STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365432	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diplomat Healthcare	9001 W 130th St North Royalton, OH 44133

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on family and staff interview, medical record review, and facility policy review, the facility failed to timely notify Resident #67's representative of a change in condition. This affected one (Resident #67) of three residents reviewed for change in condition. The facility census was 101. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE] and diagnoses included senile degeneration of the brain and dementia with agitation. Resident #67 was on hospice services for senile degeneration of the brain. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was rarely understood or understands and was unable to participate in cognitive assessment. Review of the nursing progress note dated 11/21/24 at 7:39 A.M. revealed during incontinence care at approximately 12:30 A.M., a caregiver observed Resident #67's left upper arm to be very flaccid (soft and hanging loosely or limply). There was no redness or bruising noted at this time. Resident #67 vocalized pain and had a noted grimace. LPN #279 notified the nighttime supervisor and was advised to notify hospice of current condition. LPN #279 called hospice and was given order to treat for pain and monitor condition. There was no evidence Resident #67's representative was notified of the change in condition on 11/21/24 by the facility staff. Review of the Hospice Coordination Note Report dated 11/21/24 revealed Licensed Practical Nurse (LPN) #279 called hospice on call service on 11/21/24 at 12:15 A.M. and reported Resident #67's left upper arm appeared displaced. LPN #279 indicated Resident #67 was normally very contracted but tonight the arm flopped open. There was no reported bruising or swelling. LPN #279 reported Resident #67 often yelled out and she was unable to determine if in pain. The on-call Hospice LPN #404 was notified. The Hospice Coordination Note Report dated 11/21/24 authored by Hospice LPN #404 revealed LPN #279 reported Resident #67's left arm was limp and loose, had facial grimacing, and yelling out when touched. LPN #279 indicated Resident #67's baseline was tense and contracted arms. LPN #279 indicated she believed Resident #67's left arm/shoulder was dislocated and reported no fall or trauma. Hospice physician contacted and gave order for left shoulder and upper arm x-ray. It was noted Resident #67's wife was not notified due to late hour. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Diplomat Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9001 W 130th St North Royalton, OH 44133	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospice Coordination Note dated 11/21/24 revealed Hospice LPN #402 visited Resident #67 as follow up to on-call report. Hospice LPN #402 observed Resident #67's left arm was lying along his left side with palm at waist/hip area. Hospice LPN #402 attempted to call Resident #67's wife but was unable to reach her. Hospice LPN #402 reached Resident #67's wife at 5:30 P.M. Resident #67's wife was unaware of what had happened to Resident #67's arm. Resident #67's wife was noted to be upset and planned to visit the facility the next morning. Review of the nursing progress note dated 11/26/24 at 3:05 P.M. by Assistant Director of Nursing (ADON) #223 revealed Resident #67's hospice nurse was in to visit Resident #67. Hospice nurse believed Resident #67 was in pain to left upper extremity and ordered an x-ray to be completed. Resident #67's wife was updated at this time. Review of the physician's order dated 11/26/24 revealed Resident #67 to have an immediate (STAT) x-ray of left arm for swelling and bruising. Results should be reported to hospice. Review of the Radiology Report dated 11/26/24 revealed Resident #67 had two view x-ray to left humerus. X-ray results were an angulated mid humerus fracture with soft tissue swelling. Telephone interview on 12/03/24 at 4:21 P.M. with Resident #67's wife via phone confirmed she had not been notified of the change Resident #67's arm on 11/21/24. Resident #67's wife indicated she was not notified of the change by the facility until 11/26/24 when the x-ray was ordered. Interview on 12/10/24 at 4:58 P.M. with Director of Nursing (DON) confirmed there was no evidence in the medical record to suggest Resident #67's wife/responsible party was notified on 11/21/24 when a change in condition was identified for Resident #67. Review of the facility policy titled Resident Change in Condition dated 06/27/24 revealed when a resident has a change in condition, the family/responsible party would be notified as soon as the resident was stable. Family/Responsible Party would be notified when there was an injury, incident, or need to change the medical treatment. This deficiency represents non-compliance investigated under Complaint Number OH00160241.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, family, resident, and staff interview, record review and review of the facility policy, the facility failed to ensure a clean environment free of consistent foul odors for the residents. This affected two (Residents #5 and #39) of three resident reviewed for incontinence care. The facility census was 101. Findings include: 1. Record review for Resident #5 revealed an admitted [DATE]. Diagnoses included bipolar type schizoaffective disorder and dementia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was moderately cognitively impaired. Resident #5 was dependent on staff for toileting hygiene and for personal hygiene. Resident #5 was always incontinent of bowel and bladder. Observation and interview on 12/09/24 at 11:44 A.M. revealed Resident #5 was lying on the mattress on the floor. Resident #5's room had a foul odor of urine. Resident #5's family member was visiting and verified the odor. Resident #5 did not respond appropriately to questions. Observation and interview on 12/09/24 at 11:59 A.M. with Certified Nursing Assistant (CNA) #282 stated she recently changed Resident #5's brief. Observation with CNA #282 revealed Resident #5's brief he was wearing was dry. Observation revealed a saturated brief behind Resident #5's entrance door. CNA #282 verified the brief was saturated with urine lying on the floor. CNA #282 stated the soiled brief was from the previous shift. CNA #282 verified the strong foul urine odor in the room and stated, It [the soiled brief] was that way since start of my shift. CNA #282 stated she started her shift at 6:30 A.M. 2. Record review for Resident #39 revealed an admitted [DATE]. Diagnoses included encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg above knee, and generalized muscle weakness. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact. Resident #39 had no behaviors, and was frequently incontinent of bowel, required partial/moderate assistance from staff with chair/bed transfers and with toilet transfer. Interview and observation on 12/10/24 at 8:20 A.M. with CNA #290 verified as approached Resident #39's room, a foul stool odor was lingering from Resident #39's room into the hall. After entering Resident #39's room, observation revealed a soiled brief with stool inside the trash can against the wall. The liner of the trash can had visible stool. On the floor near the trash can, there was a smear of stool with stool particles. CNA #290 stated she started her shift at 6:30 A.M. and Resident #290's room was like that a lot when she came in for her shift. CNA #290 stated the night shift does not do their job. CNA #290 stated Resident #39 could not have changed himself and put the brief there. Resident #39 stated he had a bowel movement during the night, the night shift CNA changed him during the night, and left the soiled brief in his room. Resident #39 stated the odor bothered him. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diplomat Healthcare	9001 W 130th St North Royalton, OH 44133

