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	11/25/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on resident interview, medical record review, staff interview, and facility policy review, the facility failed to ensure routine care plan conferences were conducted. This affected two residents (#150 and #73) of five residents reviewed for care plan conferences. The census was 108.Findings include:1.Record review of Resident #150 revealed an admission date of 09/04/19 with diagnosis that include Parkinson's disease, schizophrenia, bipolar disorder, hypothyroidism, dementia, and muscle weakness. Review of Resident #150's Brief Interview for Mental Status (BIMS) score completed on 08/12/25 revealed a score of 0 due to resident being unable to complete assessment questions, indicating severely impaired cognition. Review of Resident #150 care plan history from 07/01/23 through 11/12/25 revealed the resident's care plan was updated on 5/23/25, 08/19/25, 09/19/25, and 10/14/25.Interview on 11/13/24 at 11:54 A.M. with Resident #150 Power of Attorney (POA) revealed she attended a care conference in March 2025 with a previous Director of Social Services but had not had one since March 2025. Resident #150's POA reported she had left messages with the new Director of Social Services but had not heard back.2. Record review of Resident #73 revealed an admission date of 07/10/25 with diagnosis that include: dementia, muscle weakness, essential hypertension, impulse disorder and insufficient sleep syndrome. Review of Resident #73's BIMS score completed on 10/15/25 revealed a score of 00 due to resident being unable to complete assessment questions, indicating severely impaired cognition. Resident #73's spouse was listed as his emergency contact and responsible party.Review of Resident #73's record revealed an admission care conference was held on 07/22/25 with Resident #73's spouse and other facility staff. Resident #73's care plan was updated on 10/22/25 but the record did not include any additional care conferences had been held.Interview on 11/13/25 at 10:07 A.M. with Director of Social Services (DSS) #421 revealed care plan meetings are held upon admission, quarterly, and whenever there is a significant change in condition. Care conferences are held with the resident, their family members, guardians, nurses, and certified nursing assistants. DSS #421 confirmed a care conference had not been held for Resident #150 and his daughter was not in attendance. Director of Social Services #421 reported she was behind on scheduling and conducting resident care conferences. DDS #421 was not aware of any missed calls from Resident #150 daughter. DDS #421 revealed Resident #73's spouse was not involved in his care conferences and that she was just the emergency contact. Review of the facility's Comprehensive Care Planning Policy dated 03/20/25 revealed the comprehensive care plan will be prepared by an interdisciplinary team that includes but is not limited to: To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representatives is determined not to be practicable for the development of the resident's care plan. This deficiency represents non-compliance investigated under Complaint Number 2656169.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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** Based on observation, interview, record review, and facility policy review, the facility failed to inform a resident's physician of ongoing medication refusals and failed to ensure resident representative were notified of changes. This affected three residents (#62, #103 and #106) of six residents reviewed for notification of change in condition. The facility census was 108.Findings include: 1.Review of Resident #62's medical records revealed an admission date of 11/07/17. Diagnoses included bipolar, psychosis and schizoaffective disorders Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 had intact cognition. Review of current physician orders for November 2025 revealed Resident #62 was ordered Risperdal (an antipsychotic) 25 milligrams/2 milliliter injection on Wednesday every two weeks. Review of Resident #62's Medication Administration Record (MAR) from October 2025 and November 2025 revealed Resident #62 had refused biweekly Risperdal injections on 10/01/25, 10/15/25, 10/29/25, and 11/12/25. Review of Resident #62's progress notes from October and November 2025 revealed no documentation related to Resident #62's medication refusals or the physician being notified of refusals. Interview on 11/18/25 at 12:20 P.M. with Licensed Practical Nurse (LPN) #402 revealed Resident #62 had been ordered Risperdal injections every two weeks. LPN #402 stated the medications were documented as being refused, however no one had told the family or the physician. Observation at time of interview revealed four boxes of single injection Risperdal with Resident #62's name on them. Interview on 11/18/25 at 1:45 P.M. with Director of Nursing (DON) confirmed if a medication had been refused the physician and resident representative should be notified. Review of Resident #62's medical records with DON at time of interview confirmed no documentation related to medication refusals had been recorded. 