

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 10/10/2024
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457</p> <p>Based on medical record review, facility policy review, and interview, the facility failed to ensure resident-to-resident physical altercations were reported the State Agency as required. This affected ten Residents (#28, #30, #39, #48, #57, #58, #69, #77, #85, and #357) of 39 residents who reside on the secured memory care unit. The facility census was 99.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #30 revealed an admitted [DATE] and diagnoses including Alzheimer's disease, dementia with behavioral disturbance, major depressive disorder, delusional disorders, and wandering.</p> <p>Review of the Medicare Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #30 had Brief Interview for Mental Status (BIMS) score of 99 indicating Resident #30 was unable to complete the assessment. Resident #30 had memory problems, severely impaired decision making, inattention, and disorganized thinking.</p> <p>Review of Resident #30's progress note dated [DATE] at 7:32 P.M. revealed Resident #30 was walking down hallway trying to hold the hand of Resident #357. Resident #30 was redirected several times by staff however continued to try to hold Resident #357's hand. Resident #357 grabbed Resident #30 by the neck and threw her against the wall. Resident #30 had a small bruise on left side of her head and her eye appeared a little droopy. Resident #30 was assessed by the nurse with no pain noted and neurological checks were initiated. The local police and responsible party were notified of the altercation.</p> <p>Review of the closed medical record for Resident #357 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses including dementia with behavioral disturbance, traumatic brain injury, delusional disorders and hallucinations.</p> <p>Resident #357 had not yet had a MDS admission assessment completed.</p> <p>Review of the Focused Head to Toe Observation assessment dated [DATE] revealed Resident #357 had cognitive and memory loss, was oriented to person, and had a medical diagnosis of traumatic brain injury.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #357's progress note dated [DATE] at 8:32 P.M. revealed several residents including Resident #357 and Resident #30 were walking in the hallways. Resident #30 was being intrusive and touching Resident #357's arm. Staff were approaching to separate the two residents when Resident #357 grabbed Resident #30 by the neck and slammed her into the wall causing her to hit her head. Resident #357 had to be physically pried off Resident #30. Hospice services for Resident #357 were in the facility and gave order for Ativan as needed. The nurse practitioner, director of nursing, and Resident #357's wife were notified. Resident #357 was sent to the hospital for behavioral/psych evaluation.</p> <p>Review of self-reported incidents (SRIs) submitted to the Ohio Department of Health's Enhanced Information Dissemination Collection System (EIDC) (a database used for facilities to report required instances of abuse, neglect, injuries of unknown origin, and misappropriation) revealed there was no evidence the resident-to-resident physical altercation on [DATE] was reported.</p> <p>2. Review of the medical record for Resident #39 revealed an admitted [DATE] and diagnoses including paranoid schizophrenia, anxiety disorder, personality disorder, delirium, bipolar disorder, psychotic disorder with delusions, mood disorder, and age-related cognitive decline.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #39 had a BIMS score of 15 indicating intact cognition.</p> <p>Review of Resident #39's progress note dated [DATE] at 12:18 P.M. revealed Resident #39 was found on the floor next to her bed and her nose was bleeding. Resident #39 reported Resident #58 had come into her room knocked her to the ground, hit her twice in the nose with a closed fist, and choked her. Three staff had to physically remove Resident #58 from Resident #39's room. Resident #58 was yelling and crying Resident #39 had stolen his money. Resident #39 and Resident #58 were kept separated. Resident #39's nurse practitioner and guardian were notified.</p> <p>Review of the closed medical record for Resident #58 revealed an admitted [DATE]. Diagnoses including dementia with agitation and delirium. Resident #58 expired on [DATE] of unrelated medical conditions on hospice services.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #58 had BIMS score of 05 indicating severe cognitive impairment.</p> <p>Review of Resident #58's progress note dated [DATE] at 11:25 A.M. revealed staff heard yelling and found Resident #58 in Resident #39's room fixated on money. Staff removed Resident #58 from the room. Resident #58 indicated he punched Resident #39 because she had his money. Resident #58's psych physician was notified and gave new order to send to hospital for behaviors.</p> <p>Review of SRIs submitted to the Ohio Department of Health's EIDC database revealed there was no evidence the resident-to-resident physical altercation on [DATE] was reported.</p> <p>3. Review of the medical record for Resident #28 revealed an admitted [DATE] and diagnoses including Alzheimer's disease, dementia with behavioral disturbance and agitation, major depressive disorder, schizoaffective disorder, psychotic disorder, anxiety disorder, and altered mental status.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Medicare MDS Annual assessment dated [DATE] revealed Resident #28 had a BIMS score of 99 indicating Resident #28 was unable to complete the assessment. Resident #28 had memory problems, severely impaired decision making, and disorganized thinking.</p> <p>Review of Resident #28's progress note dated [DATE] at 1:58 A.M. revealed Resident #28 was at the nursing station yelling. Resident #69 was sitting a chair nearby, stood up, and struck Resident #28 in the mouth with a closed fist. Resident #28 had a small cut on left upper corner of her lip with no bleeding noted. Resident #28 and Resident #69 were separated. Resident #28's responsible party and hospice were notified of the incident.</p> <p>Review of the medical record for Resident #69 revealed an admitted [DATE] and diagnoses including dementia with behavioral disturbance, alcohol-induced mood disorder, residual schizophrenia, and major depressive disorder.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #69 had a BIMS score of 99 indicating Resident #69 was unable to complete the assessment. Resident #69 had memory problems and severely impaired decision making.