STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365670	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows Health and Rehab Ctr	1500 E 191st St Euclid, OH 44117

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on record review, staff interview, and review of the facility policy the facility failed to develop comprehensive care plans for residents who were smokers. This affected four (Residents #2, #17, #64, #65) of twenty-one residents reviewed for care plans. The facility census was 65 residents. Findings include: Review of a document provided by the facility dated 05/01/24 revealed there were 21 residents who were smokers. Residents #2, #17, #64, #65 were listed as smokers. Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses including type two diabetes, hypertension, and atrial fibrillation. Review of the care plan for Resident #2 dated 04/04/24 revealed it did not include a care plan for smoking. Review of the medical record for Resident #17 revealed an admitted [DATE] with diagnoses including type two diabetes, hypertension, and bipolar disorder. Review of the care plan for Resident #17 dated 03/14/24 revealed it did not include a care plan for smoking. Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses including schizophrenia, hypertension, and depression. Review of the care plan for Resident #64 dated 03/10/24 revealed it did not include a care plan for smoking. Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnoses including malignant neoplasm of larynx, squamous cell carcinoma, and chronic obstructive pulmonary disease (COPD). Review of the care plan for Resident #65 initiated 03/10/24 revealed it did not include a care plan for smoking. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/16/24 at 11:05 A.M. with Regional Registered Nurse (RRN) #750 confirmed Residents #2, #17, #64, and #65 were smokers, but they did not have care plans for smoking. Review of the facility policy titled Comprehensive Care Planning revised 03/02/21 revealed the facility would establish a care plan for every resident that included the resident's medical, nursing, mental, and psychosocial needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on medical record review, staff interview, family interview, and review of the facility policy, the facility failed to ensure resident care plans with updated with changes in code status. This affected one (Resident #50) of 29 residents reviewed for care plans. The facility census was 65 residents. Findings include: Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure, vascular dementia without behavioral disturbance, chronic kidney disease, cardiomegaly, and diabetes. Review of May 2024 physician's orders for Resident #50 revealed an order dated 02/04/24 for the resident be a full code (all resuscitative interventions would be performed in the event the resident's heart stopped). There was an order dated 02/20/24 for Resident #50 to be admitted to hospice care for a diagnosis of COPD. The resident remained a full code. Review of the care plan for Resident #50 dated 02/14/24 revealed the resident's code status was do not resuscitate comfort care arrest (DNR-CCA.) Interview on 05/16/24 at 9:52 A.M. with Resident #50's representative and medical decision-maker confirmed the resident was receiving hospice services but the resident was to remain a full code, meaning in the event that Resident #50's heart stopped he wanted everything possible to be done to maintain life. Interview on 05/16/24 at 11:05 A.M with Regional Nurse (RN) #750 confirmed Resident #50 was a full code, but the resident's care plan had not been updated with the correct code status. Review of the facility policy titled Comprehensive Care Planning dated 03/02/21 revealed the Minimum Data Set (MDS) Coordinator was responsible for reviewing and updating the plan of care as needed. The MDS Coordinator was to review the facility's 24-hour report daily for any changes in the resident's condition and update the care plan accordingly.

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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 0692

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36307

Based on closed medical record review and staff interview, the facility failed to timely identify and implement interventions to prevent significant/severe weight loss.

Actual Harm occurred when Resident #173 was assessed to have a severe 24.8 pound/13.3 percent (%) weight loss in 30 days without evidence of timely identification of the resident's decreased oral intake or timely intervention to address the cause of the weight loss. On 01/17/24 Resident #173 complained of tooth pain and was discovered to have a loose front tooth. The resident complained of continued pain with a decrease in oral intake. On 01/18/24 Resident #173 weighed 186.2 pounds and the next weight obtained on 02/13/24 was 161.4 pounds which reflected a 24.8 pound (severe)/13.3 % weight loss in under 30 days. This affected one resident (#173) of four residents reviewed for nutrition. The facility census was 65 residents.

Findings include:

Review of the closed medical record for Resident #173 revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses that included Alzheimer's disease, dementia, obesity, chronic respiratory failure, hypertension, osteoarthritis, gastrostomy tube (g-tube), and anxiety disorder.

Review of the care plan for Resident #173 dated 05/18/21 revealed the resident was at nutritional and hydration risk related to malnutrition, mechanically altered diet, dysphagia, and history of gastrostomy tube. Interventions included the following: monitor dietary intake and/or hydration, monitor labs, and monitor weights, monitor need for increased nutritional intervention related to diagnosis, medications and listed problems.

Review of physician's orders for Resident #173 dated 01/24/23 revealed an order for regular diet, pureed texture, thin consistency.

Review of the nutrition progress note for Resident #173 dated 04/07/23 revealed the resident had progressed with her oral meal intake and her enteral nutrition was discontinued. The gastrostomy tube was flushed with water to maintain patency.