2. Review of Resident #103's medical records revealed an admission date of 01/11/23. Diagnoses included cognitive impairments, dementia and anxiety. Review of the MDS assessment dated [DATE] revealed Resident #103 had impaired cognition. Review of Resident #103's physician orders revealed on 10/07/25 Resident #103 was ordered Benadryl (an over the counter medication used to treat allergy symptoms and skin rash) every four hours as needed and hydrocortisone cream (a topical corticosteroid used to relieve redness, itching, and swelling from skin irritation). On 10/21/25 and 10/30/25, Resident #103 was ordered Permethin (synthetic insecticide used to treat parasitic infections including scabies). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's progress notes revealed a note dated 10/07/25 which referenced Resident #103 had redness to right and left extremities. The hospice nurse was notified and orders for Benadryl and hydrocortisone cream were received. The progress note did not include resident representative notification of the new orders. Review of a note dated 10/22/25 authored by LPN #420 revealed there was a new treatment for a skin rash. The note did not include that the resident's representative had been notified of the new orders. There was no progress notes referencing the 10/30/25 order for Permethin. Interview on 11/18/25 at 1:45 P.M. with the DON confirmed there was no evidence Resident #103's representative had been notified of the new orders. The DON reported medication changes should be discussed with the resident's representative. 3. Review of Resident #106's medical records revealed an admission date of 10/04/24. Diagnoses included dementia, Huntington's disease and restlessness. Review of the MDS assessment dated [DATE] revealed Resident #106 had no cognition score due to being rarely/never understood. Review of progress note dated 10/13/25 authored by LPN #360 revealed a new order for prednisone (steroid) for seven days for inflammation. Progress note did not include resident representative notification. Interview on 11/18/25 at 1:45 P.M. with the DON confirmed there was no evidence Resident #106's representative had been notified of the new orders. The DON reported medication changes should be discussed with the resident's representative. Review of facility policy titled Resident Change in Condition Policy reviewed 06/02/25 revealed physician/family/responsible party will be notified when there has been a need to alter a resident's medical treatment. This deficiency represents non-compliance investigated under Complaint Number 2656169.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review The facility failed to ensure medication consumption was monitored to ensure medications were safely swallowed. This affected one resident (#28) of four residents observed and reviewed for medication administration. The facility census was 108. Findings include: Review of Resident #28's medical records revealed an admission date of 06/05/15. Diagnoses included stroke with left sided weakness, muscle weakness dysphagia (difficulty swallowing) and dementia.Review of Resident #28's physician's orders revealed an order dated 05/12/23 that medications may be crushed unless contraindicated. Resident #28 additionally had an order dated 06/16/25 for acetaminophen (an over-the-counter mild pain reliever) 650 milligrams (mg) every six hours as needed for pain. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had no recorded cognition score due to the resident was rarely/never understood. Observation of wound care on 11/10/25 at 11:47 A.M. with Licensed Practical Nurse (LPN) #402, LPN/Assistant Director of Nursing (LPN/ADON) #341 and Regional Registered Nurse (RRN) #452 for Resident #28 revealed Resident #28 was expressing non-verbal complaints of pain that including withdrawing his leg and foot when his right leg was touched. At the time of observation, RRN #452 had informed LPN #402 to administer pain medication as ordered. LPN #402 had exited Resident #28's room and had returned with a cup of crushed medications mixed with applesauce that LPN #402 had indicated was the resident's as-needed acetaminophen. LPN #402 administered the crushed medication to Resident #28 and exited his room. RRN #452 had remained in the room and asked if Resident #28 had swallowed his crushed medication and RRN #452 confirmed Resident #28 had not swallowed them. RRN #452 proceeded to manually massage Resident #28's throat in order to stimulate his swallowing. RRN #452 stated LPN #402 should have stayed present to ensure medications had been swallowed prior to exiting the room. This deficiency represents non-compliance investigated under Complaint Number 2657376.