</p> <p>Review of Resident #69's progress note dated [DATE] at 2:29 A.M. revealed Resident #28 was in front of Resident #69 yelling and Resident #69 struck Resident #28 in the mouth. It was noted Resident #28 got into his face and Resident #69 stood up from a chair, struck Resident #28 with a closed fist, and sat back down. Resident #69's physician was notified.</p> <p>Review of SRIs submitted to the Ohio Department of Health's EIDC database revealed there was no evidence the resident-to-resident physical altercation on [DATE] was reported.</p> <p>4. Review of the medical record for Resident #57 revealed an admitted [DATE] and diagnoses including dementia with agitation and behavioral disturbance, restlessness and agitation, impulse disorder, delusional disorders, hallucinations, post traumatic stress disorder, psychosis, and traumatic brain injury.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #57 had a BIMS score of five indicating severe cognitive impairment.</p> <p>Review of Resident #57's progress note dated [DATE] at 10:44 P.M. revealed Resident #57 was standing in the hallway shouting at Resident #85. Resident #57 swung his fist at Resident #85 and missed. Resident #85 swung his fist and hit Resident #57 on the left side of his face. Resident #57 sustained an abrasion to his face. Resident #57 did not allow the nurse to provide first aide. Resident #57's family and the nurse practitioner were notified of the incident.</p> <p>Review of the medical record for Resident #85 revealed an admitted [DATE] and diagnoses including dementia, anxiety disorder, bipolar disorder, and major depressive disorder.</p> <p>Review of the Medicare MDS Annual assessment dated [DATE] revealed Resident #85 had a BIMS score of 13 indicating intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #85's progress note dated [DATE] at 10:18 P.M. revealed Resident #57 was standing in the hallway shouting at Resident #85. Resident #57 swung with his fist at Resident #85 and missed. Resident #85 swung with his fist and hit Resident #57 on the left side of his face. Resident #85's family and nurse practitioner were notified with no new orders.</p> <p>Review of SRIs submitted to the Ohio Department of Health's EIDC database revealed there was no evidence the resident-to-resident physical altercation on [DATE] was reported.</p> <p>5. Review of the medical record for Resident #48 revealed an admitted [DATE] and diagnoses including vascular dementia with behavioral disturbance, psychosis, schizoaffective disorder, hallucinations, panic disorder, anxiety disorder, delusional disorder, and major depressive disorder.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #48 had a BIMS score of 99 indicating Resident #48 was unable to complete the assessment. Resident #48 had severely impaired decision-making, inattention, disorganized thinking, and memory problems.</p> <p>Review of Resident #48's progress note dated [DATE] at 7:26 P.M. revealed Resident #48 was having increased behaviors and anxiety. The nurse was giving Resident #77 medication and Resident #48 approached while screaming. Resident #77 picked up Resident #48 and threw her to the floor. Resident #48 and Resident #77 were separated. Resident #48 had no signs or symptoms of pain and no noted injuries. The local police and responsible party were notified.</p> <p>Review of the medical record for Resident #77 revealed an admitted [DATE] and diagnoses including dementia with behavioral disturbance and impulse disorder.</p> <p>Review of the Medicare MDS Annual assessment dated [DATE] revealed Resident #77 had a BIMS score of 99 indicating Resident #77 was unable to complete the assessment. Resident #77 had memory problems and severely impaired decision-making.</p> <p>Review of Resident #77's progress note dated [DATE] at 6:01 P.M. revealed while Resident #77 was at the cart medication waiting for his medications, Resident #48 approached the area screaming. Resident #77 picked up Resident #48 and threw her to the ground. Resident #48 and Resident #77 were separated and placed on one-on-one supervision. Resident #77 was sent to hospital for geriatric psych evaluation. The local police, physician, and responsible party for Resident #77 were notified.</p> <p>Review of SRIs submitted to the Ohio Department of Health's EIDC database revealed there was no evidence the resident-to-resident physical altercation on [DATE] was reported.</p> <p>Interview on [DATE] at 4:44 P.M. with Director of Nursing (DON) and Assistant Director of Nursing (ADON) #593 confirmed incidents on [DATE], [DATE], [DATE], [DATE], and [DATE] were not reported via the EIDC database. DON indicated she had just been promoted from ADON to DON. DON indicated the former DON made the decisions on what was reportable. DON indicated herself and ADON #593 investigated situations of potential abuse immediately and reported findings to the former DON. DON indicated she believed the resident-to-resident altercations on [DATE], [DATE], [DATE], [DATE], and [DATE] were not reported as there were no major injuries.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Ohio Resident Abuse Policy revised on [DATE] revealed all allegations of abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property would be reported to the Administrator/Abuse Coordinator. Physical abuse was defined as hitting, slapping, pinching, or kicking. Investigation would begin immediately and applicable local and state agencies would be notified. It was noted All abuse allegations would be reported to the State Agency, an investigation would be completed, and a final report would be submitted within five working days.		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809</p> <p>Based on observation record review and interview the facility failed to ensure Resident #10 was assisted with eating his meal in a timely manner. This affected one resident (Resident #10) out of three residents reviewed for meal assistance. The facility census was 99.</p> <p>Findings include:</p> <p>Resident #10 was admitted on [DATE] with diagnoses including traumatic brain injury with anoxic brain injury, psychosis, depression, mixed receptive-expressive language disorder, mood and personality disorder, encephalopathy, anxiety, dementia with behaviors, dysphagia (difficulty swallowing), and cognitive communication deficit.</p> <p>Resident #10's Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 had severe cognitive impairment, and he needed substantial/maximal assistance with eating meals.