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/10/24 at 12:20 P.M. with the Director of Nursing (DON) stated soiled briefs should be disposed of and removed from residents room at the time the care was provided. Any spills should also be cleaned at that time. Review of the facility policy titled General/Routine Environmental Cleaning and Disinfection Policy revised 06/28/24 revealed household surfaces should be cleaned on a regular basis, when spills occur, and when surfaces are visibly soiled (floors, tabletops, resident care areas, etc). This was an incidental finding during the course of the complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on staff interview, review of the facilities Self-Reported Incidents (SRI) and investigations, review of policy, and medical record review, the facility failed to timely report an injury of unknown origin to the State Survey Agency and failed to complete self-report incident investigations within five days of the required timeline. This affected two (Residents #67 and #78) of seven residents reviewed for abuse. The facility census was 101. Findings include: 1. Review of the medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included senile degeneration of the brain and dementia with agitation. Resident #67 was on hospice services for senile degeneration of the brain. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was rarely understood and was unable to participate in cognitive assessment. Resident #67 was dependent on staff for toileting hygiene, bed mobility, dressing, and transfers. Review of the nursing progress note dated 11/21/24 at 7:39 A.M. revealed during incontinence care at approximately 12:30 A.M., a caregiver observed Resident #67's left upper arm to be very flaccid (soft and hanging loosely or limply). There was no redness or bruising noted at this time. Resident #67 vocalized pain and had a noted grimace. Licensed Practical Nurse (LPN) #279 notified the nighttime supervisor and was advised to notify hospice of current condition. LPN #279 called hospice and was given order to treat for pain and monitor condition. Further review of the facilities' electronic and paper medical records for Resident #67 revealed there was no evidence of follow-up to Resident #67's arm becoming flaccid from 11/21/24 until 11/26/24. There was no evidence of any falls or accidents recorded for Resident #67. Resident #67's last fall was on 11/01/24. Review of the Hospice Coordination Note Report dated 11/21/24 revealed LPN #279 called hospice on call service on 11/21/24 at 12:15 A.M. and reported Resident #67's left upper arm appeared displaced. LPN #279 indicated Resident #67 was normally very contracted but tonight the arm flopped open. There was no reported bruising or swelling. LPN #279 reported Resident #67 often yelled out and she was unable to determine if in pain. The on-call Hospice LPN #404 was notified. The Hospice Coordination Note Report dated 11/21/24 authored by Hospice LPN #404 revealed LPN #279 reported Resident #67's left arm was limp and loose, had facial grimacing, and yelling out when touched. LPN #279 indicated Resident #67's baseline was tense and contracted arms. LPN #279 indicated she believed Resident #67's left arm/shoulder was dislocated and reported no fall or trauma. Review of the nursing progress note dated 11/26/24 at 3:05 P.M. by Assistant Director of Nursing (ADON) #223 revealed Resident #67's hospice nurse was in to visit Resident #67. Hospice nurse believed Resident #67 was in pain to left upper extremity and ordered an x-ray to be completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365432	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diplomat Healthcare	9001 W 130th St North Royalton, OH 44133

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician's order dated 11/26/24 revealed Resident #67 to have an immediate (STAT) x-ray of left arm for swelling and bruising. Review of the Radiology Report dated 11/26/24 at 8:01 P.M. revealed Resident #67 had two view x-rays to left humerus. X-ray results were 32.5 degree angulated mid humerus fracture with soft tissue swelling. Review of the SRI control number 254520 revealed the facility reported an injury of unknown source for Resident #67 to the State Survey Agency on 11/26/24 at 9:49 P.M. The facility's SRI investigation started on 11/26/24 revealed there was no evidence the progress note LPN #279 authored on 11/21/24 where Resident #67's left arm was found flaccid from a normally contracted position was addressed as an injury of unknown origin in the investigation. Review of the interdisciplinary team (IDT) progress note dated 11/27/24 at 11:51 A.M. revealed Resident #67 was reviewed for left humeral fracture as an injury of unknown origin. Interview on 12/10/24 at 10:47 A.M. with the Director of Nursing (DON) confirmed the self-reported incident for injury of unknown origin for Resident #67's left arm was not opened until 11/26/24 when x-ray results showed a humeral fracture. DON confirmed the SRI was not opened on 11/21/24 when Resident #67 first showed signs of an unexplained change in condition. 2. Review of the medical record for Resident #78 revealed an admitted [DATE] and diagnoses including Alzheimer's disease, dementia with behavioral disturbance, and impulse disorder. Resident #78 was scored 0.0 on Brief Interview for Mental Status (BIMS) assessment indicating severe cognitive impairment. Review of self-reported incident (SRI) investigation dated 10/14/24 revealed Resident #78 was involved in a verbal altercation with a visitor. There were no sustained injuries or psychosocial outcomes. Review of SRIs submitted to the Ohio Department of Health's Enhanced Information Dissemination Collection System (EIDC) (a database used for facilities to report required incidents of abuse, neglect, injuries of unknown origin, and misappropriation) revealed SRI #252959 was initiated on 10/14/24 and completed on 10/22/24. This was beyond five working days of the initial incident. Interview on 12/10/24 at 2:14 P.M. with Assistant Administrator #264 revealed submission of SRI #252959 had been an oversight due to a busy schedule. Assistant Administrator #264 confirmed SRI #252959 was initiated on 10/14/24 and completed on 10/22/24. Review of the facility policy titled Ohio Resident Abuse Policy dated 07/11/24 revealed an investigation of an abuse allegation which by definition included injury of unknown origin would be completed within five working days from the alleged occurrence. All allegations of abuse or injuries of unknown origin must be reported immediately to the Administrator, Director of Nursing, and applicable State Agency. The investigation must be completed within five working days from the alleged occurrence. This deficiency represents non-compliance investigated under Complaint Number OH00160241.