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, review of hospital medical records, review of a local in-progress police report, policy review and interview, the facility failed to adequately and accurately identify and record a decline in a wound for Resident #150. This affected one resident (#150) of three residents reviewed for wounds and skin impairments. The facility census was 108. Actual Harm occurred on 10/21/25 when Resident #150 was admitted to the hospital with altered mental status, a urinary tract infection, dehydration, and malnutrition and assessed to have an unstageable pressure ulcer (a full-thickness wound where the depth of the damage cannot be determined because the wound bed is obscured by dead tissue) to the coccyx (tailbone area) that measured seven centimeters (cm) in length by eight cm in width. Resident #150's coccyx's wound was noted to have a foul odor and a moderate amount of serosanguineous drainage with 60% of the wound bed noted to have brown and black eschar (dead tissue) and the remainder was a mixture of yellow slough and red and moist wound bed. Resident #150's family declined surgical debridement and Resident #150 was admitted to palliative care. Resident #150 was hospitalized until 10/24/25, at which time he transferred to a local residential hospice facility where he later passed away on 11/02/25. Findings include:Review of Resident #150's closed medical records revealed an admission date 09/04/19 with diagnoses including Parkinsons, dementia, muscle weakness and need for personal care assistance. Resident #150 was transferred to a local hospital on [DATE] and did not return to the facility. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #150 had no cognition score due to being rarely/never understood. Resident #150 was noted to be dependent on staff for toileting, bathing, and bed mobility tasks. Review of a Braden Scale (tool used to predict a patient's risk for developing pressure ulcers) dated 10/10/25 revealed Resident #150 scored a 15 indicating he was at mild risk for developing pressure ulcers. Review of the care plan revised on 10/14/25 revealed Resident #150 was at risk for activities of daily living (ADL) decline. The care plan noted Resident #150 was dependent on staff for toileting, bathing, and bed mobility and was incontinent of bowel and bladder. Resident #150 was additionally noted to be at risk for pressure ulcer development. Listed interventions included to provide incontinence care as needed, utilize barrier cream after incontinence episodes, utilize a pressure reducing mattress, complete weekly skin evaluations, keep skin as dry and clean as possible, avoid friction to the skin, and report any signs of skin breakdown. Review of a wound progress note authored by Wound Nurse Practitioner (WNP) #450 dated 10/16/25 revealed Resident #150 was seen for moisture-associated skin dermatitis (MASD, inflammation of the skin caused by prolonged exposure to moisture) to the sacrum and bilateral buttocks. The MASD was described as partial thickness and measured six centimeters (cm) in length by six cm in width with 0.2 cm depth. The wound bed was recorded to be 70% pink and 30% epithelial with moderate serous (clear) drainage. The wound status was determined to be unchanged but referenced the resident was having large, soft stools, and noted excoriations to the right buttock. The treatment orders included to cleanse the area with normal saline, apply calcium alginate (absorbent wound dressing used for moderate to heavy drainage), and cover with a clean dry dressing daily and as needed, and to continue the current treatment for one week. There were no additional or new orders/interventions to address the large, soft stools referenced in the progress note or to ensure the resident's skin was not subjected to prolonged moisture related to the resident's incontinence. Review of a head-to-toe assessment dated [DATE] authored by Licensed Practical Nurse (LPN) #376 revealed Resident #150 had moisture-associated skin damage (MASD) to his buttocks. Review of Resident #150's progress notes revealed a note dated 10/21/25 at 11:33 A.M. authored by Licensed Practical Nurse/Assistant Director of Nursing (LPN/ADON) #341 reflected Resident #150's Power of Attorney (POA) was called regarding a change in condition. The note further referenced an unnamed Nurse Practitioner (NP) provided an order to send Resident #150 to a local emergency room for evaluation. A follow up note timed 2:16 P.M. authored by LPN #376 revealed Resident #150 had been noted to have a continual decline in cognition, was unable to answer questions or communicate needs. Resident #150 was not swallowing food, medications, and pocketing was noted. The note referenced a call was placed to an unnamed NP who ordered the resident be sent out to a local emergency room for evaluation. Review of hospital records dated 10/21/25 revealed Resident #150 was transferred to a local emergency department for evaluation. The record stated the facility noted Resident #150 had mental status changes since the night of 10/19/25 (however, the resident's medical record from the facility did not include documentation of these