</p> <p>Resident #10's plan of care edited on 09/25/24 indicated Resident #10 had and increased nutrition/hydration risk related to a diagnosis of traumatic brain injury, and history of weight loss and insertion of a gastronomy tube, and required a mechanically altered diet. Interventions on the plan of care indicated for the staff to encourage Resident #10 to dine in the dining room as appropriate and to provide assistance with meals as needed to encourage oral intakes.</p> <p>An observation on 10/09/24 at 8:15 A.M. revealed the staff were collecting the breakfast meal trays from the residents who had finished eating their breakfast in the memory care unit on the third floor of the facility. Resident #10's meal tray was sitting on the counter in the dining room and was untouched. Resident #10 was observed lying in his room in bed and was awake.</p> <p>An interview with State tested Nursing Assistant (STNA) #588 on 10/09/24 at 9:15 A.M. indicated the breakfast trays had arrived to the nursing unit between 7:30 A.M. and 8:00 A.M. STNA #588 stated Resident #10 had not been assisted with eating his breakfast tray because there were four STNAs assigned to work on the third floor and only three STNAs had arrived to provide direct care for the residents. STNA #588 stated she would complete the tasks for her assigned residents first and then start to provide the care for the residents assigned to the other STNA who had not arrived to work.</p> <p>An interview with Licensed Practical Nurse (LPN) #529 on 10/09/24 at 9:25 A.M. indicated he was assigned to the residents on the other side of the third floor and indicated one or the STNAs had not arrived to work her shift on time. LPN #529 was standing in the nursing station and indicated STNA #588 would assist Resident #10 with his breakfast tray.</p> <p>An observation of STNA #588 on 10/09/24 from 9:15 A.M. to 9:45 A.M. revealed she was busy performing her job duties and was assisting other residents with their morning care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with LPN #528 on 10/09/24 at 9:30 A.M. revealed she would assist the residents in the dining room with their breakfast meal while she was administering the residents their medications. LPN #528 stated after she had completed the medication administration she would then assist the residents with eating their meal as needed. LPN #528 indicated she had completed the medication administration to the residents and had just arrived back to the nursing unit after her break. LPN #528 stated the reason she had not assisted Resident #10 with his breakfast was because she was waiting for the STNA #588 to assist him out of bed to the dining room.</p> <p>On 10/09/24 at 9:45 A.M. STNA #588 was observed heating Resident #10's tray in the microwave and placed the re-heated breakfast foods in front of Resident #10. STNA #588 then sat down to feed Resident #10.</p> <p>On 10/09/24 at 9:50 A.M. STNA #588 verified the above findings at the time of the observation and agreed Resident #10's breakfast meal had sat untouched for approximately two hours and fifteen minutes before Resident #10 was assisted with eating his meal.</p> <p>A review of the facility policy titled Dining Experience at Mealtimes Policy effective 09/21/20 indicated staff should provide residents with hygiene prior to the meal. Residents would be prepared for the meal by the nursing staff by inserting dentures, hearing aides, and ensure the resident was well groomed and dressed appropriately. Residents would be encouraged to sit in a regular chair and eat in the dining room as appropriate. Staff would assist the resident as needed with their meal after the meal arrived. Staff would encourage and assist the resident to consume their food and beverages.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157969.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interview, the facility failed to ensure appropriate assessments and resident care was completed for Resident #203's groin condyloma (genital warts). This finding affected one (Resident #203) of three residents reviewed for wound care.</p> <p>Findings include:</p> <p>Review of Resident #203's Solid Tumor Service History and Physical Exam form dated 08/28/24 at 2:25 P.M. indicated the resident endorses that about two weeks ago he had his port placed and developed generalized weakness, decreased appetite, fatigue and widespread blisters. During this time, the resident also noted that he began having oozing and bloody drainage from his penile condyloma. He stated that the condyloma initially was small and first noted approximately [AGE] years ago but had since increased in size. The resident previously saw dermatology for the widespread blisters and was given prednisone. The blisters were improving but present. The exam performed indicated a large verrucous (wart-like growth) mass surrounding the penis with site of leakage covered with a partially saturated dressing.</p> <p>Review of Resident #203's Urology Consult Note dated 08/28/24 at 4:43 P.M. revealed on evaluation, the resident was afebrile, and the resident's vital signs were within normal limits. Imaging reviewed and showed a 15.5 cm left renal mass concerning for malignancy, as well as an 18 cm penile and pubic condyloma mass extending down into the scrotum. The exam revealed a large condyloma over the penis, obscuring any sort of penile shaft or meatus, unable to see the urethral opening. Areas of purulence, around area of condyloma where the resident stated urine comes out. The resident would need a discussion regarding the renal mass and the penile condyloma with urologic oncology. An outpatient appointment was scheduled for 09/04/24. The physical exam showed a massive foul-smelling fungating (term used to describe skin lesion that occurs when a cancer breaks through the skin's surface) condyloma mass overlying the suprapubic region and entirely encompassing the penis. Unable to visualize the penile shaft, glans or urethral meatus with areas of purulence within.</p> <p>Review of Resident #203's hospital Solid Tumor Service Progress Note dated 08/30/24 at 7:55 A.M. revealed a wound culture of the condyloma was ordered with Zosyn antibiotic ordered. If the culture was negative, consider stop taking the Zosyn antibiotic. No acute intervention for the condyloma or renal mass and to follow up as an outpatient.</p> <p>Review of Resident #203's closed medical record revealed the resident was admitted on [DATE] with diagnoses including condyloma latum (groin area), muscle weakness and malignant neoplasm of the esophagus. Resident #203 was discharged on [DATE].