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on staff interview, review of facility self-reported incident (SRI) investigation, review of facility policy, hospice record review, and medical record review, the facility failed to thoroughly investigate a resident's injury of unknown origin. This affected one (Resident #67) of seven residents reviewed for abuse. The facility census was 101. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included senile degeneration of the brain and dementia with agitation. Resident #67 was on hospice services for senile degeneration of the brain. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was rarely understood and was unable to participate in cognitive assessment. Resident #67 was dependent on staff for toileting hygiene, bed mobility, dressing, and transfers. Review of the nursing progress note dated 11/21/24 at 7:39 A.M. revealed during incontinence care at approximately 12:30 A.M., a caregiver observed Resident #67's left upper arm to be very flaccid (soft and hanging loosely or limply). There was no redness or bruising noted at this time. Resident #67 vocalized pain and had a noted grimace. Review of the Hospice Coordination Note Report dated 11/21/24 revealed Licensed Practical Nurse (LPN) #279 called hospice on call service on 11/21/24 at 12:15 A.M. and reported Resident #67's left upper arm appeared displaced. LPN #279 indicated Resident #67 was normally very contracted but tonight the arm flopped open. There was no reported bruising or swelling. LPN #279 reported Resident #67 often yelled out and she was unable to determine if in pain. The on-call Hospice LPN #404 was notified. The Hospice Coordination Note Report dated 11/21/24 authored by Hospice LPN #404 revealed LPN #279 reported Resident #67's left arm was limp and loose, had facial grimacing, and yelling out when touched. LPN #279 indicated Resident #67's baseline was tense and contracted arms. LPN #279 indicated she believed Resident #67's left arm/shoulder was dislocated and reported no fall or trauma. Hospice physician contacted and gave order for left shoulder and upper arm x-ray. Review of the nursing progress note dated 11/26/24 at 3:05 P.M. by Assistant Director of Nursing (ADON) #223 revealed Resident #67's hospice nurse was in to visit Resident #67. Hospice nurse believed Resident #67 was in pain to left upper extremity and ordered an x-ray to be completed. Review of physician's order dated 11/26/24 revealed Resident #67 to have an immediate (STAT) x-ray of left arm for swelling and bruising. Review of the Radiology Report dated 11/26/24 at 8:01 P.M. revealed Resident #67 had two view x-rays to left humerus. X-ray results were 32.5 degree angulated mid humerus fracture with soft tissue swelling. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Diplomat Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9001 W 130th St North Royalton, OH 44133	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the SRI control number 254520 revealed the facility reported an injury of unknown source for Resident #67 to the State Survey Agency on 11/26/24. Review of the facility's SRI investigation started on 11/26/24 revealed there was no evidence of hospice records located in the investigation. There was no evidence the progress note LPN #279 authored on 11/21/24 where Resident #67's left arm was found flaccid from a normally contracted position was addressed in the investigation. There was no evidence of witness interviews completed related to the findings on 11/21/24. Interview on 12/10/24 at 10:47 A.M. with the Director of Nursing (DON) confirmed the facility did not complete a thorough investigation into Resident #67's injury of unknown origin. The DON confirmed the information from 11/21/24 was omitted, there were no hospice notes included in the facilities investigation, and there were no witness statements obtained related to Resident #67's change in condition on 11/21/24. Review of the facility policy titled Ohio Resident Abuse Policy dated 07/11/24 revealed an investigation of an abuse allegation which by definition included injury of unknown origin would be completed within five working days from the alleged occurrence. The investigation would include interviewing all witnesses, obtaining statements from each witness, and obtaining all medical reports and statements. Evidence of the investigation should be documented. All evidence should be analyzed to make a determination of the probable source of the injury of unknown origin. This deficiency represents non-compliance investigated under Complaint Number OH00160241.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on observation, record review, review of hospice notes, review of a facility self-reported incident, review of hospital records, facility policy review and interview, the facility failed to provide adequate, necessary and timely treatment for Resident #67, a resident with cognitive impairment who was dependent on staff for activities of daily living, following an acute change in condition. The facility also failed to thoroughly investigate the change in condition to determine the circumstances surrounding the change. Actual Harm occurred beginning on 11/21/24 when Licensed Practical Nurse (LPN) #279 observed Resident #67's normally contracted left arm to be flaccid with increased pain noted. There was no evidence a hospice-ordered x-ray examination was completed on 11/21/24. Resident #67 had not been re-assessed or his change in condition addressed until 11/26/24 (five days later) when a visiting hospice nurse identified the resident had continued pain and bruising to the left arm and inquired about the delay in obtaining the ordered x-ray examination. An x-ray completed on 11/26/24 identified a left humerus fracture. The resident was transported to the hospital for additional evaluation and treatment. This affected one Resident (#67) of three residents reviewed for changes in condition. The facility census was 101. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses including senile degeneration of the brain, dementia with agitation, reduced mobility, age related osteoporosis, and muscle wasting and atrophy. Resident #67 was on hospice services for senile degeneration of the brain. Review of a physician's order dated 04/18/24 revealed Resident #67 had an order for Oxycodone (treats moderate to severe pain) 10 milligram (mg) every four hours as needed (PRN) for pain. The resident also had a physician's order dated 06/10/24 for Acetaminophen 325 mg two tablets every six hours PRN and Acetaminophen 650 mg suppository one time per day PRN (not exceed three grams of Acetaminophen in a 24-hour period from all sources). A physician's order dated 09/20/24 revealed Resident #67 had order for Morphine (treats severe pain) 10 mg PRN every two hours for pain. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was rarely understood or able to understand and was unable to participate in cognitive assessment. Resident #67 had unclear speech, short and long-term memory problems, and severely impaired decision making. Resident #67 was dependent on staff for toileting hygiene, bed mobility, dressing, and transfers. Resident #67 was noted to have functional limitations in range of motion to all four of his extremities. Record review revealed a physician's order dated 10/17/24 for Oxycodone 10 mg every six hours for pain. Review of a Certified Nurse Practitioner (CNP) progress note dated 11/11/24 revealed Resident #67 was at baseline for mentation and known to yell out intermittently. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a Hospice Client Episode Coordination Note dated 11/20/24 revealed Hospice Registered Nurse (RN) #403 visited Resident #67. Hospice RN #403 noted Resident #67 leaned in bed to the right side. Hospice RN #403 noted having to reposition Resident #67 several times. Hospice RN #403 reported Resident #67 was yelling out during the visit. It was noted Resident #67 had a healing laceration to right forehead from a fall approximately three weeks prior. The note revealed Resident #67's upper and lower extremities were stiff and contracted with pain during movement. Review of a nursing progress note dated 11/21/24 at 7:39 A.M. by Licensed Practical Nurse (LPN) #279 revealed during incontinence care at approximately 12:30 A.M., a caregiver observed Resident #67's left upper arm to be very flaccid (soft and hanging loosely or limply). There was no redness or bruising noted at this time. Resident #67 vocalized pain and had a noted grimace. LPN #279 notified the nighttime supervisor and was advised to notify the hospice provider of Resident #67's current condition (this was noted to be an acute change in condition (from contracted and stiff to flaccid). LPN #279 called hospice and received an order to treat the resident for pain and monitor the resident's condition. It was noted a hospice nurse would come in to see Resident #67 in the morning. LPN #279 medicated Resident #67 with as needed pain medications and medications were noted to be effective. The note included LPN #279 noted Resident #67's arm had no bruising or redness at the end of her shift. LPN #279 indicated Resident #67's condition was shared with the oncoming nurse. Review of a Hospice Coordination Note Report dated 11/21/24 revealed Licensed Practical Nurse (LPN) #279 called hospice on call service on 11/21/24 at 12:15 A.M. and reported Resident #67's left upper arm appeared displaced. LPN #279 indicated Resident #67 was normally very contracted but tonight the arm flopped open. There was no reported bruising or swelling. LPN #279 reported Resident #67 often yelled out and she was unable to determine if in pain. The on-call Hospice LPN #404 was notified. The Hospice Coordination Note Report dated 11/21/24 authored by Hospice LPN #404 revealed LPN #279 reported Resident #67's left arm was limp and loose, the resident had facial grimacing and yelling out when touched. LPN #279 indicated Resident #67's baseline was tense and contracted arms. LPN #279 indicated she believed Resident #67's left arm/shoulder was dislocated and reported no fall or trauma. Hospice physician contacted and gave order for left shoulder and upper arm x-ray. It was noted Resident #67's wife was not notified due to late hour. The Hospice Coordination note dated 11/21/24 revealed LPN #279 called hospice on call service on 11/21/24 at 5:25 A.M. and reported as needed pain medication was effective for Resident #67. The Hospice Coordination Note dated 11/21/24 revealed Hospice LPN #402 visited Resident #67 as follow-up to on-call report. Resident #67 was found in bed leaning towards the right side. Resident #67 did not wake to verbal or touch stimuli. Resident #67 was noted to be pale and open mouth breathing with snoring. Hospice LPN #402 observed Resident #67's left arm was lying along his left side with palm at waist/hip area. Hospice LPN #402 noted Resident #67's baseline was bilateral upper and lower extremity contractures. Resident #67's arms would normally be bent at elbows and tightly pressed across chest. Hospice LPN #402 discussed findings with LPN #224. LPN #224 indicated she was unaware of the change in condition or order for x-ray. Hospice LPN #402 returned to room and talked with Certified Nursing Assistant (CNA) #263. CNA #263 reported she had heard about Resident #67's arm becoming loose and asked if care could still be provided. Hospice LPN #402 instructed to be gentle and limit movement to left side. Hospice LPN #402 attempted to call Resident #67's wife but was unable to reach her. Hospice LPN #402 noted being unable to locate LPN #224 upon departure and left a written note encouraging comfort for Resident #67 and to notify hospice when x-ray results were obtained. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER: Diplomat Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 9001 W 130th St North Royalton, OH 44133	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for November 2024 revealed Resident #67 received PRN Morphine on 11/20/24 at 5:47 P.M., 11/21/24 at 1:01 P.M., 11/22/24 at 12:48 P.M. and 7:10 P.M., 11/23/24 at 6:38 P.M., 11/24/24 at 11:23 A.M. and 7:26 P.M., and 11/25/24 at 10:11 P.M. Pain was noted to range from a rating of six to 10 on a zero to 10 scale (zero being no pain and 10 being the worst possible pain). Resident #67 received routine Oxycodone. There was no administration of PRN Acetaminophen. Resident #67 received PRN Ativan on 11/20/24 at 5:47 P.M., 11/23/23 at 6:38 P.M., and 11/24/24 at 7:25 P. M. for behavior issues including yelling, moaning, and combativeness with care. Resident #67 received PRN Oxycodone on 11/21/24 at 12:23 A.M. Further review of the resident's electronic and paper medical records for Resident #67 revealed there was no evidence of follow up monitoring/assessment/treatment by facility staff to Resident #67's arm becoming flaccid from 11/21/24 until 11/26/24. The Hospice Coordination Note dated 11/26/24 at 8:50 A.M. revealed Hospice LPN #402 visited Resident #67. Hospice LPN #402 observed Resident #67's left arm to be yellow and swollen from the shoulder to past the elbow. Resident #67 grimaced in pain when touched and was yelling out with a distressed facial appearance. Hospice LPN #402 discussed with LPN #261 and found an x-ray had not been completed. Hospice LPN #402 wrote an order for x-ray to left arm with two views. Review of the nursing progress note dated 11/26/24 at 3:05 P.M. by Assistant Director of Nursing (ADON) #223 revealed Resident #67's hospice nurse was in to visit Resident #67. Hospice nurse believed Resident #67 was in pain to left upper extremity and ordered an x-ray to be completed. Resident #67's wife was updated at this time. Review of the physician's order dated 11/26/24 revealed Resident #67 to have an immediate (STAT) x-ray of left arm for swelling and bruising. Results should be reported to hospice. The Hospice Coordination Note dated 11/26/24 revealed Hospice Licensed Social Worker (LSW) #400 visited Resident #67 on 11/25/24 at 4:20 P.M. Hospice LSW #400 noted Resident #67 making a yelling noise during visit. Hospice LSW #400 contacted Resident #67's wife. Resident #67's wife reported his arm used to be contracted but now it was loose and hanging down. Resident #67's wife reported an x-ray was supposed to be done last week; however, she had not gotten any results. The Hospice Coordination Note dated 11/26/24 revealed LPN #211 called hospice on-call service on 11/26/24 at 7:37 P.M. and reported Resident #67 had a severely fractured left arm after a fall. Resident #67 had been medicated with Oxycodone 10 mg but was still yelling in pain. Review of Radiology Report dated 11/26/24 at 8:01 P.M. revealed Resident #67 had two-view x-ray examination to left humerus. X-ray examination report revealed a 32.5 degree angulated mid humerus fracture with soft tissue swelling. Review of a facility Self-Reported Incident (SRI), tracking number 254520 revealed the facility reported an injury of unknown source for Resident #67 to the State agency on 11/26/24 at 9:49 P.M. