #101 was lying face down on the floor with her left leg resting on the side of the bed, STNA #400 walked around the bed, pushed the bed away from the resident causing Resident #101's left leg to drop to the floor with a thud. STNA #400 exclaimed damn (name of resident) and exited the room without speaking to Resident #101. Resident #101 was heard crying and yelling out help me, help me . is anybody going to get me up? (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Video footage timed 7:06 P.M. revealed STNA #400 re-entering Resident #101's room with three additional staff members. Resident #101 remained on the floor yelling out help me and she let me fall on the floor. The staff members were observed placing a Hoyer pad underneath Resident #101 and applying a gown. Resident #101's daughter could be heard asking staff what happened. STNA #400 responded I was putting the sheet on the bed and instead of her holding on to the bed, she was digging in her nose. Resident #101 stated I was holding on to the bed. STNA #400 began to argue stating No you weren't you were digging in your nose. Resident #101 said STNA #400 was lying and STNA #400 stated Girl bye. Video footage timed 7:10 P.M. revealed staff assisting Resident #101 back into bed via a Hoyer lift. An unidentified staff member asked Resident #101 if she was having pain and Resident #101 replied all over. Video footage timed 7:12 P.M. revealed staff placed an incontinence brief on Resident #101. No physical assessment was completed, and vital signs were not obtained. Video footage timed 7:14 P.M. revealed Resident #101 stating I can't believe she let me hit the floor. The staff members present in the room did not respond. Video footage timed 7:30 P.M. revealed EMS arrived. Resident #101 stated I don't believe that girl let me fall out of this bed. Review of the facility's fall investigation with an initiation date of [DATE] revealed a statement authored by STNA #400. The statement indicated STNA #400 placed Resident #101 in bed at approximately 7:00 P.M., while placing a fitted sheet on Resident #101's bed the resident was digging in her nose and tried to throw away a tissue in the trash and while reaching for the trash Resident #101's body went over the edge of the bed. Review of the facility investigation revealed no evidence a second staff person was in the room to assist with the resident's transfer to bed or to assist with personal care/bed mobility. Further review of the investigation revealed no documentation neuro checks were completed. The investigation indicated Resident #101 was transferred out of the facility. The investigation included hospital paperwork dated [DATE] that indicated Resident #101 had a CT scan and a chest x-ray. The hospital paperwork indicated Resident #101 had a closed left sided rib fracture. The results of the CT were not included with the paperwork. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on [DATE] at 7:30 A.M. with Resident #101's daughter revealed on [DATE] she received a call from Resident #101 via an electronic device. Resident #101 told her she had fallen out of bed, and she was lying on the floor. Resident #101's daughter stated Resident #101 told her she was hurting all over. Resident #101 was transported to the hospital after the fall and was returned to the facility shortly after. Resident #101's daughter had concerns about Resident #101 being returned to the facility so quickly especially since she was on blood thinners. Resident #101's daughter stated she had spoken with the nurse (couldn't recall name) and asked that thestaff check on her mother more frequently. The daughter stated the nurse informed her Resident #101's CT scan was negative, and that Resident #101 had a rib fracture. Resident #101's daughter went to the facility on [DATE] and spoke with SS #134 and showed him the video footage of the fall; she also sent the link to view the video via text message to SS #134. Resident #101's daughter stated SS #134 did not say much about the video, but she was told the facility would begin an investigation. Resident #101's daughter further stated she reviewed additional camera footage and on the evening of [DATE] the camera, which was motion activated had not detected anyone entering Resident #101's room; the camera did not detect anyone from the evening of [DATE] until the morning of [DATE] at 5:30 A.M. At 5:30 A.M. a nurse entered to change Resident 101's wound dressing. The camera footage also showed staff placing Resident #101 into a dialysis chair and Resident #101 appeared to be unresponsive at that time. Resident #101's daughter was told Resident #101 was taken to the hospital and on the way to the hospital she crashed. The daughter was told by hospital staff Resident #101's blood pressure and blood sugar were low and she became unresponsive on the way to the hospital and passed away sometime after arriving to the hospital. Telephone interview on [DATE] at 11:48 A.M. with LPN #205 revealed on [DATE] shortly after 7:00 P.M. STNA #400 informed her Resident #101 was on the floor. STNA #400 did not provide any specific details of the fall. LPN #205 and three other staff members entered Resident #101's room and she observed Resident #101 was face down on the floor by her bed and was complaining of pain all over. LPN #205 stated she did not observe any obvious injuries. Resident #101 told her she had told STNA #400 she was falling out of bed. LPN #205 assisted with getting Resident #101 back into bed and then called EMS (911). LPN #205 stated Resident #101's daughter was notified of the fall via an electronic device located in the room at the time of the fall. LPN #205 stated Resident #101 required two person staff assistance for all care. LPN #205 had collected STNA #400's statement and STNA #400 told her as she was assisting Resident #101 with a bed change, Resident #101 was digging in her nose and had not been holding onto the bed. Resident #101 returned to the facility sometime between 11:00 P.M. and 12:00 A.M. and another nurse had taken over care of Resident #101 after her return. LPN #205 did not care for Resident #101 after her return from the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky River Gardens Rehab and Nursing Ctr	4102 Rocky River Dr Cleveland, OH 44135