</p> <p>Review of Resident #203's progress note dated 08/31/24 at 7:01 P.M. authored by Licensed Practical Nurse (LPN) #543 revealed the resident had a urology appointment on 09/04/24 at 10:00 A.M. The resident's personal belongings were listed in the matrix. A focused head to toe assessment was performed and the resident was noted to have a patch over the implanted chemotherapy port to the right side of the chest. Ace bandages were on the resident's bilateral lower extremities to decrease edema caused by lymphedema and a large verrucous mass surrounded the penis with site of leakage covered with a dressing. The medications were verified by the nurse practitioner.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #203's medical record did not reveal evidence of an comprehensive assessment of the resident's groin area which appeared to have drainage or wound care orders to address the drainage in the groin area while the resident was admitted at the facility.</p> <p>Interview on 10/08/24 at 2:08 P.M. with LPN Assistant Director of Nursing (ADON) #593 stated she did not have time to assess Resident #203 for wounds as she only worked on 09/03/24 while the resident resided in the facility. LPN ADON #593 was unaware if the resident had any wounds.</p> <p>Interview on 10/09/24 at 10:23 A.M. with LPN #543 stated she admitted Resident #203 and noticed the dressing on the resident's groin/penis area. She stated the resident was leaking clear looking fluid underneath of the condyloma mass and she placed dry dressings to absorb the drainage. LPN #543 stated she forgot to mention the drainage to the physician to obtain physician orders for a dressing.</p> <p>Review of the Skin and Wound Care Best Practices revised 09/19/24 revealed the purpose of the policy was to provide evidence based preventative skin care and wound treatment to prevent unavoidable skin complications.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157620.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457</p> <p>Based on record review and interview, the facility failed to ensure individualized cared planned interventions were in place to prevent resident behaviors resulting in resident to resident altercations on the secured memory care unit (SCMU). This affected nine Residents (#28, #30, #39, #48, #57, #58, #69, #77, and #85) of ten residents reviewed for behavioral health services. The facility census was 99.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #28 revealed an admitted [DATE] and diagnoses including Alzheimer's disease, dementia with behavioral disturbance and agitation, major depressive disorder, schizoaffective disorder, psychotic disorder, anxiety disorder, and altered mental status.</p> <p>Review of the Medicare MDS Annual assessment dated [DATE] revealed Resident #28 had a BIMS score of 99 indicating Resident #28 was unable to complete the assessment. Resident #28 had memory problems, severely impaired decision making, and disorganized thinking. There were no behaviors noted.</p> <p>Review of Resident #28's care plan interventions related to behavioral symptoms revealed to allow distance in seating areas, assess whether behaviors endanger the resident or others, intervene as necessary, avoid overstimulation, avoid power struggle with resident, offer reassurance if resident was having delusions or hallucinations, ignore verbal abuse, maintain a calm environment and approach to resident, praise appropriate resident behaviors, provide daily schedule resembling prior lifestyle, provide consistency, and refocus when resident becomes verbally abusive. Although the care plan identified numerous interventions it lacked Resident #28's individualized stressors, the resident's response to these stressors and specific interventions to address them.</p> <p>Review of Resident #28's progress note dated 08/13/24 at 1:58 A.M. revealed Resident #28 was involved in a physical altercation with Resident #69. Resident #28 was at the nursing station yelling. Resident #69 was sitting a chair nearby, stood up, and struck Resident #28 in the mouth with a closed fist. Resident #28 had a small cut on left upper corner of her lip.</p> <p>Review of Resident-to-Resident Risk Tool dated 08/13/24 revealed the root cause of the physical altercation between Resident #28 and Resident #69 was noise on the unit.</p> <p>Review of the Quality Assessment and Performance Improvement (QAPI) dated 08/13/24 revealed both residents resided on secured unit, have diagnoses of dementia, and both residents have behaviors due to noise on unit. Resident #28's care plan was updated to include verbal behaviors; however, it was not specific to what triggered verbal behaviors.</p> <p>Interview on 10/10/24 at 12:47 P.M. with MDS #545 and MDS #603 confirmed Resident #28's care plan did not include individualized interventions to manage and modify resident behaviors to prevent resident to resident altercations.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/10/24 at 1:13 P.M. with Director of Nursing (DON) and Regional Nurse #805 reported they were aware of the lack of individualization in resident care plans and had been slowly working on improving them.</p> <p>2. Review of the medical record for Resident #30 revealed an admitted [DATE] and diagnoses including Alzheimer's disease, dementia with behavioral disturbance, major depressive disorder, delusional disorders, and wandering.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #30 had BIMS score of 99 indicating Resident #30 was unable to complete the assessment. Resident #30 had memory problems, severely impaired decision making, inattention, and disorganized thinking. There were no noted behaviors.</p> <p>Review of Resident #30's care plan interventions related to behavioral symptoms revealed assess whether behaviors endanger resident or others, intervene as necessary, avoid over stimulation, maintain a calm environment and approach, and allow resident to express feelings. Although the care plan identified numerous interventions it lacked Resident #30's individualized stressors, the resident's response to these stressors and specific interventions to address them.</p> <p>Review of the progress note dated 06/26/24 at 7:30 P.M. revealed Resident #30 was involved in a physical altercation with Resident #357. Resident #30 and Resident #357 were walking in the hallway. Resident #30 was attempting to hold Resident #357's hand. Resident #357 grabbed Resident #30 by the neck and threw her against the wall. Resident #30 sustained bruising to left side of her head and her eye had appeared droopy following the altercation.