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility fall investigation, emergency medical services (EMS) run report, and facility policy review, the facility failed to ensure an accurate and thorough fall investigation was completed. This affected one resident (#150) of three residents reviewed for falls. The facility census was 108.Findings include: Review of Resident #150's closed medical records revealed an admission date 09/04/19 with diagnoses including Parkinson's, dementia, muscle weakness and need for personal care assistance. Resident #150 was transferred to a local hospital on [DATE] and did not return to the facility.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #150 had no cognition score due to being rarely/never understood. Resident #150 was noted to be dependent on staff for toileting, bathing, and bed mobility tasks. Review of the care plan revised on 08/12/25 revealed Resident #150 was at risk for activities of daily living (ADL) decline. Interventions included two staff assistance with personal hygiene, bed mobility, transfers and toileting. Resident #150 was at risk for falls and interventions included keeping the bed in the lowest position with brakes locked.Review of a progress note dated 10/02/25 timed 4:06 A.M. authored by Licensed Practical Nurse (LPN) #414 revealed she had been alerted Resident #150 had fall. Upon assessment Resident #150 was observed to have had a small one inch laceration to his forehead and another small laceration on his right knee. Resident #150's heart rate was 130 beats per minute (elevated, normal range is 60-100) and oxygen saturation was 65% (low, normal range is 92-100%). On call physician was notified and Resident #150 was sent to the hospital.Review of the facility fall investigation dated 10/02/25 revealed a statement authored by Certified Nursing Assistant (CNA) #336 that stated Resident #150 was last observed at approximately 2:20 A.M. and at approximately 3:00 A.M,. Resident #150 was observed on the floor by the right side of his bed. CNA #336 had immediately notified the nurse. Review of Post Fall Huddle authored by LPN #414 revealed date of fall at 10/02/25 at 3:00 A.M. with Resident #150 last being toileted at 2:20 A.M. Review of an EMS report dated 10/01/25 revealed a call for EMS services was received at 11:44 P.M. The report noted EMS personnel arrived on scene at 11:52 P.M. The EMS narrative included a call was received for a patient who had fallen and upon EMS arrival at the facility, an unnamed nurse had met EMS personnel at the elevator and stated Resident #150 was found next to his bed two hours prior to EMS arrival. The report noted it was assumed Resident #150 had fallen. The unnamed nurse stated they had helped Resident #150 back into bed and had contacted EMS for abnormal vital signs and reported Resident #150 had a small laceration to his forehead which the nurse stated was from a prior fall. The report noted the resident was transported to a local hospital and EMS departed the scene on 10/02/25 at 12:03 A. M. Review of hospital paperwork dated 10/02/25 timed 4:30 A.M. revealed EMS had arrived to facility for a chief complaint of a fall and abnormal vital signs and EMS stated Resident #150 had a fall two hours prior. Staff had assisted Resident #150 back into bed and he had went back to sleep and staff had taken his vital signs that morning and Resident #150 was tachycardic (elevated heart rate) and hypoxic (low oxygen saturation).Telephone interview on 11/17/25 at 12:43 P.M. with Resident #150's Power of Attorney (POA) revealed she had received a call on 10/02/25 at approximately 3:45 A.M. that stated Resident #150 had fallen and was being sent to the emergency department. The POA further stated she had obtained a copy of the EMS report that stated a call was place on 10/01/25 before midnight. Interview on 11/17/25 at 3:36 P.M. with the Director of Nursing (DON) and Regional Registered Nurse (RRN) #431 confirmed fall investigation had included Resident #150 had a fall on 10/02/25 at approximately 3:00 A.M. Review of EMS run report confirmed a call was placed on 10/01/25 at 11:44 P.M. The DON and RRN #431 reported they were unable to provide an explanation of the discrepancies in time frames for when Resident #150 fell and when EMS was summoned to the facility in response to Resident #150's fall. Review of the facility policy Fall Prevention and Management Policy dated 07/07/25 revealed falls will be reviewed by an interdisciplinary team. Such reviews should include results of fall risk assessment, discussion with resident and/or any witnessing parties as to potential causal factors, review of the environment where the fall occurred, and discussion as to any new interventions which may help to prevent future falls. This deficiency represents non-compliance investigated under Complaint Number 2656169.