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Focused Head to Toe Observation form dated 11/26/24 at 10:15 P.M. revealed Resident #67 had a left humerus fracture. Resident #67 was aphasic but responded to intense pain stimuli. The resident was noted to have bilateral upper and lower extremity contractures. There was noted bruising to the left upper extremity. Resident #67 was unable to verbalize pain; however, non-verbal pain symptoms were noted as behaviors, facial expressions, and non-verbal vocal sounds. Review of an Event Report dated 11/26/24 dated 10:33 P.M revealed Resident #67 had an injury of unknown origin. Resident #67 was in pain and an x-ray of his left arm showed a left humerus fracture. Resident #67 was unable to provide a description of the event. Resident #67 was yelling out when moved for care. Review of a nursing progress note dated 11/26/24 at 11:51 P.M. by LPN #211 revealed x-ray results had returned and revealed Resident #67 had an angulated mid humerus fracture to his left arm. LPN #211 notified the resident's hospice provider, wife, and nurse practitioner. The nurse practitioner gave an order to send Resident #67 to hospital in the morning so as not to upset Resident #67 late at night. Resident #67 was given pain medication and was noted to be resting comfortably. Review of Nursing Home to Hospital Transfer Form dated 11/26/24 revealed Resident #67 was transferred to hospital for left humerus fracture. The nurse was unable to assess the resident's pain level. Resident #67 required further evaluation of the left humerus fracture and was on comfort care. Resident #67 was alert but disoriented and unable to follow simple instructions. The Hospice Coordination Note dated 11/26/24 at 12:00 A.M. authored by Hospice LPN #401 revealed the hospice on-call service was notified by LPN #211 of Resident #67's x-ray results. It was noted Resident #67 had a fracture of left arm with increased pain and anxiety. LPN #211 indicated a fall had happened over a month ago and there had been multiple delays in obtaining the x-ray. It was noted LPN #211 implied the x-ray was not obtained as hospice had declined it however there was an order received from hospice physician for an x-ray. The Hospice physician requested the actual results report be sent for review. LPN #211 indicated she was going to send Resident #67 to the emergency room in the morning per the facility Nurse Practitioner. The hospice physician agreed after reviewing the x-ray results. Review of the nursing progress note dated 11/27/24 at 6:51 A.M. by LPN #211 revealed there was an issue with transport for Resident #67 to the hospital. Transport was re-scheduled for between 8:00 A.M. and 8:30 A.M. Review of nursing progress note dated 11/27/24 at 8:45 A.M. by LPN #222 revealed Resident #67 was transported to hospital via transport services. Review of interdisciplinary team (IDT) progress note dated 11/27/24 at 11:51 A.M. revealed Resident #67 was reviewed for a left humeral fracture as an injury of unknown origin. Resident #67 had an order for non-weight bearing status and was sent to emergency room for further evaluation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of hospital Final Report for x-ray of left humerus and left forearm dated 11/27/24 at 10:25 A.M. revealed an acute fracture of the proximal humeral shaft, acute fracture along the posterior margin of the humeral head, and posterior supervisor dislocation of the humeral head in relation to the glenoid fossa. There was soft tissue swelling along the upper arm and shoulder. The hospital record included Resident #67 was found on the floor at the nursing home. Resident #67 arrived at hospital in makeshift splint with contractures and known left humerus fracture. Resident #67 was unresponsive. The Hospice Coordination Note dated 11/27/24 authored by Hospice RN #403 revealed Resident #67 remained at hospital as of 4:00 P.M. Orthopedic physician indicated Resident #67's arm would not have surgical interventions or casting. Resident #67's arm would be placed in sling. Review of Resident #67's hospital Emergency Department Discharge Instructions dated 11/27/24 revealed an order to keep the sling in place, give Morphine every two hours as needed for pain, and continue hospice care. The Hospice Coordination Note dated 11/27/24 at 6:12 P.M. revealed Hospice LPN #401 visited Resident #67 who was yelling and anxious, speech nonsensical, and unable to make needs known. Resident #67 had returned to the facility at approximately 6:00 P.M. from the hospital with left arm in a sling. Assessment of Resident #67's arm revealed his left arm was immobile, flaccid, and slightly swollen near shoulder. Resident #67 flinched when touched. Review of nursing progress note dated 11/27/24 at 6:36 P.M. by LPN #222 revealed Resident #67 returned from the hospital. Resident #67 wore a sling to the left arm related to the humeral fracture. Resident #67 returned with orders for continued pain control. Review of the Weekly Observation Assessment form dated 11/28/24 revealed Resident #67 had bruising to left upper arm. Telephone interview on 12/03/24 at 2:00 P.M. with LPN #211 revealed when she arrived for work on 11/26/24 there were x-ray results for Resident #67. LPN #211 indicated was unaware of what had happened to Resident #67's arm. She reported being told by the Certified Nursing Assistants (CNAs) when they moved the resident's arm, it seemed like it hurt Resident #67. LPN #211 noted Resident #67 did have a fall at the beginning of November 2024. LPN #211 indicated there had not been any other incidents to her knowledge since last fall on 11/01/24. LPN #211 noted Resident #67 could be difficult to care for due to contractures making it hard to turn and reposition him. Telephone interview on 12/03/24 at 2:38 P.M. with LPN #279 revealed on 11/21/24, CNA #296 came to her and reported something was wrong with Resident #67's arm. LPN #279 stated she observed the arm in the way it was written in her progress note as very flaccid. LPN #279 stated Resident #67's arm was usually contracted. LPN #279 stated there was no bruising or redness. LPN #279 noted no reported trauma or falls to suggest injury. LPN #279 stated she did not remember any other information about the situation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Telephone interview on 12/03/24 at 3:05 P.M. with Hospice LPN #402 revealed on 11/21/24 the hospice on-call service was notified of a change in Resident #67's arm and an x-ray was ordered. Hospice LPN #402 indicated she did a follow up visit on 11/21/24 and noted Resident #67's left arm to be laying at his left side. Hospice LPN #402 indicated she spoke to the nurse on duty and was told she knew nothing about an x-ray for Resident #67 and she was too busy at the time to look further into it. Hospice