</p> <p>Review of Resident-to-Resident Risk Tool dated 06/26/24 revealed the root cause of the physical altercation between Resident #30 and Resident #357 was history of aggressive behaviors.</p> <p>Review of the Quality Assessment and Performance Improvement (QAPI) dated 06/27/24 revealed both residents had dementia with behavioral disturbances, both residents ambulate on the unit throughout the day and reside on secured unit related to elopement risk. Staff were educated on abuse and potential triggers/de-escalation related to behaviors; however, there was no evidence of what specific triggers Resident #30 had.</p> <p>Interview on 10/10/24 at 12:47 P.M. with MDS #545 and MDS #603 confirmed Resident #30's care plan did not include individualized interventions to manage and modify resident behaviors to prevent resident to resident altercations.</p> <p>Interview on 10/10/24 at 1:13 P.M. with DON and Regional Nurse #805 reported they were aware of the lack of individualization in resident care plans and had been slowly working on improving them.</p> <p>3. Review of the medical record for Resident #39 revealed an admitted [DATE] and diagnoses including paranoid schizophrenia, anxiety disorder, personality disorder, delirium, bipolar disorder, psychotic disorder with delusions, mood disorder, and age-related cognitive decline.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #39 had a BIMS score of 15 indicating intact cognition. There were no noted behaviors and Resident #39 had no or minimal depressive symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #39's care plan interventions related to behavioral symptoms revealed to allow resident to verbalize feelings, assess whether behaviors endanger resident or others, intervene as necessary, monitor behavior in response to medications. Although the care plan identified numerous interventions it lacked Resident #39's individualized stressors, the resident's response to these stressors and specific interventions to address them.</p> <p>Review of Resident #39's progress note dated 07/17/24 at 12:18 P.M. revealed Resident #39 was involved in a physical altercation with Resident #58. Resident #39 was found on the floor next to her bed and her nose was bleeding. Resident #39 reported Resident #58 had come into her room knocked her to the ground, hit her twice in the nose with a closed fist, and choked her. Three staff had to physically remove Resident #58 from Resident #39's room.</p> <p>Review of Resident-to-Resident Risk Tool dated 07/17/24 revealed the root cause of the physical altercation between Resident #39 and Resident #58 was unprovoked physical aggression.</p> <p>Interview on 10/10/24 at 12:47 P.M. with MDS #545 and MDS #603 confirmed Resident #39's care plan did not include individualized interventions to manage and modify resident behaviors to prevent resident to resident altercations.</p> <p>Interview on 10/10/24 at 1:13 P.M. with DON and Regional Nurse #805 reported they were aware of the lack of individualization in resident care plans and had been slowly working on improving them.</p> <p>4. Review of the medical record for Resident #48 revealed an admitted [DATE] and diagnoses including vascular dementia with behavioral disturbance, psychosis, schizoaffective disorder, hallucinations, panic disorder, anxiety disorder, delusional disorder, and major depressive disorder.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #48 had a BIMS score of 99 indicating Resident #48 was unable to complete the assessment. Resident #48 had severely impaired decision-making, inattention, disorganized thinking, and memory problems. There were no noted behaviors and Resident #48 had no or minimal depressive symptoms.</p> <p>Review of Resident #48's care plan interventions related to behavioral symptoms revealed to allow resident to have control over situations, begin with short concise interactions with resident and increase the interactions as suspicion decreases, maintain calm environment and approach, assess whether behaviors are a danger to resident or others, intervene as necessary, monitor resident mood and response to medications, if resident becomes disruptive provide comfort measures for basic needs, encourage to verbalize feelings, and provide support and reassurance in new situations. Although the care plan identified numerous interventions it lacked Resident #48's individualized stressors, the resident's response to these stressors and specific interventions to address them.</p> <p>Review of the progress note dated 08/30/24 at 7:26 P.M. revealed Resident #48 was involved in a physical altercation with Resident #77. Resident #48 was having increased behaviors and anxiety. The nurse was giving Resident #77 his medications and Resident #48 approached while screaming. Resident #77 picked up Resident #48 and threw her to the floor. Resident #48 had no signs or symptoms of pain and no noted injuries.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident-to-Resident Risk Tool dated 08/30/24 revealed the root cause of the physical altercation between Resident #48 and Resident #77 was physical aggression related to yelling. Staff were educated on abuse and potential triggers/de-escalation related to behaviors; however, there was no evidence of what specific triggers Resident #48 had.</p> <p>Interview on 10/10/24 at 12:47 P.M. with MDS #545 and MDS #603 confirmed Resident #48's care plan did not include individualized interventions to manage and modify resident behaviors to prevent resident to resident altercations.</p> <p>Interview on 10/10/24 at 1:13 P.M. with DON and Regional Nurse #805 reported they were aware of the lack of individualization in resident care plans and had been slowly working on improving them.</p> <p>5. Review of the medical record for Resident #57 revealed an admitted [DATE] and diagnoses including dementia with agitation and behavioral disturbance, restlessness and agitation, impulse disorder, delusional disorders, hallucinations, post-traumatic stress disorder, psychosis, and traumatic brain injury.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #57 had a BIMS score of five indicating severe cognitive impairment. There were no noted behaviors and Resident #57 had no or minimal depressive symptoms.