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on [DATE] at 12:12 P.M. with LPN #150 revealed she had cared for Resident #101 on the evening of [DATE] from 7:00 P.M. to [DATE] at 7:00 A.M. LPN #150 stated she entered Resident #101's room around 9:30 P.M. to administer Resident #101's evening medications and Resident #101 was sleepy but had spoken. Resident #101 appeared to be too sleepy to give her the medications and so she had not administered the medications. LPN #150 stated she entered Resident #101's to check on her a few times throughout the evening and she continued to sleep. When LPN #150 entered Resident #101's room on the morning of [DATE] at approximately 5:30 A.M. to complete her wound care, Resident #101 was sleepier than she had been earlier. Resident #101 was not easily arousable and was not responding appropriately. LPN #150 said she took Resident #101's blood pressure and it was low. LPN #150 called the physician and received orders to call 911. LPN #150 called 911 between 7:00 A.M. and 7:30 A.M. and Resident #101 was transported to the hospital. LPN #150 continued to get Resident #101 ready for dialysis and out of bed and took her from her room to the hall before calling 911 because she stated she felt the condition the resident was displaying was somewhat normal for her. The hospital called about an hour later and reported Resident #101 had passed away. Interview on [DATE] at 12:57 P.M. with Registered Nurse (RN) #185 revealed she had responded and assisted with Resident #101's fall on [DATE]. When RN #185 entered Resident #101's room she observed Resident #101 face down on the floor and Resident #101 was yelling out in pain. RN #185 was not aware how the fall occurred and stated Resident #101's assigned nurse (LPN #205) had called 911 and Resident #101 was transported to the hospital. RN #185 did not care for Resident #101 after her return from the hospital. Interview on [DATE] at 1:07 P.M. with STNA #103 revealed she was not present when Resident #101 fell out of bed, however she cared for her the next morning after her return from the hospital. STNA #103 stated Resident #101 usually used her call light early in the morning for assistance out of bed, but that morning Resident #101 did not use her call light or ask to get out of bed. When STNA #103 entered Resident #101's room that morning (could not recall time) Resident #101 appeared to be more tired than normal and did not want to get up. Interview on [DATE] 1:54 P.M. with RDCS #401 and the ADON revealed they completed an investigation into Resident #101's fall. RDSC #401 stated STNA #400 was terminated because she did not follow Resident #101's plan of care regarding the number of staff required when providing care. RDCS #401 stated Resident #101 was transported to the hospital after the fall and returned shortly after. RDSC #401 stated the hospital paperwork did not include results of the CT scan, but the hospital called and informed the nurse of the results being negative. RDCS #401 stated neurological (neuro) checks were not completed because the resident's CT scan was negative. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365392	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 8:54 A.M. with the DON revealed she received a call on the evening of [DATE] from LPN #205 informing her Resident #101 had a fall and was being transported to the hospital. LPN #205 had not provided specific information regarding how the fall occurred. The DON stated Resident #101 was transported to the hospital and returned shortly after. The DON was surprised Resident #101 had returned so quickly. The hospital gave the discharge paperwork to Resident #101. The DON asked Resident #101 for the hospital paperwork the following morning. The hospital paperwork indicated Resident #101 had a rib fracture. The paperwork did not include the results of the CT scan. The DON confirmed neuro checks were not completed upon Resident #101's return and said they were not completed because the CT results were reported as being negative. Resident #101's daughter was present at the facility on [DATE] and she had video footage of Resident #101's fall. Resident #101's daughter played the video; however, the DON did not see the video she only heard the audio. The DON asked Resident #101's daughter to send the actual video because she was unable to open the link to view. The DON stated when she listened to the audio of the video, she heard Resident #101 ask to be pulled back and she heard the crash. The facility initiated an investigation on [DATE] which included Resident #101 was a two person assist with care and during the investigation she educated STNA #400 regarding following proper resident care and fall protocol that included not leaving a resident who was on the floor. The DON reviewed STNA #400's statement regarding the fall and stated STNA #400's statement was not truthful based on what she had heard on the video. The DON viewed the video footage the morning of [DATE] which was the morning she was notified Resident #101 had been lethargic and had low blood pressure and was being sent to the hospital. Upon review of the video footage STNA #400 was terminated. Interview on [DATE] at 12:54 P.M. with RDCS #401 revealed she was aware video footage existed regarding Resident #101's fall but she had not viewed the video until [DATE]. Telephone interview on [DATE] at 3:36 P.M. with STNA #400 revealed she cared for Resident #101 on multiple occasions, and she was aware Resident #101 required two-person assistance with care. STNA #400 stated she had often cared for Resident #101 by herself and on the evening of [DATE] Resident #101 requested to be put into bed and she had used the Hoyer lift by herself to place Resident #101 into bed. STNA #400 stated she gave Resident #101 a bed bath and began placing the fitted sheet on the resident's bed. Resident #101 was up on her side in bed and STNA #400 had a hand on Resident #101 the whole time and she told Resident #101 to hold on to the bed. STNA #400 stated Resident #101 had not held on to the bed, rolled out of the bed and fell to the floor. STNA #400 left the room to go get help and returned with the nurse and some additional staff. They got Resident #101 up and placed her back into her bed and the nurse called 911. Resident 101 was taken to the hospital and returned later that evening. STNA #400 had not cared for Resident #101 upon her return from the hospital. STNA #400 stated the following day ([DATE]) she arrived to work between 3:00 P.M. and 4:00 P.M. and the DON told her she was not allowed to care for[TRUNCATED]