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	04/12/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on interview and record review the facility failed to ensure resident funds were disbursed as required and in a timely manner after death. This affected one resident (Resident #120) of five residents reviewed for resident funds. The facility census was 110. Findings include: Review of Resident #120's medical record revealed an admitted [DATE] and diagnoses including paranoid schizophrenia, unspecified psychosis, major depressive disorder, schizophrenia unspecified, unspecified severe protein-calorie malnutrition, psychotic disorder with hallucinations due to known physiological condition and history of COVID-19. Review of a Minimum Data Set (MDS) 3.0 dated [DATE] revealed Resident #120 expired in the facility. Review of a nurses' note dated [DATE] revealed Resident #120 expired in the facility. Review of Resident #120's resident fund statement revealed as of [DATE], Resident #120 had an ending balance of $1069.28. There was no evidence of final disbursal for review. Interview on [DATE] at 4:25 P.M. with Business Office Manager (BOM) #405 revealed she contacted Resident #120's guardian a week after she died regarding the funds and he had said he would contact the family. BOM #405 stated she never heard anything back after that. BOM #405 verified Resident #120's resident funds were not disbursed within 30 days as required after her death.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on record review and interview the facility failed to ensure a significant change Minimum Data Set (MDS) 3.0 assessment was completed for Resident #14. This affected one resident (#14) of 25 residents reviewed for MDS assessments. The facility census was 110. Findings include: Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, diabetes, high blood pressure, anxiety, and depression. Review of the physician orders for Resident #14 revealed the resident was admitted to hospice services on 02/20/24 for dementia with behavioral disturbance. Review of the comprehensive annual MDS 3.0 assessment, dated 03/11/24 for Resident #14 under Section J, Health Conditions, revealed the resident was severely cognitively impaired and did not have a life expectancy of less than six months but was receiving hospice services. Interview with MDS Registered Nurse (RN) #540 on 04/12/24 at 11:50 A.M. confirmed Resident #14 was receiving hospice services and Section J was coded incorrectly because a significant change assessment was not completed after the resident was admitted to hospice on 02/20/24. MDS RN #540 stated it was missed when she completed an MDS audit.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, interview, and record review the facility failed to accurately complete [NAME] Data Set (MDS) assessments for Resident #5, #14 and #90. This affected three residents (Residents #5, #14, and #90) out of 25 residents reviewed for accurate [NAME] Data Set (MDS) assessments. The facility census was 110. Findings Include: 1. A record review of Resident #5's medical record revealed Resident #5 was admitted to the facility on [DATE] with the diagnoses including high blood pressure, Chronic Obstructive Pulmonary Disease (COPD), history of falls with multiple fractures of the lumbar vertebrae, thoracic vertebrae, and skull. Resident #5 required assistance from staff, was cognitively intact and ambulated with a front wheeled walker and stand by assist of staff. Review of Resident #5's signed physician orders for the month of April 2024 revealed orders including fall floor mat to right side of the bed dated 01/21/24, bed in the lowest position dated 01/21/24, and bed against the wall dated 01/21/24. Review of Resident #5's assessments revealed admission fall risk assessment dated [DATE] Resident #5 was assessed as a high fall risk. Further fall risk assessments dated 01/10/24, 01/15/24, 01/16/24, 01/21/24, 04/07/24 continued to rate Resident #5 as a high fall risk. Review of Resident #5's progress note dated 01/10/24 at 8:09 P.M. authored by LPN #409 revealed Resident #5 was observed laying in bed with a large hematoma located to the back of her head. There was a laceration observed in the center of the hematoma with moderate amount of bleeding observed. Resident #5 was sent to the hospital emergency room for evaluation and treatment. Review of Resident #5's progress note dated 01/16/24 at 1:00 P.M. authored by LPN #442 revealed Resident #5 was observed face down on the floor of the bathroom. Resident #5 was attempting to use the bathroom independently. Resident #5 was observed with a laceration to the forehead and a skin tear located to the left hand. Resident #5 was sent to the hospital emergency room for evaluation and treatment. Review of Resident #5's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Section J Health Conditions - J1800 Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) was marked as No. Section J1900 Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) B - Number of falls since Admission or Prior assessment - Injury was marked as No. An observation on 04/11/24 at 9:51 A.M. revealed Resident #5 laying in a low bed against the wall with a blue fall mat located to the right side of the bed. Resident #5 was resting quietly watching television. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/11/24 at 12:15 P.M. with MDS Registered Nurse (RN) #540 confirmed Resident #5 had two falls on 01/06/24 and 01/10/24 with injury since admission to the facility on [DATE] and the admission MDS dated [DATE] was not completed accurately to reflect the two falls and the injury incurred. 