</p> <p>Review of Resident #57's care plan interventions related to behavioral symptoms revealed to assess whether behaviors endangers resident or others, intervene as necessary, avoid over stimulation, avoid power struggle with resident, convey acceptance towards resident, explore with resident effective versus ineffective coping mechanisms, offer reassurance for delusions and hallucinations, maintain a calm environment and approach, obtain a psych consult, praise resident when behaviors are appropriate, provide daily schedule resembling prior lifestyle, refocus conversation when becomes verbally abusive, provide one on one sessions as necessary, provide consistent staff as often as possible, remove from group activities when behaviors are unacceptable, and when resident becomes physically abusive keep distance with others. Although the care plan identified numerous interventions it lacked Resident #57's individualized stressors, what the resident's prior lifestyle entailed, the resident's response to these stressors and specific interventions to address them.</p> <p>Review of the progress note dated 08/29/24 at 10:44 P.M. revealed Resident #57 was involved in a physical altercation with Resident #85. Resident #57 was standing in the hallway shouting at Resident #85. Resident #57 swung his fist at Resident #85 and missed. Resident #85 swung his fist and hit Resident #57 on the left side of his face. Resident #57 sustained an abrasion to his face.</p> <p>Review of Resident-to-Resident Risk Tool dated 08/30/24 revealed the root cause of the physical altercation between Resident #57 and Resident #85 was physical aggression related to yelling.</p> <p>Review of the Quality Assessment and Performance Improvement (QAPI) dated 08/30/24 revealed both residents have diagnoses of dementia, both have history of verbal aggression towards others, and both residents have psychological disorders with psychotropic medications. Resident #85's care plan was updated to include physical aggression and Resident #57's care plan was updated to include verbal and physical aggression. Staff were educated on abuse and potential triggers/de-escalation related to behaviors; however, there was no evidence of what specific triggers Resident #57 had.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/10/24 at 12:47 P.M. with MDS #545 and MDS #603 confirmed Resident #57's care plan did not include individualized interventions to manage and modify resident behaviors to prevent resident to resident altercations.</p> <p>Interview on 10/10/24 at 1:13 P.M. with DON and Regional Nurse #805 reported they were aware of the lack of individualization in resident care plans and had been slowly working on improving them.</p> <p>6. Review of the closed medical record for Resident #58 revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses including dementia with agitation and delirium.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #58 had BIMS score of 05 indicating severe cognitive impairment. There were no noted behaviors.</p> <p>Review of Resident #58's care plan interventions related to behavioral symptoms revealed maintain calm environment and approach, assess whether behavior endangers resident or others, intervene as necessary, maintain slow approach with resident, encourage resident to verbalize feelings, and avoid use of restraints. Although the care plan identified numerous interventions it lacked Resident #58's individualized stressors, the resident's response to these stressors and specific interventions to address them.</p> <p>Review of the progress note dated 07/17/24 at 11:25 A.M. revealed Resident #58 was involved in a physical altercation with Resident #39. Staff heard yelling and found Resident #58 in Resident #39's room fixated on money. Staff removed Resident #58 from the room. Resident #58 indicated he punched Resident #39 because she had his money. Resident #58 was transferred to the hospital for evaluation following the altercation.</p> <p>Review of Resident-to-Resident Risk Tool dated 07/17/24 revealed the root cause of the physical altercation between Resident #39 and Resident #58 was unprovoked physical aggression. Staff were educated on abuse and potential triggers/de-escalation related to behaviors; however, there was no evidence of what specific triggers Resident #58 had.</p> <p>Interview on 10/10/24 at 12:47 P.M. with MDS #545 and MDS #603 confirmed Resident #58's care plan did not include individualized interventions to manage and modify resident behaviors to prevent resident to resident altercations.</p> <p>Interview on 10/10/24 at 1:13 P.M. with DON and Regional Nurse #805 reported they were aware of the lack of individualization in resident care plans and had been slowly working on improving them.</p> <p>7. Review of the medical record for Resident #69 revealed an admitted [DATE] and diagnoses including dementia with behavioral disturbance, alcohol-induced mood disorder, residual schizophrenia, and major depressive disorder.</p> <p>Review of the Medicare MDS Quarterly assessment dated [DATE] revealed Resident #69 had a BIMS score of 99 indicating Resident #69 was unable to complete the assessment. Resident #69 had memory problems and severely impaired decision making. There were no noted behaviors and Resident #69 had no or minimal depressive symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #69's care plan interventions related to behavioral symptoms revealed to assess whether behaviors or mood was danger to the resident or others, intervene as necessary, attempt non-pharmacological interventions, allow resident to express feelings, encourage family to visit, encourage point system to help with managing behaviors, provide emotional support as needed, and referral to psych as needed. Although the care plan identified numerous interventions it lacked Resident #69's individualized stressors, the resident's response to these stressors and specific interventions to address them.</p> <p>Review of Resident #69's progress note dated 08/13/24 at 2:29 A.M. revealed Resident #69 was involved in a physical altercation with Resident #28. Resident #28 was in front of Resident #69 yelling, Resident #69 stood up from a chair, struck Resident #28 in the mouth with a closed fist, and sat back down.</p> <p>Review of Resident-to-Resident Risk Tool dated 08/13/24 revealed the root cause of the physical altercation between Resident #28 and Resident #69 was noise on the unit.</p> <p>Review of the Quality Assessment and Performance Improvement (QAPI) dated 08/13/24 revealed both residents resided on secured unit, have diagnoses of dementia, and both residents have behaviors due to noise on unit. Resident #69's care plan was updated to include verbal behaviors. Staff were educated on abuse and potential triggers/de-escalation related to behaviors; however, there was no evidence of what specific triggers Resident #69 had.