Review of the dietary assessment for Resident #173 dated 11/08/23 revealed the resident received a regular diet, pureed texture, thin consistency liquids and consumed approximately 76 to 100 % of meals. The resident's most recent weight on 10/09/23 was 185.6 pounds.

Review of the nurse progress note for Resident #173 dated 01/17/24 revealed the facility staff contacted Certified Nurse Practitioner (CNP) #650 because the resident had a loose front tooth which appeared to cause the resident some discomfort.

Review of the weight records for the facility revealed Resident #173 weighed 186.2 pounds on 01/18/24.

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NAME OF PROVIDER OR SUPPLIER Willows Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 E 191st St Euclid, OH 44117	

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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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the progress note for Resident #173 dated 01/17/24 per CNP #650 revealed the CNP examined the resident due to reports from nursing that the resident had a sore tooth and was refusing food and drinks. Further review of the note revealed the resident had a loose tooth noted to the lower front jaw and the CNP gave orders for mouth care every shift and to make an appointment with the dentist for loose tooth. Review of the nursing progress note for Resident #173 dated 01/17/24 revealed the CNP also gave an order for Orajel mouth gel to gum line before meals and snacks. Review of the Medication Administration Record (MAR) for Resident #173 from 01/17/24 to 02/17/24 revealed documentation that Orajel was administered to resident's gum line before meals and snacks for pain as ordered. Review of the weight records for the facility revealed Resident #173 weighed 186.2 pounds on 01/18/24. Review of progress note for Resident #173 per NP #850 dated 01/19/24 revealed the facility staff reported resident had a front lower teeth that was loose. NP #850 attempted to examine the resident, but the resident refused to open her mouth. Review of the progress note for Resident #173 dated 01/19/24 revealed the facility called the dentist for an appointment for the resident and was awaiting a call back. Review of the progress note for Resident #173 dated 01/21/24 at 7:37 P.M. revealed the resident ate 50% of meals served on this date. Review of the progress note for Resident #173 dated 01/22/24 timed at 7:19 P.M. revealed the resident ate 50% of her meal. Review of the progress note for Resident #173 dated 01/25/24 timed at 7:20 P.M. the resident ate 50% of meals served on this date. Review of the physician's orders for Resident #173 revealed and order dated 01/22/24 revealed an order for a dental exam and x-ray on 02/20/24 at 10:00 A.M. Review of the progress note for Resident #173 dated 01/30/24 at 6:56 P.M. revealed the resident ate 50% of the lunch meal. Review of the progress note for Resident #173 dated 01/31/24 timed at 6:52 P.M. revealed the resident ate 50% of meals served. Review of the medication administration note for Resident #173 dated 02/01/24 timed at 3:26 P.M. revealed the resident was given two Tylenol tablets for mouth pain. Review of the progress note dated 02/02/24 at timed at 7:02 P.M. revealed the resident at 25% of meals served. (continued on next page)

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	365670	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the progress note for Resident #173 dated 02/05/24 revealed the facility set up a same-day emergency dental appointment for resident on 02/05/24. Review of the progress note for Resident #173 dated 02/05/24 revealed the dentist would call to schedule the resident for oral surgery to remove the loose front tooth. Review of the progress note for Resident #173 dated 02/06/24 timed at 5:48 P.M. revealed the resident refused the breakfast meal and ate 25% of the lunch and dinner meals. Review of the progress note for Resident #173 dated 02/07/24 timed at 8:08 P.M. revealed the resident at 50% of the meal. Review of the progress note for Resident #173 dated 02/11/24 timed at 5:57 P.M. revealed the resident ate 50% of her meals. Review of the Minimum Data Set (MDS) assessment for Resident #173 dated 02/10/24 revealed the resident was cognitively impaired and was able to feed herself with set-up assistance and was dependent on staff for all other activities of daily living (ADLs.) Review of the weight records for the facility revealed Resident #173 weighed 161.4 pounds on 02/13/24. The facility reweighed the resident and confirmed the resident's weight was 161.4 pounds. Review of the physician orders for Resident #173 revealed an order dated 02/13/24 for Boost supplement three times a day due to weight loss. Review of the progress note for Resident #173 dated 02/18/24 timed at 4:20 P.M. revealed the resident had difficulty breathing, had a low blood pressure of 75/33 and a low oxygen saturation level of 85 %. Resident #173 was sent to the hospital due to a change in condition and was admitted . The resident did not return to the facility following the hospitalization . Interview on 05/14/24 at 10:14 A.M. with Registered Dietitian (RD) #912 revealed Resident #173 was admitted to the facility in May of 2021 and received all nutrition via g-tube at that time. RD #912 confirmed the resident's diet was upgraded to oral meals in April of 2023, but the resident still had a g-tube in place and the facility maintained the patency of the tube with regular water flushes. RD #912 further confirmed Resident #173 had a significant (severe by Centers for Medicare/Medicaid (CMS) definition -weight loss of greater than five percent in one month) weight loss of 24.8 pounds, a weight loss of 13.3% from 01/18/24 to 02/13/24. RD #912 confirmed she recommended a Boost supplement for Resident #173 three times per day but not until on 02/13/24. RD #912 confirmed the facility identified Resident #173 had a loose and sore tooth on 01/17/24 and did not obtain additional weights for Resident #173 from 01/18/24 to 02/13/24 nor did the facility implement any additional nutritional interventions during this time frame. (continued on next page)