2. A record review of Resident #5's medical record revealed Resident #5 was admitted to the facility on [DATE] with the diagnoses including high blood pressure, Chronic Obstructive Pulmonary Disease (COPD), history of falls with multiple fractures of the lumbar vertebrae, thoracic vertebrae, and skull. Resident #5 required assistance from staff, was cognitively intact and ambulated with a front wheeled walker and stand by assist of staff. Review of Resident #5's admission assessment revealed there were no completed assessments for enabler or restraint used by Resident #5. Review of Resident #5's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Section P - Restraints and Alarms P0100 Physical Restraints E. Trunk Restraints was marked as used less than daily. An observation on 04/10/24 at 3:50 P.M. revealed Resident #5 was sitting independently on the edge of the bed eating a snack. There was a front wheeled walker located across the room from the bed. There was no wheelchair present in the room. Interview on 04/11/24 at 10:00 A.M. with State tested Nursing Assistant (STNA) #471 revealed Resident #5 ambulated with a front wheeled walker and stand by assist from staff. Resident #5 does not use a wheelchair or had any type of restraint or enabler for positioning in bed. Interview on 04/11/24 at 12:15 P.M. with MDS RN #540 confirmed Resident #5 does not use a trunk restraint and the Admission MDS dated [DATE] was marked as a trunk restraint being used less than daily by Resident #5. 39969 3. Review of the medical record for Resident #90 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia with behavioral disturbance, and post-traumatic stress disorder (PTSD). Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #90 had impaired cognition. The assessment also indicated physical restraints were used less than daily. Observation on 04/10/24 at 8:49 A.M. of Resident #90 revealed the resident was sitting in the dining room and no restraints were observed. Attempted interview at this time with Resident #90 revealed Resident #90 was noninterviewable. Interview on 04/11/24 at 11:57 A.M. with Licensed Practical Nurse (LPN) #478 revealed she had never Resident #90 with any restraints. Interview on 04/11/24 at 12:15 P.M. with MDS Registered Nurse (RN) #540 stated they did not have any residents on restraints in the facility. MDS RN #540 stated she accidentally marked that restraints were used on Resident #90's 01/01/24 quarterly MDS assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	32650 4. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, diabetes, high blood pressure, anxiety, and depression. Review of the physician orders for Resident #14 revealed the resident was admitted to hospice services on 02/20/24 for dementia with behavioral disturbance. Review of the comprehensive annual Minimum Data Set (MDS) 3.0 assessment, dated 03/11/24, for Resident #14 under Section J, Health Conditions, revealed the resident was severely cognitively impaired and did not have a life expectancy of less than six months but was receiving hospice services. Section M, Skin conditions, revealed the resident had no pressure ulcers but also had one Stage two pressure ulcer to the left buttock. Interview with MDS Registered Nurse (RN) #540 on 04/12/24 at 11:50 A.M. confirmed Resident #14 was receiving hospice services and that the resident had a pressure ulcer to her left buttock MDS RN #540 confirmed Section J and Section M of the MDS assessment were coded incorrectly.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on record review, and interview the facility failed to ensure a skin assessment upon admission was timely obtained for the accurate initial assessment of skin impairment for Resident #11. This affected one resident (Resident #11) out of four residents reviewed for pressure ulcers. The facility census was 110. Findings Include: A record review for Resident #11 revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, heart failure, peripheral vascular disease (PVD), and Alzheimer's disease. Resident #11 had intact cognition and requires assistance from staff for personal hygiene cares, dressing, and transfers. Review of Resident #11's baseline care plan dated 02/02/24 revealed interventions including use of pressure reducing mattress, pressure reducing cushion in wheelchair, encourage use of appropriate footwear while out of bed, and assess/monitor skin for impairments. A review of Resident #11's admission assessment dated [DATE] revealed Resident #11 refused staff to perform a head-to-toe skin assessment to assess any skin impairments acquired prior to admission. Review of Resident #11's progress notes dated 02/2/24 to 02/11/24 revealed no further documentation of attempts by staff to complete the admission head to toe skin assessment for Resident #11. Review of Resident #11's weekly skin assessment dated [DATE] revealed abrasions located to bilateral lower legs. No further skin impairments were documented. A review of Resident #11's shower/skin observation sheets dated 02/02/24 to 04/02/24 revealed no new skin areas were observed or noted by staff during Resident #11's showers and or bed baths. An interview on 04/12/24 at 10:22 A.M. with facility wound nurse LPN #419 confirmed Resident #11 did not have an admission skin assessment completed by staff upon admission and there were no further attempts to complete a skin assessment due to Resident #11's initial refusal on admission to the facility. LPN #419 stated, The nurses should have attempted to complete the skin assessment within 8 hours of admission. If the resident refused, the nurse should have asked another nurse to attempt to complete the assessment. Review of the facility's policy titled, Prevention of Pressure Ulcers/Injuries dated 07/01/17 revealed, Assess the resident on admission (within eight hours) for exiting pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review, interview, and review of policy and procedure, the facility failed to ensure pharmacy recommendations were timely addressed for Resident #90 and #109. This affected two residents (#90 and #109) of five residents reviewed for unnecessary medications. The facility census was 110. Findings include: 1. Review of the medical record for Resident #90 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia with behavioral disturbance, and post-traumatic stress disorder (PTSD). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #90 had impaired cognition. Review of the pharmacy recommendation for Resident #90 dated 10/31/23 was for Divalproex (anticonvulsant) 250 milligrams (mg) twice a day. The pharmacy recommendation documented questioning if a gradual dose reduction (GDR) could be attempted at this time to verify this resident was on the lowest possible dose? If no, please indicate response below. There was a list of five different response to select from, but no response was checked. On the bottom of the form, revealed the nurse practitioner checked the box that read disagree, no change indicated, current benefit outweighs potential risk. The Nurse Practitioner (NP) signed and dated the pharmacy recommendation on 12/06/23. Interview on 04/12/24 at 8:24 A.M. with Regional Director of Clinical Services (RDCS) #538 stated they would like to see the pharmacy recommendations addressed within 30 days and verified response was not selected and it was not addressed by the NP until 12/06/23. 32650 2. Review of the medical record revealed Resident #109 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, prostate cancer, shared psychotic disorder, anxiety, and depression. Review of the physician orders for Resident #109 revealed an order for Zyprexa (an antipsychotic medication) 7.5 milligrams (mg) for mood at bedtime every day. Review of the pharmacist recommendations revealed on 12/21/23 the pharmacist requested an appropriate diagnosis for the use of the antipsychotic medication, Zyprexa, for Resident #109. The pharmacist provided appropriate diagnoses of Schizophrenia, Schizoaffective disorder, delusional disorder, mania, bipolar disorder, depression with psychotic features, refractory major depression, schizophreniform disorder, psychosis, atypical psychosis, or brief psychotic disorder, delirium with manic/psychotic symptoms. On 01/12/24 the psychiatric NP signed the pharmacist recommendation but did not provide an appropriate diagnosis for the use of Zyprexa for Resident #109. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Regional Director of Clinical Services on 04/11/24 at 1:30 P.M. confirmed the NP did not select an appropriate diagnosis provided by the pharmacist after signing the pharmacist's recommendation. Review of policy Medication Regimen Reviews, revised April 2007 did not indicate a time frame for responses to pharmacy recommendations by the physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, interview, and record review the facility failed to assess and monitor the use of a necessary antipsychotic medication. This affected one resident (Resident #10) out of five residents reviewed for unnecessary medications. The facility census was 110. Findings Include: Observation on 04/10/24 at 10:15 A.M. revealed Resident #10 resting quietly in bed. Further observations on 04/11/24 at 2:25 P.M. and on 04/12/24 at 11:25 A.M. revealed Resident #10 resting quietly in bed with no behaviors observed. A review of Resident #10's medical record revealed Resident #10 was admitted to the facility on [DATE] with the following diagnoses including Chronic Obstructive Pulmonary Disease (COPD), heart failure, high blood pressure, and Alzheimer's Disease. Resident #10 had impaired cognition and was dependent on staff for all personal hygiene cares, transfers and dressing. Review of Resident #10's signed physician orders dated 04/01/24 revealed an order dated 12/25/23 for the use of antipsychotic medication Zyprexa 2.5 milligrams (MG) to be given daily for behaviors. Review of Resident #10's Pharmacy Recommendations dated 09/10/23 revealed recommendation for the physician to address the diagnoses for the use of Zyprexa for behaviors. Response was marked as other - please see Doctor's Orders/Progress Notes. Review of Resident #10's progress notes dated 09/10/24 to 10/01/24 revealed there was no documentation or entries to reflect the physician addressing or changing the diagnoses for the continued use of Zyprexa. Review of Resident #10's behavioral documentation dated 02/01/24 to 04/11/24 revealed Resident #10 did not exhibit any behaviors which were documented by staff. An interview on 04/12/24 at 12:01 P.M. with the Director of Nursing (DON) confirmed Resident #10's diagnosis for the use of Zyprexa was for behaviors, and Resident #10 was not exhibiting any behaviors in the last 90 days. The DON stated, The diagnosis of behaviors is not an appropriate diagnosis for the use of the antipsychotic medication Zyprexa. The resident has had no behaviors like she had on admission. Review of the facility's policy titled, Medication regimen Reviews dated 04/01/07 revealed, The primary purpose of this review is to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47569 Based on observation, interview, and record review the facility failed to maintain a medication administration error rate of less than 5%. The facility had 37 opportunities for medication error with two medication errors