</p> <p>Interview on 10/10/24 at 12:47 P.M. with MDS #545 and MDS #603 confirmed Resident #69's care plan did not include individualized interventions to manage and modify resident behaviors to prevent resident to resident altercations.</p> <p>Interview on 10/10/24 at 1:13 P.M. with DON and Regional Nurse #805 reported they were aware of the lack of individualization in resident care plans and had been slowly working on improving them.</p> <p>8. Review of the medical record for Resident #77 revealed an admitted [DATE] and diagnoses including dementia with behavioral disturbance and impulse disorder.</p> <p>Review of the Medicare MDS Annual assessment dated [DATE] revealed Resident #77 had a BIMS score of 99 indicating Resident #77 was unable to complete the assessment. Resident #77 had memory problems and severely impaired decision-making. There were no noted behaviors.</p> <p>Review of Resident #77's care plan interventions related to behavioral symptoms revealed to administer medications, allow distance in seating areas, allow resident to discuss anger, assess whether behavior endangers resident or others, intervene as necessary, avoid over-stimulation, avoid power struggle with resident, offer reassurance with delusions and hallucinations, provide a calm environment and approach, obtain a psych consult, offer one step directions for tasks, praise when behaviors are appropriate, provide consistent staff as much as possible, remove to calm place when behaviors are not acceptable, provide daily schedule resembling prior lifestyle, keep distance when resident becomes physically abusive, reduce stressors, and involve family in identifying activities that reduce behaviors. Although the care plan identified numerous interventions it lacked Resident #77's individualized stressors, what the resident's prior lifestyle schedule was, the resident's response to these stressors and specific interventions to address them.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the progress note dated 08/30/24 at 6:01 P.M. revealed Resident #77 was involved in a physical altercation with Resident #48. Resident #77 was at the medication cart waiting for his medications and Resident #48 approached the area screaming. Resident #77 picked up Resident #48 and threw her to the ground. Resident #77 was transferred to the hospital for geriatric psych evaluation.</p> <p>Review of Resident-to-Resident Risk Tool dated 08/30/24 revealed the root cause of the physical altercation between Resident #48 and Resident #77 was physical aggression related to yelling. Staff were educated on abuse and potential triggers/de-escalation related to behaviors; however, there was no evidence of what specific triggers Resident #77 had.</p> <p>Interview on 10/10/24 at 12:47 P.M. with MDS #545 and MDS #603 confirmed Resident #77's care plan did not include individualized interventions to manage and modify resident behaviors to prevent resident to resident altercations.</p> <p>Interview on 10/10/24 at 1:13 P.M. with DON and Regional Nurse #805 reported they were aware of the lack of individualization in resident care plans and had been slowly working on improving them.</p> <p>9. Review of the medical record for Resident #85 revealed an admitted [DATE] and diagnoses including dementia, anxiety disorder, bipolar disorder, and major depressive disorder.</p> <p>Review of the Medicare MDS Annual assessment dated [DATE] revealed Resident #85 had a BIMS score of 13 indicating intact cognition. There were no noted behaviors and Resident #85 had no or minimal depressive symptoms.</p> <p>Review of Resident #85's care plan interventions related to behavioral symptoms revealed to administer medications, monitor effectiveness, assess whether behaviors endanger resident or others, intervene as necessary, avoid over stimulation, avoid power struggle with resident, maintain a calm environment and approach, convey acceptance towards resident, obtain a psych consult, offer one step directions for tasks, praise resident behaviors as appropriate, provide consistent staff as much as possible, remove resident when behaviors not acceptable, provide daily schedule resembling prior lifestyle, keep distance when resident becomes physically abusive, refocus conversation when resident becomes verbally abusive. Although the care plan identified numerous interventions it lacked Resident #85's individualized stressors, what the resident's prior lifestyle schedule was, the resident's response to these stressors and specific interventions to address them.</p> <p>Review of the progress note dated 08/29/24 at 10:18 P.M. revealed Resident #85 was involved in a physical altercation with Resident #57. Resident #57 was standing in the hallway shouting at Resident #85. Resident #57 swung with his fist at Resident #85 and missed. Resident #85 swung with his fist and hit Resident #57 on the left side of his face.</p> <p>Review of Resident-to-Resident Risk Tool dated 08/30/24 revealed the root cause of the physical altercation between Resident #57 and Resident #85 was physical aggression related to yelling.</p> <p>Review of the Quality Assessment and Performance Improvement (QAPI) dated 08/30/24 revealed both residents have diagnoses of dementia, both have history of verbal aggression towards others, and both residents have psychological disorders with psychotropic medications. Staff were educated on abuse and potential triggers/de-escalation related to behaviors; however, there was no evidence of what specific triggers Resident #85 had.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/10/24 at 12:47 P.M. with MDS #545 and MDS #603 confirmed Resident #57's care plans did not include individualized interventions to manage and modify resident behaviors to prevent resident to resident altercations.</p> <p>Interview on 10/10/24 at 1:13 P.M. with DON and Regional Nurse #805 reported they were aware of the lack of individualization in resident care plans and had been slowly working on improving them.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>35768</p> <p>Based on observation, interview, and policy review, the facility failed to secure medications appropriately. This had the potential to affect all 99 residents residing in the facility.</p> <p>Findings include:</p> <p>Observation on 10/07/24 at 2:00 P.M. revealed a medication cart on the third floor had 14 unsecured unidentified medications. Interview during the observation, Licensed Practical Nurse (LPN) # 528 verified the observations stating loose medications should be discarded.</p> <p>Observation on 10/07/24 at 2:09 P.M. revealed a medication cart on the third floor had 19 unsecured unidentified medications. Interview during the observation, LPN #535 verified the observations stating loose medications should be discarded.