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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** Based on observation, interview, record review, and facility policy review, the facility failed to ensure adequate incontinence care was provided to Resident #28. This affected one resident (#28) of three residents reviewed for incontinence care. The facility census was 108. Findings include:Review of Resident #28's medical record revealed an admission date of 06/05/15. Diagnoses included stroke with left sided weakness, muscle weakness, and dementia. Review of Resident #28's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had no recorded cognition score due to resident was rarely/never understood. Resident #28 was incontinent of bowel and bladder and was dependent on staff for toileting. Review of the care plan updated 11/04/25 revealed Resident #28 was incontinent of bowel and bladder. Interventions included to assist with incontinence care as needed. Resident #28 was noted to be at risk for skin breakdown and had listed interventions to apply a skin barrier ointment after incontinence episodes. Review of Resident #28's current physician orders for November 2025 revealed an order to cleanse buttocks with soap and water and apply thick zinc barrier (barrier ointment used to form a protective barrier on the skin to shield the skin from irritants and moisture) every shift and as needed. Observation of incontinence care on 11/10/25 at 11:39 A.M. for Resident #28 with Certified Nursing Assistant (CNA) #385 revealed a large amount of dried stool to the crease of Resident #28's buttocks. Resident #28 was observed to have two bath blankets and a fitted sheet underneath him, which had large amounts of dried urine and other identifiable debris. There was an odor of urine coming from Resident #28's bed and bed linens. Interview with CNA #385 at time of observation revealed she had provided Resident #28 with incontinence care approximately one hour prior. CNA #385 reported Resident #28 had a reddened area to his buttocks and coccyx (tailbone) area at times and stated he required barrier cream to be applied after incontinence care. Observation of incontinence care at the time of interview revealed no evidence of barrier cream residue on Resident #28. CNA #385 confirmed the presence of the dried stool and confirmed she had not applied barrier cream to Resident #28 after she last provided incontinence care. CNA #385 confirmed she had not seen the soiled linens when she had previously provided incontinence care one hour prior. Review of facility policy titled Perineal Care Incontinence Care Procedure reviewed 10/30/25 revealed to turn patient on his/her side and wash the rectal area, working outward to include the buttocks. The policy additionally stated to apply a moisture barrier if care planned. This deficiency represents non-compliance investigated under Complaint Numbers 2656169, 2614362 and 2597119.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure residents were offered sufficient fluid intake to maintain proper hydration and health. This affected one resident (#150) and had the potential to affect all residents residing in the facility. The facility census was 108.Findings include: 1. Review of Resident #150's closed medical records revealed an admission date 09/04/19 with diagnoses including Parkinson's, dementia, muscle weakness and need for personal care assistance. Resident #150 was transferred to a local hospital on [DATE] and did not return to the facility. Review of the Medical Nutritional Therapy Observation dated 08/19/25 completed by Registered Dietitian (RD) #408 revealed that Resident #150's nutrition risk included dementia and potential for decreased awareness of hunger and thirst. RD #408 estimated Resident #150's fluid needs as 2040-2380 milliliters per day and that his current diet orders provided 1440 ml of fluid.Review of Resident #150 fluid intake revealed Resident #150 consumed 960 ml of fluids on 10/18/25 and 10/19/25 and consumed 650 ml of fluids on 10/20/25. Record review of Resident #150 hospital records dated 10/21/25 through 10/23/25 revealed resident was admitted to the hospital on [DATE] with sodium levels of 167 millimoles per liter (mmol/L). Resident was admitted for diagnosis that included change in mental status, acute urinary tract infection and acute hypernatremia (a condition of abnormally high sodium levels in the blood, often caused by dehydration from insufficient water intake, excessive sweating, vomiting, or diarrhea).Interview on 11/17/25 at 9:16 P.M. with the Director of Nursing (DON) and Regional Registered Nurse (RRN) #451 reviewed Resident #150's hospital laboratory results and the facility's fluid intake documentation. The DON and RRN #451 confirmed Resident #150 had decreased fluid intake on 10/18/25, 10/19/25, and 10/20/25 which could have contributed to the resident's dehydration identified at the hospital on [DATE]. 