occurring resulting in a medication error rate of 5.41%. This affected one resident (Resident #46) out of four residents observed for medication administration. The facility census was 110. Findings Include: Medication administration observation on 04/11/24 at 7:25 A.M. revealed Licensed Practical Nurse (LPN) #476 preparing morning medication for Resident #46. LPN #476 placed the tablets into a medication pouch to be crushed and poured into a medication cup. LPN #476 took a soft gel capsule of Omega 3 Fish Oil and placed it in a separate pouch to crush and pour the liquid into the medication cup. The soft gel was crushed with a small amount of the liquid being poured into the medication cup. LPN #476 then took a soft gel capsule of B Vitamin Complex and placed it in a separate pouch to crush and pour the liquid into the medication cup. The soft gel was crushed with the liquid staying in the pouch. LPN #476 attempted to squeeze the liquid into the medication cup, this attempt was not successful, and the liquid medication remained in the pouch. LPN #476 mixed the crushed medications with applesauce and administered the medication to Resident #46. Review of Resident #46's physician signed medication orders dated 04/01/24 revealed Resident #46 received the following medications during morning medication administration, Calcium Acetate 667 milligrams (mg), Abilify 20 mg, Aspirin 81 mg, Duloxetine 80 mg, Isosorbide Mononitrate 30 mg, Levetiracetam 250 mg, B-Complex Vitamin, Carvedilol 3.125 mg, Eliquis 5 mg, Omega 3 Fish Oil 1,000 mg, Ranolazine 1000 mg, and Topiramate 200 mg. Resident #46 required medications to be crushed for ease in swallowing. Review of the manufacturing guidelines for Omega 3 Fish Oil revealed the soft gel capsules should not be crushed or split for the removal of the liquid may lead to incorrect dosage. Review of the manufacturing guidelines for the B Vitamin Complex revealed the soft gel capsule form of the medication should not be pierced, split, or crushed due to the removal of the medication may lead to incorrect dosage. Interview with LPN #476 confirmed the soft gel capsules of Omega 3 Fish Oil, and the B Vitamin Complex should not have been crushed, and a different form of the medication should have been used so that it could have been crushed and administered correctly. Review of the facility's policy titled, Administering Medications revised in December 2012 revealed, Medications shall be administered in a safe and timely manner, and as prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based observation, interview, and facility policy review the facility failed to keep medication in a secured environment, and failed to discard expired tuberculin solution. This had the potential to affect all 110 residents in the facility. The facility census was 110. Findings Include: 1. Observation on [DATE] at 11:15 A.M. revealed the second-floor medication room door was ajar and not latched completely allowing the door to be pushed open without the use of the door handle. The door handle was part of a code locking system with the number 7 button stuck enabling the door to be unlocked. Observation on [DATE] at 11:20 A.M. revealed the third-floor medication room door was closed but not locked. By turning the door handle it opened the door without having to enter the code to unlock the door. Observation on [DATE] at 3:26 P.M. revealed State tested Nursing Assistant (STNA) #418 opening the door of the third-floor medication room and entering without having a nurse as an escort into the medication room. STNA #418 then exited the medication with several boxes of gloves to be used in the resident's rooms. Interview on [DATE] at 3:24 P.M. with Licensed Practical Nurse (LPN) #534 revealed the second-floor medication room door has not been able to be locked in several days due to the number 7 on the code box being stuck. Interview on [DATE] at 3:30 P.M. with STNA #418 revealed the third-floor medication room was also where the resident supplies were stored, and the door had not been locked for several days. The STNAs could go into the medication room to get the supplies needed to take care of the residents. Interview on [DATE] at 4:00 P.M. with the Director of Nursing (DON) confirmed the medication rooms on the second and third floors were unlocked, and the staff were able to enter and exit without using a code to unlock the doors. Review of the facility policy titled, Storage of Medications dated ,d+[DATE] revealed, Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys. 2. Observation on [DATE] at 10:48 A.M. in the first floor medication refrigerator revealed two partially used vials of Apisol Tuberculin (TB) solution with out opened dates on either the vials or the manufacturer boxes. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 10:55 A.M. with Licensed Practical Nurse (LPN) #475 confirmed the two partially used TB solution vials without an opened date on the vials or the boxes. LPN #475 stated, Those vials and boxes should have an opened date on them. Observation on [DATE] at 11:05 AM in the third floor medication room refrigerator revealed one partially used vial of Aplisol TB solution without an opened date on the vial or the manufacturer's box. Interview on [DATE] at 11:10 A.M. with the Assistant Director of Nursing (ADON) confirmed the one partially used vial of Aplisol TB solution without an opened dated on the vial or the box. The ADON stated, The vials and the boxes should have an opened date and not be used passed 30 days from the opened date. Review of the Aplisol TB solution manufacturer guidelines revealed, Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.