</p> <p>Observation on 10/07/24 at 2:29 P.M. revealed a medication cart on the first floor had 9 unsecured unidentified medications. Interview during the observation, LPN #538 verified the observations stating loose medications should be discarded.</p> <p>Review of the facility policy titled Storage and Expiration Dating of Medications and Biologicals, dated 2024 noted staff should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, and refrigerators.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768</p> <p>Based on record review, observations, and interview, the facility failed to sanitize blood sugar glucometers appropriately. This had the potential to affect five residents (Resident #20, #21, #37, #80, and #95) of 13 residents who required blood sugar testing and monitoring.</p> <p>Findings include:</p> <p>Observations on 10/07/24 at 1:42 P.M. revealed Licensed Practical Nurse (LPN) #538 was checking a blood glucose level for Resident #37 with a glucometer. LPN #538 placed the glucometer in the top drawer of the medication cart without sanitizing.</p> <p>Interview on 10/07/24 at 1:52 P.M., LPN #538 verified that she did not sanitize the glucometer and preceded to sanitize the glucometer with an alcohol wipe. LPN #538 stated the bleach wipes were too strong to use for cleaning. LPN #538 revealed she was assigned to complete blood sugar checks with a glucometer for Resident #20, #21, #37, #80, and #95.</p> <p>a. Review of medical record for Resident #20 noted an admitted [DATE]. Diagnoses included unspecified dementia and type two diabetes mellitus. Resident #20 had intact cognition.</p> <p>Review of Resident #20's medication administration record (MAR) revealed orders to complete blood sugar testing daily.</p> <p>b. Review of medical record for Resident #21 noted an admitted [DATE]. Diagnoses included altered mental status and type two diabetes mellitus. Resident #21 had intact cognition.</p> <p>Review of Resident #21's MAR revealed orders to complete blood sugar testing twice a day.</p> <p>c. Review of medical record for Resident #37 noted an admitted [DATE]. Diagnoses included unspecified dementia and type two diabetes mellitus. Resident #37 had impaired cognition.</p> <p>Review of Resident #37's MAR revealed orders to complete blood sugar testing three times a day.</p> <p>d. Review of medical record for Resident #80 noted an admitted [DATE]. Diagnoses included unspecified dementia and type two diabetes mellitus. Resident #80 had intact cognition.</p> <p>Review of Resident #80's MAR revealed orders to complete blood sugar testing twice a day.</p> <p>e. Review of medical record for Resident #95 noted an admitted [DATE]. Diagnoses included hypertension and type two diabetes mellitus. Resident #95 had impaired cognition.</p> <p>Review of Resident #95's MAR revealed orders to complete blood sugar testing three times a day.</p> <p>Review of the facility policy titled, Glucometer/Point of Care Blood Testing and Disinfecting Procedure, dated 2020 revealed staff were supposed to sanitize the glucometer with a disinfectant wipe after each use.</p>		

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 10/10/2024
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)		
<p>F 0925</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>45442</p> <p>Based on observation, facility policy, facility staff and contractor interview, the facility failed to maintain an effective pest control management system related to gnats in the kitchen. This has the potential to affect all 99 residents who receive meals from the kitchen. The facility indicated there were no residents who received nothing by mouth.</p> <p>Findings include:</p> <p>Observation during the initial tour of the kitchen on 10/07/24 at 9:30 A.M. with Food Service Director (FSD) #517 revealed while in the dish room approximately 10 gnats were flying around near the exit door in the dish room. FSD #517 confirmed the gnats at the time of the observation.</p> <p>Observation on 10/08/24 at 11:17 A.M. in the kitchen revealed gnats present in the dish room area. Regional Dietitian #806 confirmed the presence of gnats in the dish room area.</p> <p>Observation on 10/09/24 at 1:55 P.M. revealed gnats were still flying around in the dish area. Interview at the time of the observation with [NAME] #516 confirmed the observation.</p> <p>Interview on 10/09/24 at 1:59 P.M. with FSD #517 confirmed she had power washed the dish room area but had not notified the maintenance director or administrator of gnats still being present in the kitchen.</p> <p>Interview on 10/09/24 at 2:02 P.M. with Maintenance Director #546 confirmed the exterminator was at the facility on 10/08/24 but was not aware of continued concerns with gnats in the kitchen and was not treated.</p> <p>Interview on 10/09/24 at 2:05 P.M. with Assistant Administrator #502 confirmed he was not aware of continued concerns with gnats in the kitchen until it was mentioned by this surveyor.</p> <p>Interview on 10/10/24 at 10:26 p.m. with Exterminator #807 stated the facility has been having an ongoing issue with fruit flies for the past few months. Exterminator #807 stated the kitchen is checked at monthly visits, and the gnats have been increasingly worse in the past month. Exterminator #807 stated the chemical treatment should be effective immediately. Exterminator #807 stated he comes out and addresses concerns at the facility monthly, will come out additionally if the facility notifies him and confirmed he had not been notified of concerns of fruit flies until the afternoon of 10/09/24.</p> <p>Review of the facility pest control invoices for the past 12 months revealed fruit flies were identified as a concern on 12/05/23, 01/06/24, 04/01/24, 05/06/24, 06/05/24, 07/03/24, 08/05/24, 08/15/24, 09/04/24, and 10/01/24.</p> <p>(continued on next page)</p>		

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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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<p>F 0925</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Review of the revised facility policy dated 08/12/2018 called; Pest Control Policy revealed if pests are seen in the kitchen, the director of food and nutrition services or designee shall be informed. Appropriate action will be taken to eliminate any reported pest situation in the department. If a pest control situation is reported, the contractor will be notified and may be requested to make an unscheduled visit to address concerns.</p>		