LPN #402 stated she returned on 11/26/24 and noted Resident #67's arm had swollen and was yellow. Hospice LPN #402 stated there was knot/lump at his shoulder. Hospice LPN #402 stated she again asked about x-ray results and was told it was never ordered by hospice. Hospice LPN #402 stated this was not true and an x-ray had been ordered on 11/21/24 through on-call service. Interview on 12/03/24 at 3:38 P.M. with the Director of Nursing (DON) revealed the facility SRI investigation for injury of unknown origin revealed no additional trauma or incidents for Resident #67. The DON indicated Resident #67's fall on 11/01/24 could have contributed to the humeral fracture found on 11/26/24. The DON confirmed she had been notified on 11/21/24 when Resident #67's arm was found flaccid. The DON indicated she was told by facility nurses that hospice had only wanted to monitor and keep the resident comfortable in regard to pain. The DON indicated she was unaware of an order for x-ray on 11/21/24. The DON indicated Resident #67 was frequently on the facility pain monitoring report prior to the incident and did not notice any changes or new patterns on report. Telephone interview on 12/03/24 at 4:50 P.M. with CNA #296 revealed on 11/21/24 at approximately 12:00 P. M. she had gone into Resident #67's room to provide incontinence care. CNA #296 noted Resident #67 was making his normal noises when she entered the room. CNA #296 stated she attempted to remove Resident #67's t-shirt and he screamed. CNA #296 stated this startled her but Resident #67 had stopped screaming so she continued with care. CNA #296 indicated she took the shirt off him without additional screaming and provided incontinence care. CNA #296 stated she then tried to put a gown on him and grabbed his left arm by the elbow. CNA #296 stated Resident #67's left arm was like a noodle at this time so she set it down on the bed covered Resident #67 and went to get the nurse. CNA #296 did not report any trauma or incidents involving Resident #67 during care or her shift. CNA #296 denied any rough care for Resident #67. Observation on 12/09/24 at 11:56 A.M. revealed Resident #67 lying in bed, positioned on his back. His eyes were open and he was heard making groaning noises repeatedly. The resident did not look at the surveyor or answer any questions when asked. Telephone interview on 12/09/24 at 1:52 P.M. with RN #294 revealed on 11/21/24 she was the nighttime supervisor. RN #294 indicated LPN #279 had asked her to come and assess Resident #67. RN #294 indicated she did not note any bruising, redness, or swelling to Resident #67's arm. RN #294 stated she was told Resident #67 was having pain in his left arm, so she did not move his arm to check to see if it was limp. RN #294 stated she informed LPN #279 to call hospice and keep the resident comfortable. RN #294 returned to her floor and told LPN #279 to update her with any changes. RN #294 stated she was not made aware of any x-ray orders for Resident #67. Interview on 12/10/24 11:41 A.M. with LPN #224 revealed on 11/21/24 Hospice LPN #402 had asked her about an x-ray. LPN #224 stated she had not worked and did not know what had happened. LPN #224 stated she did not get a report from LPN #279 on the situation with Resident #67 at the start of her shift. LPN #224 stated an CNA had told her about Resident #67's arm. LPN #224 stated with being on the first floor during day shift a lot of people come to the nursing station so if an order was not written down or charted it would likely get lost in the shuffle. (continued on next page)

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	365432	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of facility policy Resident Change in Condition Policy dated 06/27/24 revealed a licensed nurse would recognize and intervene in the event of a change in resident condition. If the attending physician does not respond in a timely manner, then the Medical Director could be contacted for guidance and orders. The nurse would record information related to the change in condition and subsequent events and notifications in the health record. Changes in condition would be included on reports and communicated during morning meetings. This deficiency represents non-compliance investigated under Complaint Number OH00160241. This deficiency is a recite from the annual survey dated 10/10/24.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observations, staff interviews, record review, and review of the facility policy, the facility failed to ensure physician orders were implemented to promote healing of a resident's wound to his foot. This affected one (Resident #67) of three residents reviewed for wounds. The facility census was 101. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included senile degeneration of the brain, dementia with agitation, generalized muscle weakness, and muscle wasting and atrophy. Review of the annual Minimum Data Set (MDS) assessment, dated 10/14/24, revealed Resident #67 had unclear speech, was rarely/never understood or understands, and was moderately cognitively impaired. Resident #67 was dependent on staff for lower body dressing, putting on /taking off footwear, personal hygiene, and bed mobility. Review of the wound care progress note for Resident #67 dated 10/17/24 completed by Wound Care Certified Nurse Practitioner (CNP) #303 revealed Resident #67 was being seen for follow up wound care services. The lower extremities included no tenderness, no edema, mild stiffness, and grossly normal alignment. The wound location was left medial bunion and it was a skin tear. The depth was full thickness that measured 2.4 centimeters (cm) in length by 2.5 cm in width by 0.2 cm in depth. The wound base had 50% granulation, 10% slough, and 40% hyper-granulation. The wound status was improved/healing. Apply Prevalon boots (a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure). The individualized treatment plan included education was provided to nursing staff. Educated on the importance of offloading importance to promote wound healing. Review of Resident #67's physician orders dated 11/21/24 revealed a treatment to cleanse skin tear to the left bunion area with normal saline, pat dry, apply calcium alginate to wound bed, cover with small super absorbent pad, wrap with ABD and kerlix daily and as needed. The physician orders for the month of December 2024 identified orders for heel lift boots at all times as tolerated. Additional orders dated 12/03/24 included a bariatric bed with an air mattress for safety and repositioning. Review of the plan of care dated 12/05/24 revealed Resident #67 had a skin tear to the left medial bunion. The goal included the resident's skin tear will heal without complications. Interventions included recording location, size, width, depth color, surrounding skin, presence/absence of drainage, pain, and signs of healing. