

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Slovene Home for the Aged		STREET ADDRESS, CITY, STATE, ZIP CODE 18621 Neff Rd Cleveland, OH 44119	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure urinary drainage bags were covered with privacy bags. This affected one resident (#68) of three reviewed for urinary catheters. The facility census was 83. Findings include: Review of the medical record for Resident #68 revealed an admitted [DATE] with diagnoses that included chronic respiratory failure with hypoxia, type two diabetes mellitus, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #68 was alert and oriented and was dependent on staff for Activities of Daily Living (ADLs). Review of the care plan dated 02/13/24 revealed Resident #68 required a suprapubic urinary catheter related to obstructive and reflux uropathy with interventions that included to store collection bag inside a protective dignity pouch. Review of the physician orders dated 05/01/24 revealed an order to maintain privacy bag and suprapubic catheter holder every shift. Observation on 09/23/24 at 9:41 A.M. revealed Resident #68's urinary catheter bag was seen from the hallway outside of his room. Observation revealed a yellow liquid substance (urine) filled the bag. No privacy bag was covering the bag. Observation revealed multiple staff and residents walking and/or ambulating past his room. Observation and interview on 09/23/24 at 9:42 A.M. with Occupational Therapist (OT) #600 revealed Resident #68's urinary catheter bag was seen from the hallway and was uncovered. OT #600 revealed urinary catheter bags were to be covered with a privacy bag. OT #600 confirmed and verified the above findings. Interview on 09/23/24 at 9:57 A.M. with State tested Nursing Assistant (STNA) #601 revealed Resident #68 had a urinary catheter bag and was to be changed every two hours or as needed. STNA #601 revealed all urinary catheter bags were to be covered with a privacy bag. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365567	Facility ID: 365567 If continuation sheet Page 1 of 11

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document titled Urinary Catheter Care revised March 2019, revealed the facility had a policy in place that privacy bags were to be used to cover the drainage bag. Review of the document revealed the facility did not implement the policy.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on observation, interview, record review, and policy review, the facility failed to ensure all fall interventions were in place for one resident (Resident #51) of five residents reviewed for accidents. The facility census was 83. Findings Include: Resident #51 was admitted to the facility on [DATE] with diagnoses including multiple fractures of the left sided ribs, diabetes, high blood pressure, hyperlipidemia, gastric reflux, insomnia, over active bladder, major depressive disorder, Alzheimer's, dementia without behavioral disturbance, osteoarthritis, urge incontinence and cataracts. Review of the quarterly comprehensive Minimum Data Set Assessment (MDS) 3.0 dated 06/30/24 revealed the resident was severely cognitively impaired, needed assistance for all personal care, and had fallen once since the previous assessment dated [DATE]. Review of the medical record revealed Resident #51 had fallen on 04/03/24 when she attempted to transfer herself from her bed to her wheelchair. The resident was dependent on staff for transfers. No injury occurred with the fall. The intervention put in place after the fall was instituting neurological checks. On 07/13/24 Resident #51 sustained a witnessed fall when she leaned forward in her wheelchair and slid out onto the floor. The aide pushing the resident's wheelchair and the resident's nurse were not able to reach the resident before she landed on the floor. The intervention put in place was to put dycem (a material used to prevent sliding from the resident's wheelchair) on the seat of the wheelchair. Review of the physician's orders for Resident #51 revealed she was to have a perimeter mattress to her bed, a low bed at all times, anti-rollbacks to the wheelchair, dycem to the top and bottom of the wheelchair cushion, a wedge cushion whenever the resident was in the wheelchair, a stand and pivot transfer with the assistance of one staff member, and to remain in her wheelchair behind the nurses' station until assisted into bed. Observation on 09/23/24 at 12:08 P.M. revealed Resident #51 was in bed and the bed was in a high position instead of her bed being in a low position per her physician's orders. Observation on 09/25/24 at 10:46 A.M. revealed Resident #51 was in bed and the bed was in a high position instead of the low position per physician's orders. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse (RN) #864 on 09/25/24 at 11:10 A.M. revealed she went to the physician's orders and said her interventions were a perimeter mattress to her bed, anti-rollbacks to the wheelchair, dycem to the top and bottom of the wheelchair cushion, a wedge cushion whenever the resident was in the wheelchair, and to remain in her wheelchair behind the nurses' station until assisted into bed. When asked if there were any other interventions related to her bed RN #864 again reviewed Resident #51's orders and said the resident's bed was to be in a low position at all times. Observation of the resident's bed revealed it was in high position. RN #864 confirmed that the bed was not in the low position. RN #864 then left the bed in its high position and returned to what she was doing. Observation on 09/25/24 at 11:17 A.M. State tested Nursing Assistant (STNA) #816 entered the resident's room and lowered the bed. Review of the facility's Fall Risk Reduction Protocol, dated March 2021, revealed beds were to be in a low position.