2. Observation on 11/10/25 at 4:53 P.M. revealed multiple residents were seated in the dining room. Two residents had small medication water cups but no styrofoam water cups. Continued observation at 5:01 P.M. revealed staff began to pass beverages for dinner that included milk, juice, and coffee. Interview on 11/10/25 at 5:11 P.M. with Certified Nursing Assistant (CNA) #380 revealed styrofoam cups were used to provide residents with water and were passed out to residents earlier in the day. CNA #380 guessed that styrofoam cups were probably in the resident ' s rooms. Observation on 11/17/25 at 11:44 A.M. of dining room C in the memory care unit revealed 14-15 residents were eating lunch, with only 2 residents with drinks. Continued observation at 11:46 A.M. of dining room A reveled Resident #84 and Resident #81 did not have anything to drink. Interview on 11/17/25 at 11:46 A.M. with CNA #397 confirmed Resident #84 and Resident #81 had no drinks provided to them. CNA #397 proceeded to provide the two residents with drinks after surveyor intervention. CNA #397 passed out drinks to dining room C residents at 11:51 A.M. She revealed lunch was passed out between 11:30 A.M. through 11:40 A.M. and she was not sure why residents were not provided with drinks. Observation and interviews on 11/17/25 at 11:54 A.M. revealed Resident #79 and Resident #92 had empty juice cups. Both residents reported they were still thirsty. Resident #92 said she had a water cup in the room but Resident #79 was unsure if he had a water cup.Interview on 11/17/25 at 11:56 A.M. with CNA #397 confirmed Resident #79 and Resident #92 had empty juice cups and were still thirsty. CNA #397 refilled resident ' s cups after surveyor intervention.Interview on 11/18/25 at 4:44 P.M. with the Administrator and Assistant Director of Nursing (ADON) #356 revealed the plastic cups served at meals are 8 ounce cups of water. The facility does water passes at 10:00 A.M., 2:00 P.M. and HS (hour of sleep, bed time) with styrofoam cups. The Administrator was unsure why water was not being passed out during meal times. ADON #356 stated staff should be documenting intakes based on how much water they have consumed and not just how much water a resident is provided. Observation on 11/18/25 at 5:00 P.M. of the secured unit with the DON and ADON #356 revealed the dinner beverage cart was present on the unit stocked with juice, lemonade, coffee, and milk. Observation of approximately 20 residents in dining room A revealed only 2 residents had water provided to them. Continued observation in dining room C revealed approximately 8 residents observed, all who did not have water provided to them. Review of the Resident Council meeting dated 09/09/25 and 10/07/25 revealed both meetings had complaints about water not being passed out. Review of in-servicing completed on 09/10/25 and 10/02/25 with staff revealed all staff had been re-educated that all staff were responsible for providing water to residents.Review of facility's Hydration Policy dated 06/22/20 revealed residents will be offered/administered sufficient fluid intake to maintain hydration. A variety of fluids will be

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	11/25/2025

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure laboratory results were timely obtained and results timely reported to the provider to allow for timely treatment of a urinary tract infection (UTI). This affected one resident (#12) of three residents reviewed for UTIs. The facility census was 108. Findings include: Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, atrial fibrillation, major depressive disorder, hyperlipidemia, anxiety, hypertension and malignant neoplasm of large intestine.Continued record review revealed on 09/02/25, Resident #12 was seen by the nurse practitioner for UTI symptoms and ordered Urinalysis with Culture and Sensitivity (UA C&S). UA C&S orders were not placed until 09/04/25. On 09/04/25 a urine sample was collected and the sample was sent to the lab for testing. The urinalysis showed the resident's urine was turbid in color and tested positive for nitrite, leukocytes, epithelial, white blood cells, and bacteria. The facility received the urine culture results on 09/07/25 that indicated the resident had Escherichia coli extended-spectrum beta-lactamase (ESBL, an enzyme produced by certain bacteria that makes them resistant to many common antibiotics) in the urine. Further record review revealed on 09/10/25, Assistant Director of Nursing (ADON) #356 reported final UA C&S result to the nurse practitioner and received an order for Nitrofurantoin monohyd (an antibiotic) capsule 100 milligram (mg) twice daily for 7 days. Review of Resident #12's Medical Administration Record (MAR) for September 2025 revealed the ordered Nitrofurantoin monohyd was started on 09/10/25. Resident #12 completed the medication on 09/17/25. Interview on 11/17/25 at 3:23 P.M. with the Director of Nursing (DON) revealed she would check to see what the delay in reporting the urine culture was. The DON further stated the nurses are expected to report any abnormal laboratory results as soon as possible to the physician or ordering provider.Interview on 11/17/25 at 3:26 P.M. with ADON #356 revealed she reported the results of the urine culture to the nurse practitioner on 09/10/25 when she noticed the lab result had not been reported to the nurse practitioner. She was unsure what the reason for the delay in reporting the result was. Review of the facility policy Resident Change in Condition dated 06/27/24 revealed the Physician/Provider and Resident/Family/Responsible Party will be notified when there has been a need to alter the resident's medical treatment, including a change in provider orders.This deficiency represents non-compliance investigated under Complaint Number 2657376 and 2614362.