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 12/09/24 at 11:56 A.M. revealed Resident #67 was lying in bed on a low air loss mattress. The left outer foot was lying directly on the mattress. The low air loss mattress was beeping and the light on the device connected to the mattress revealed low pressure. The mattress appeared partially/mostly deflated. Resident #67 had his eyes open, and he was making groaning noises. Certified Nursing Assistant (CNA) #282 stated Resident #67 groaned all the time. CNA #282 stated the bed malfunctioned, and the beeping noise the bed made occurred all the time. CNA #282 stated she would shut the beeping noise off and it would just start again after a few minutes. CNA #282 stated she worked last Friday (three days prior) and the bed noise was doing it then. CNA #282 confirmed the bed was partially deflated. Observation and interview on 12/09/24 at 12:09 P.M. with Registered Nurse (RN) #247 confirmed Resident #67's mattress read low pressure. RN #247 stated she will have to call the hospice provider who provided the mattress. RN #247 stated she first noticed the malfunctioned mattress the day before and confirmed she had not notified the hospice provider yet. Observation with RN #247 confirmed Resident #67's bottom was touching the frame of the bed. There was air pushed to the top and bottom of the mattress (not fully inflated) but none in the center. Resident #67's left outer ankle wound had a dressing covering the wound and the area laying directly on the mattress. There was no pressure relieving heel boot on Resident #67's left foot. Interview on 12/09/24 at 4:13 P.M. with Licensed Practical Nurse (LPN) #230 stated the company that provided Resident #67's bed came out to look at it and said it was unfixable. The bed company will bring another mattress tomorrow. Observation of wound care and interview on 12/09/24 at 4:35 P.M. with Assistant Director of Nursing (ADON) #223 and #238 revealed Resident #67 was lying on his back. The low air loss mattress was beeping. ADON #223 stated the company was coming tomorrow (12/10/24) to fix the mattress, they came today but it was unfixable. ADON #223 verified there was air pushed to the top and bottom of the mattress (not fully inflated) but the center of the mattress was fully deflated. ADON #223 verified Resident #67 did not have the ordered heel boot on his left foot, the left leg was contracted and the wound (covered with a dressing) on the left foot was lying directly on the mattress. ADON #223 stated sometimes the facility was washing the pressure relieving heel boot. Observation and interview on 12/10/24 at 7:59 A.M. with CNA #282 verified Resident #67 did not have a heel boot on his left foot. CNA #282 stated the heel boot must be dirty or something. CAN #282 stated she started her shift at 6:30 A.M., and the heel boot was not on the left foot when she started her shift. Interview on 12/10/24 at 12:10 P.M. with Assistant Director of Nursing (ADON) #223 stated Resident #67's wound to the left bunion started as a callus over his bunion. The callus fell off on 06/06/24, then it was opened so they considered it a skin tear. Interview on 12/10/24 at 10:17 A.M. with the Director of Nursing (DON) stated if a specialized boot was ordered for a resident and was not available, the staff should have went to the therapy department to see if they had another one. Review of the facility policy titled Skin and Wound Care Best Practices, revised 11/05/24 included pressure injuries and wounds will be treated with evidence-based interventions as ordered by the provider. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00160241.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on staff interview and medical record review, the facility failed to ensure a resident received appropriate assistance during incontinence care to prevent accidents. This affected one (Resident #67) of three residents reviewed for accidents. The facility census was 101. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE] and diagnoses including senile degeneration of the brain, dementia with agitation, and muscle wasting and atrophy. Resident #67 was on hospice services for senile degeneration of the brain. Review of the plan of care initiated 06/06/23 revealed Resident #67 had the potential for falls. Interventions included two staff members for incontinence care and repositioning (added 11/01/24), get resident up in chair when restless, perimeter mattress, occupational therapy evaluation, observe frequently, and place in a supervised area when out of bed. Review of the Fall Risk assessment dated [DATE] revealed Resident #67 was at high risk for falls. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was rarely understood or understands and was unable to participate in cognitive assessment. Resident #67 had unclear speech, short- and long-term memory problems, and severely impaired decision making. Resident #67 was dependent on staff for toileting hygiene and bed mobility. Review of the Occupational Therapy Discharge Summary dated 11/01/24 revealed Resident #67 required one to two staff maximal assistance for sitting balance and total dependence on staff for activities of daily living. Review of Post Fall Huddle Form dated 11/01/24 revealed at approximately 11:15 A.M., Resident #67 was being changed by Certified Nursing Assistant (CNA) #282 and Resident #67 slipped out of her hand and rolled over onto the floor. Resident #67 first hit head then rolled onto left side. Resident #67 was unable to report what had happened. Interventions included two staff assistance and wedge pillow while turning as Resident #67 moved a lot. Review of the undated witness statement from CNA #282 revealed on 11/01/24, she provided care to Resident #67. CNA #282 stated she turned Resident #67 towards her in bed and his feet/legs began to go off the bed. CNA #282 stated she had tried to stop Resident #67 from falling but was unable. Resident #67 slid out of bed and CNA #282 got the nurse to assess. Review of the Event Report dated 11/01/24 revealed Resident #67 had a witnessed fall in his room. Resident #67 fell from the bed. Resident #67 had generalized pain of nine out of 10. Resident #67 had skin tear on head with bruising and a bump. The nurse provided direct pressure to the skin tear then applied steri strips (an adhesive strip used on minor wounds). Post fall monitoring was initiated, physician notified, and resident representative notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER: Diplomat Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 9001 W 130th St North Royalton, OH 44133	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/03/24 at 1:30 P.M. with CNA #282 confirmed Resident #67 had fallen from the bed while she was completing incontinence care. CNA #282 stated while she was completing incontinence care she had turned Resident #67 towards her in bed. CNA #282 indicated Resident #67's feet started to come out of bed and he slid out of bed. CNA #282 indicated she had tried to use her body to stop Resident #67 from falling but was unsuccessful and had to lower him to the floor. CNA #282 indicated Resident #67 had a bump on his forehead. CNA #282 stated since the incident, they have started using two people for Resident #67 during care. CNA #282 stated Resident #67 was totally dependent on staff for activities of daily living and had contracted arms and legs. CNA #282 stated when Resident #67 was turned in bed due to stiffness/contractures, his whole body drops down as one. Interview on 12/03/24 at 1:44 P.M. with Registered Nurse (RN) #247 stated she had been notified on 11/01/24 Resident #67 had a fall. RN #247 stated the CNA turned Resident #67 during incontinence care and Resident #67 fell to the floor. RN #247 stated there was a skin tear on Resident #67's forehead and she applied steri strips. This deficiency represents non-compliance investigated under Complaint Number OH00160241.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Diplomat Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9001 W 130th St North Royalton, OH 44133	