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	04/12/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on observation, interview and policy review, the facility failed to ensure foods were labeled, dated and not retained when expired. This had the potential to affect 106 residents receiving food from the facility's kitchen as four residents (Residents #19, #41, #74 and #103) were ordered nothing-by-mouth (NPO). The facility census was 110. Findings include: Observation of the facility's nourishment refrigerators on [DATE] starting at 9:51 A.M. with Food Service Director (FSD) #440 revealed the following: In the first floor resident refrigerator, there were two expired yogurts dated [DATE], two expired yogurts dated [DATE] and a half-gallon of milk dated [DATE]. In the second floor resident refrigerator, there was an unidentified pink substance on the inside base of the refrigerator and there was frozen popsicle material on the inside base of the freezer. In the third floor resident refrigerator, there were two containers labeled with Resident #85's room number on it but no date. Interviews with FSD #440 verified the above findings at the time of observation. FSD #440 indicated she or another dietary staff would check the refrigerators every Friday for expired food. FSD #440 stated housekeeping staff helped with this process but ultimately nursing staff were supposed to take expired food out of the refrigerators. FSD #440 stated these refrigerators were also cleaned weekly. FSD #440 confirmed there was no documentation regarding staff going through these refrigerators for expired food. Review of the facility policy, Food Brought by Family/Visitors, revised February 2014 revealed perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the residents' name, the item and the use by date. The nursing staff is responsible for discarding perishable foods on or before the use by date. The nursing and/or food service staff must discard any foods prepared for the resident that show obvious signs of potential foodborne danger.

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	365392	A. Building B. Wing	04/12/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review, interview, and review of policy and procedure, the facility failed to ensure accurate documentation of a resident's weight in the medical record. This affected one resident (#107) of three residents (#41, #114, and #107) reviewed for nutrition. The facility census was 110. Findings include: Review of the medical record for Resident #107 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, diabetes mellitus with diabetic nephropathy, protein-calorie malnutrition, and dementia with behavioral disturbance. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #107 had impaired cognition, weighed 175 pounds (lbs.), had no significant weight changes, and did not receive a specialized diet. Review of the weights and vitals summary for Resident #107 revealed: 08/23/23 174.4 lbs. on standup scale 10/01/23 172.3 lbs. on standup scale 12/15/23 176.2 lbs. while in wheelchair 01/17/24 175.2 lbs. on standup scale 02/08/24 174.7 lbs. while in wheelchair 03/07/24 173.6 lbs. on standup scale 03/09/24 173.6 lbs. while in wheelchair 03/22/24 175.0 lbs. using a mechanical lift scale 03/24/24 174.2 lbs. while in wheelchair 03/26/24 127.7 lbs. using Hoyer (mechanical lift scale) 04/05/24 126.4 lbs. while in wheelchair Interview on 04/11/24 at 5:12 P.M. with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #436 revealed Resident #107 had always been thin and never a huge guy. LPN #436 stated the weight of 170 lbs. were most likely inaccurate and that the resident ate 50-100 % of his meals. DON stated Resident #107's son was a physician who visited often and had no concerns. (continued on next page)

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	365392	A. Building B. Wing	04/12/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/12/24 at 11:11 A.M. with the DON and Registered Dietitian (RD) #541 stated Resident #107 had a large wheelchair that weighed 40.8 lbs. and that the documented weights dated 08/23/23 through 03/24/24 included the wheelchair weights. DON stated the resident was always weighed in his wheelchair and the documented methods of weighing Resident #107 standing or using the mechanical lift were also inaccurate. DON stated the resident did not require the use of the mechanical life. DON and RD #541 stated Resident #107 weight had been consistent with no significant weight changes and had not appeared with any significant weight changes. RD #541 stated the resident had a recent hospitalization and had some weight loss but had a gained. RD #541 stated Resident #107 was reweighed today at 131 lbs. Reviewed policy Charting and Documentation revised July 2017 revealed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.