STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365661	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Rehabilitation and Healthcare Center, The	2801 E Royalton Rd Broadview Heights, OH 44147

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 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** 34297 Based on record review, interview, and facility policy review the facility failed to ensure Resident #200's scattered bruises were comprehensively assessed and monitored to include descriptions, measurements, and progression. This finding affected one resident (#200) of three residents reviewed for falls. The facility census was 116. Findings include: Review of Resident #200's medical record revealed the resident was admitted on [DATE] and discharged against medical advice (AMA) on 08/10/24 with diagnoses including cerebral infarction, muscle weakness, and aphasia. Review of Resident #200's Admission Evaluation dated 08/02/24 revealed the resident was alert to person, had aphasia, and was sometimes difficult to communicate his needs. The resident did not have skin impairments. Review of Resident #200's Wound Evaluation form dated 08/03/24 revealed the resident had redness and irritation on his buttocks. No other skin conditions were documented. Review of Resident #200's Fall Occurrence Evaluation form dated 08/04/24 revealed at 1:21 P.M. the resident was found by Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Coordinator #808 lying on his right side with the right shoulder hyperextended. The resident was assessed, and all parties were notified. The resident was discharged to the hospital for an x-ray to rule out injury. Review of Resident #200's 5-Day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #200 exhibited a memory problem and was frequently incontinent of urine and bowel. Review of Resident #200's Skin Inspection form dated 08/09/24 revealed no new skin areas were observed. Review of Resident #200's medication administration records (MAR) and treatment administration records (TAR) from 08/05/24 to 08/12/24 revealed orders dated 08/05/24 to monitor for bruising to the resident's bilateral arms and legs every shift and to monitor for bruising to the right eye every shift. The documentation confirmed the monitoring was completed as ordered; however, there was no description of the bruising. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #200's progress note dated 08/10/24 at 5:42 P.M. authored by the Director of Nursing (DON) revealed Resident #200's wife was upset and wanted to take the resident home. She then called the emergency medical squad (EMS) and police department to transport the resident to the emergency room (ER). The resident continued to require maximum assistance of staff. EMS and police in agreement that the resident required 24-hour nursing care at the time. Police and EMS in agreement with the staff that the resident was not capable of making decisions for himself and assisted the facility staff with education related to Against Medical Advice (AMA) discharges. The resident's wife remained difficult and insistent that staff arrange transport home. Multiple attempts were made to redirect the wife by the police and staff. The wife became belligerent and aggressive and continued with disruptive behavior. The police and EMS verified that the resident was safe and well cared for. The police and EMS left the building. The resident's wife was angry at the police department and was sitting in the room contacting another police department. Review of Resident #200's progress note dated 08/10/24 at 7:27 P.M. authored by Licensed Practical Nurse (LPN) #811 indicated Resident #200 was discharged AMA with the wife and daughter present. The policy and procedure of discharging AMA was thoroughly explained to the family and verbally acknowledge with the family's understanding of the policy. Resident #200 was noted with no signs of distress or further concerns present. The family was helped with transporting the resident to the personal vehicle and the physician was notified. Interview on 09/09/24 at 6:39 A.M. with the Director of Nursing (DON) indicated she was aware Resident #200 fell at home prior to admission into the facility and on 08/04/24 while he was admitted as a resident. The DON confirmed the resident sustained bruising to the right side of his face and various bruises on his arms and legs which appeared the day after the fall. Interview on 09/09/24 at 5:48 A.M. with LPN #809 indicated Resident #200 had bruising on his fell , arms, and legs if she was not mistaken from a fall. She denied concerns with dignity and respect or abuse. Interview on 09/09/24 at 7:25 A.M. with Registered Nurse (RN) Assistant Director of Nursing (ADON) #814 indicated from what she remembered, Resident #200 had behaviors and bruising from a fall sustained while a resident. RN ADON #814 indicated the bruising was not evident immediately but appeared the next day, and an order to monitor the bruises was obtained at that time. She confirmed the resident's wife was made aware of the bruising and staff were monitoring the bruising. Interview on 09/09/24 at 12:40 P.M. with RN ADON #814 confirmed Resident #200's bruising was documented on the initial fall report as scattered bruises, but the medical record did not reveal evidence of comprehensive assessments and monitoring of the bruising to include descriptions, measurements, and progression. Telephone interview on 09/09/24 at 1:15 P.M. of Nurse Practitioner (NP) #823 with the Administrator and RN ADON #814 in attendance revealed she did not specifically recall any significant bruising on Resident #200, including the resident's face. Review of the undated Pressure Ulcers/Skin Breakdown Clinical Protocol form revealed the staff would examine the skin of a new admission for ulcerations or alterations. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or non-healing wounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency was an incidental finding discovered during the course of the complaint investigation.