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, record review and interview, the facility failed to ensure Resident #11, who was cognitively impaired, dependent on staff for incontinence care/management and had moisture associated dermatitis (MASD) was provided necessary incontinence care to promote optimal skin integrity and prevent additional complications from the MASD. This affected one resident (#11) of three residents reviewed for incontinence care. The facility census was 101. Findings include: Record review for Resident #11 revealed an admitted [DATE] with diagnoses including cerebral infarction due to occlusion or stenosis of left middle cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following cerebral infarction, dementia, and muscle weakness. Review of the care plan for Resident #11 dated 06/06/23 revealed Resident #11 experienced bladder incontinence related to hemiplegia /hemiparesis following cerebral infarction. Interventions included to provide incontinence care after each incontinent episode. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was moderately cognitively impaired. The assessment revealed Resident #11 required substantial/maximum assistance from staff with toileting and was always incontinent of bowel and bladder. Review of a Wound Management note revealed on 11/11/24, Resident #11 was noted to have moisture associated skin damage (MASD) to the gluteal fold and bilateral buttocks, measuring 17 centimeters (cm) in length by 14.5 cm. wide. On 12/05/24, Resident #11's MASD measured 17 cm by 14 cm and the status was stable and comments included Resident #11 continued to refuse incontinence care as frequently as needed. On 12/10/24 at 8:17 A.M. Resident #11 was observed sitting up in bed. Resident #11 was covered up with a white blanket. The left side of the blanket and a portion of the sheet viewed was observed to be saturated with a yellow substance (that appeared to be urine). The resident's room also had a strong foul urine odor. An attempt to interview Resident #11 at the time of the observation revealed the resident did not respond to questions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365432	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diplomat Healthcare	9001 W 130th St North Royalton, OH 44133

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 8:20 A.M., interview with Certified Nursing Assistant (CNA) #290 revealed she started her shift on this date at 6:30 A.M. and was assigned to care for Resident #11. At the time of the interview, the CNA revealed she had not yet been in to provide incontinence care to Resident #11 (since her shift began). In addition, the CNA also voiced concerns that night shift staff did not do their job (eluding to the provision of incontinence care for Resident #11). During the interview, the CNA did not provide any information or evidence that the resident had refused incontinence care on this date, but did indicate the resident would not allow all CNAs to work with her and stated the resident did require a lot of staff time because she was so particular. CNA #290 went on to provide information for how to best work with Resident #11, an gave an example of giving her juices. An observation of Resident #11 with CNA #290 verified the left side of Resident #11's blanket was visibly soiled (due to incontinence). CNA #290 removed Resident #11's blanket, and Resident #11 had a soiled brief on. Observation revealed the sheet, and pad surrounding Resident #11's lower back, buttocks, and upper thighs were saturated with urine. The left side of the blanket was saturated with urine. Resident #11 and the room she resided in had a strong foul odor of urine. CNA #290 confirmed Resident #11 always allowed her to do care for her, she just didn't like people she didn't know. In addition, CNA #290 revealed Resident #11's bottom was sore and sometimes bled (related to incontinence). Interview on 12/10/24 at 10:17 A.M. with the Director of Nursing (DON) revealed residents were to be checked and changed every two hours and as needed. Interview on 12/10/24 at 3:52 P.M. with Assistant Director of Nursing (ADON) #223 revealed sometimes Resident #11 only wanted certain staff to change her, there were three CNAs she would regularly allow. The ADON revealed it was her expectation that staff always approached the resident for care and then were to notify the nurse if the resident refused. ADON #223 stated she told Resident #11 she needed to allow the staff to change her at least once a shift but some nurses were afraid to just tell her she needed changed when she refused. ADON #223 confirmed Resident #11 continued to have MASD to her bilateral buttocks (due to incontinence). ADON #223 confirmed effective/individualized interventions were not in place for offering Resident #223 snacks or juice to allow staff to change her when she refused. The facility did not provide any evidence Resident #11 had refused incontinence care on 12/10/24 between 6:30 A.M. and 8:20 A.M. or information as to when the resident had last been provided incontinence care by night shift staff prior to 6:30 A.M. on this date. This deficiency represents non-compliance investigated under Complaint Number OH00159770.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365432	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diplomat Healthcare	9001 W 130th St North Royalton, OH 44133

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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. 42011 Based on observation and staff interview, the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect all residents who received meals from the kitchen with the exception of one resident, Resident #63 who received nothing by mouth. The facility census was 101. Findings include: Observation on 12/10/24 at 11:33 A.M. of the kitchen area revealed the trash can in the kitchen had a swivel lid and the trash was overflowing above the lid. Food and Nutrition Aide #229 confirmed the overflowing uncovered trash can in the kitchen. Observation and interview with Dietary Manager (DM) #221 of kitchen on 12/10/24 at 11:35 A.M. revealed a tall cart across from the tray line with pudding, silverware, cups, and cereal stored on the shelves of the cart. Each of the multiple shelves, top and bottom, including the four legs had a thick scummy build up covered in thick dust particles. The kitchen floor was dirty and had multiple sticky area throughout the kitchen. Under the coffee pot was a large coffee spill on the floor. DM #221 confirmed each shelf, top and bottom (including the legs of the shelving units) that stored the clean cooking and serving items was covered with a thick, scummy substance with thick dust like particles, the kitchen floor was dirty and had sticky areas throughout the floor, the large coffee spill. DM #221 confirmed the items stored on the shelves were used for cooking food and serving the food and drinks to the residents. This was an incidental finding discovered during the course of the complaint investigation.