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure weekly weights were taken and documented per physician orders for a resident that was at risk for weight loss. This affected one resident (#68) of eight residents reviewed for nutrition. The facility census was 83. Findings include: Review of the medical record for Resident #68 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, type two diabetes mellitus, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #68 was alert and oriented and was dependent on staff for Activities of Daily Living (ADLs). Review of the care plan dated 02/16/24 revealed Resident #68 was at risk nutritionally and the care plan dated 07/25/24 revealed Resident #68 had a weight loss with interventions including to monitor weights weekly as ordered and monitor weights as ordered per policy. Review of the physician orders dated 06/13/24 revealed an order for weekly weights once a day on Wednesdays. Review of the physician orders dated 07/25/24 revealed an order for a change of condition of weight loss and to chart in progress notes every shift. Review of the progress note dated 08/11/24 at 10:42 A.M. revealed Resident #68 had poor appetite and did not eat his breakfast meal. Review of the late entry progress note dated 08/12/24 at 3:53 P.M. revealed Resident #68 had loss weight and was encouraged to eat during meals. Review of the progress note dated 09/23/24 at 2:58 P.M. revealed Resident #68 refused breakfast and ate half of his lunch meal. Review of the progress note dated 0923/24 at 10:42 P.M. revealed Resident #68 refused dinner. Review of the weekly weights dated 06/01/24 to 09/25/24 revealed Resident #68 weighed 146.5 pounds (lbs) on 07/17/24 then the next recorded weight was dated 08/27/24, 143.0 lbs and on 09/25/24, 142.5 lbs. Review of the weekly weights revealed no weights were taken or recorded from 08/01/24 through 08/20/24. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 09/23/24 at 9:41 A.M. with Resident #68 revealed his breakfast tray was sitting on the overbed table untouched. Resident #68 revealed he did not want to eat the breakfast meal and was not hungry. Interview on 09/23/24 at 9:57 A.M. with State tested Nurse Assistant (STNA) #601 revealed Resident #68 refused to eat sometimes. Interview on 09/23/24 at 10:07 A.M. with Licensed Practical Nurse (LPN) #814 revealed Resident #68 was to be monitored for weight loss through weight tracking. LPN #814 verified and confirmed Resident #68 was missing weights for dates 08/01/24 through 08/20/24. Interview on 09/25/24 at 3:25 P.M. with Dietician (DT) #892 revealed Resident #68 was being monitored for weight loss and meal intakes. DT #892 revealed Resident #68 was to be weighed in order to implement necessary interventions to maintain weight and/or decrease weight loss. Review of the facility document titled Vital Signs and Weights dated April 2021, revealed the facility had a policy in place that weights were monitored regularly and documented in the electronic medical record to take the appropriate action when variances were noted.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 42730 Based on record review, observation and interview, the facility failed to ensure meals were served in a timely manner. This had the potential to affect all residents residing on the Westpark Unit (#1, #2, #5, #6, #7, #8, #9, #10, #12, #14, #15, #17, #18, #19, #20, #21, #22, #23, #24, #27, #28, #31, #32, #33, #34, #35, #36, #39, #40, #41, #42, #47, #48, #50, #51, #52, #55, #56, #58, #60, #61, #67, #68, #71, #73, #74, #179, #180, #181, #182, #229), except resident #54 and #56 who received no food by mouth (NPO). The facility census was 83. Findings include: Review of the facility document titled Meal Times undated, revealed the facility served breakfast between 7:30 A.M. and 8:30 A.M., lunch between 12:15 P.M. and 1:15 P.M., and dinner between 5:15 P.M. and 6:15 P.M. Observation and interview on 09/23/24 at 12:30 P.M. with Kitchen Aide (KA) #602 of the Westpark Unit dining room, revealed the lunch meal service had not started yet and she could not start until she received help. Observation and interview on 09/23/24 at 1:06 P.M. with Licensed Practical Nurse (LPN) #814 revealed the lunch meal had not been served and was late. LPN #814 revealed the Westpark Unit dining room was served first and the resident rooms last. Observation and interview on 09/23/24 at 1:12 P.M. with Dietary Manager (DM) #604 revealed the lunch meal was late, and the meal service could not begin without floor staff being available. Observation on 09/23/24 at 1:14 P.M. revealed the first dining room meal was plated and served. Observation on 09/23/24 at 1:30 P.M. revealed the first room tray was plated and placed on the holding cart. Interview on 09/23/24 at 1:33 P.M. with DM #604 confirmed and verified lunch meal room trays had still not been served. Observation on 09/23/24 at 1:38 P.M. revealed Resident #21 came out of her room and was verbally complaining about not getting her food for the lunch meal. Observation on 09/23/24 at 1:54 P.M. revealed the lunch meal room trays had still not been passed. Observation and interview on 09/23/24 at 2:00 P.M. with Stated tested Nurse Assistant (STNA) #828 revealed room trays were delivered after the dining room and residents who required feeding assistance. STNA #828 revealed room trays were never in order on the holding cart, therefore slowing down the process due to searching for each room tray amongst others on the holding cart. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/23/24 at 2:10 P.M. revealed the lunch meal room trays arrived to the Westpark until and were ready to be served. Observation on 09/24/24 at 12:15 P.M. revealed the Westpark Unit meal cart arrived to the servery and dining room meals were plated. Observation on 09/24/24 at 1:14 P.M. revealed the lunch meal room tray pass was initiated. Interview on 09/24/24 at 1:30 P.M. with DM #604 confirmed and verified the lunch meal was served late on 09/23/24 and 09/24/24.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation and interviews, and facility policy, the facility failed to serve hot and palatable foods. This had the potential to affect all residents, except resident #54 and #56 who received no food by mouth (NPO). The facility census was 83. Findings include: Interview on 09/23/24 at 9:46 A.M. with Resident #21 revealed food from the kitchen was not good and was always served late. Interview on 09/23/24 at 9:49 A.M. with Resident #179 revealed food from the kitchen was very cold and always had to be warmed up by staff. Interview on 09/23/24 at 10:45 A.M. with Resident #47 revealed food from the kitchen was bland and had no seasoning. Interview on 09/23/24 at 12:17 P.M. with Resident #44 revealed food from the kitchen was not good and had no taste and/or flavor. Interview on 09/23/24 at 3:47 P.M. with Resident #69 revealed the taste and appearance of food from the kitchen was unappetizing. Observation on 09/23/24 at 12:36 P.M. with Kitchen Aide (KA) #602 of the lunch meal tray line revealed the meal consisted of chicken pot pie, vegetables, soup and biscuits. Observation revealed the food items tested at or above 160 degrees fahrenheit, except the mechanical pot pie, which had a temperature of 76.8 degrees fahrenheit. KA #602 confirmed and verified the low temperature of the mechanical pot pie. Observation on 09/23/24 at 1:44 P.M. with Dietary Manager (DM) #604 of the lunch meal retake of the temperatures revealed all food items were now tested between at 140 and 148.8 degrees fahrenheit. Review of the weekly menu for the lunch meal dated 09/24/24 revealed mushroom barley soup, [NAME] stuffed cabbage, steamed carrots, dinner roll, and warm pear cobbler. Review of the menu revealed juice, white or chocolate milk, and coffee or tea will be served with all meals. Observation on 09/24/24 at 11:50 A.M. with DM #604 of the lunch meal tray line revealed the meal consisted of stuffed cabbage, soup, and steamed carrots. Observation revealed all items tested at or above 178 degrees fahrenheit. Observation of a test tray on 09/24/24 at 1:30 P.M. with DM #604 revealed DM #604 used a calibrated facility thermometer to take food temperatures of the test tray items, and DM #604 revealed the stuffed cabbage tested at 117 degrees fahrenheit (F), steamed carrots at 101 degrees F, and the milk tested at 53.1 degrees F. DM #604 confirmed and verified the findings. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility document titled Meal Quality and Temperature revised January 2023, revealed the facility had a policy in place that food and drinks were palatable, and served at a safe and appetizing temperature to ensure resident satisfaction.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observations, interviews, and facility policies, the facility failed to ensure food was prepared and served under sanitary conditions. This had the potential to affect all residents, except resident #54 and #56 who received no food by mouth (NPO). The facility census was 83. Findings include: Observation and interview on 09/23/24 at 8:30 A.M. during the tour of the kitchen revealed a box of hairnets available at the entrance of the kitchen. Observation revealed Kitchen Aide (KA) #603 was observed to be without a hairnet in place while preparing the breakfast meal. KA #603 confirmed and verified she was without a hairnet. Observation and interview on 09/23/24 at 12:30 P.M. with Licensed Practical Nurse (LPN) #814 during the Westpark Unit lunch meal, revealed Resident #28's uncovered breakfast tray was on top of the microwave, adjacent to the dining room. LPN #814 confirmed and verified the findings. Observation and interview on 09/24/24 at 8:12 A.M. with Dietary Manager (DM) #604 during tour of the three serveries located on the [NAME], Westpark, and [NAME] Units revealed the following: The microwave located on the [NAME] Unit was observed to be full of old food, dried food splatter, unknown sticky substance and uncleaned. The uncovered breakfast tray belonging to Resident #20 was left on top of the countertop located on the Westpark Unit. Two breakfast trays with unfinished meals were left on the countertop located on the [NAME] Unit. DM #604 confirmed and verified the findings at the time of the observation. Observation and interview on 09/24/24 at 12:35 P.M. with KA #602 during the lunch meal tray line, located on the Westpark Unit, revealed KA #602 wearing a surgical mask. KA #602 was observed plating the lunch meal, when she reached up and pulled down the surgical mask with her gloved hand and proceeded to grab the serving utensils to continue to plate food. KA #602 confirmed and verified the findings. Review of the facility document titled Sanitation and Infection Prevention/Control revised January 2023 revealed the facility had a policy in place that any time contamination is suspected, utensils and surfaces should be washed, rinsed, and sanitized before and after use. Review of the documents revealed the facility did not implement the policy.		