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	365670	A. Building B. Wing	05/23/2024

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 05/15/24 at 2:47 P.M. with Regional Nurse (RN) #750, the Interim Director of Nursing (DON), and Licensed Practical Nurse (LPN) #901 confirmed Resident #173 complained of mouth pain in mid-January 2024 and on 01/17/24 staff confirmed resident had a loose tooth which caused the resident pain. RN #750 revealed the facility did schedule an emergency dental appointment and extraction for Resident #173. LPN #901 confirmed staff began to provide a Boost supplement to Resident #173 starting on 02/13/24 due to resident's weight loss. Further interview with RN #750 and the Interim DON confirmed Resident #173 had a significant weight loss of 24.8 pound, 13.3% from 01/18/24 to 02/13/24. Interview confirmed the facility did not obtain any weights during this time frame for the resident nor did the facility initiate interventions to prevent weight loss until 02/13/24.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure accurate pre-dialysis communication was provided to the dialysis center, failed to ensure the dialysis provider provided the facility with timely post-dialysis information, and failed to respond to concerns from the dialysis center. This affected one (Resident #36) of one resident reviewed for dialysis. The facility census was 65 residents. Findings include: Review of the medical record for Resident #36 revealed an admitted [DATE] with diagnoses including end stage renal disease, dependence on dialysis, diabetes, peripheral vascular disease, bilateral below the knee amputation, schizoaffective disorder, and noncompliance with renal dialysis. Review of the physician's orders for Resident #36 revealed an order for the resident to receive hemodialysis outside the facility on Mondays, Wednesdays, and Fridays. The facility was to send a bagged meal/snack with Resident #36 to dialysis. A dialysis communication tool was to be completed and sent to dialysis with the resident. A skin check was to be completed upon return from dialysis. Resident #36 was not on a fluid restriction and was to receive a renal diet with double protein portions. Review of the pre-dialysis communication tools from February 2024 through May 2024 from the facility to the dialysis center for Resident #36 revealed the facility completed the tool and sent it to the dialysis provider for each visit, but the facility did not complete the dialysis tool accurately. Resident #36 was marked as being on a fluid restriction and that the resident was not to have bagged meal/snack sent with him on the following dates: 02/02/24, 02/12/24, 03/08/24, 03/15/24, 04/07/24, 04/19/24, 04/22/24, 04/24/24, 04/26/24, 04/29/24, 05/10/24, and 05/13/24. Review of the post-dialysis communication tool for Resident #36 from the dialysis center to the facility revealed the dialysis provider was to send back information regarding how much fluid was removed from the resident, the post-dialysis weight, how the resident tolerated the session. No information was provided to the facility upon treatment completion for Resident #36 on the following dates: 04/19/24, 04//22/24, 04/29/24, 05/10/24. Review of the progress notes for Resident #36 dated 04/19/24 to 05/21/24 revealed they did not include documentation of the facility contacting the dialysis provider for treatment information for the following dates: 04/19/24, 04//22/24, 04/29/24, or 05/10/24. Review of the dialysis communication tool returned by the dialysis provider to the facility dated 03/15/24 for Resident #36 revealed the dialysis provider noted the resident was complaining of pain to his buttocks and that the facility staff had not been treating the resident's bottom. Review of the progress notes for Resident #36 dated 03/15/24 to 05/21/24 revealed they did not include documentation that the facility was aware of the dialysis provider's concerns or that the facility followed up with the dialysis provider. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the dialysis communication tool returned by the dialysis provider to the facility dated 04/26/24 revealed the resident was complaining of pain in his genitals and was having discharge from it and that this was an ongoing problem, and nothing was being done. Review of the progress notes for Resident #36 dated 04/26/24 to 05/21/24 revealed they did not include documentation that the facility was aware of the dialysis provider's concerns or that the facility followed up with the dialysis provider. Interview on 05/21/24 at 3:30 P.M. with Regional Registered Nurse (RRN) #750 confirmed the pre-dialysis tool sent to the dialysis provider for Resident #36 was not consistently completed with accuracy regarding the resident's fluid status and diet interventions. RNN #750 further confirmed the facility should have followed up with the dialysis provider for the dates in which the facility did not receive post-dialysis documentation. RNN #750 confirmed the facility did not follow up with the dialysis provider regarding the concerns noted on the post-dialysis communication forms dated 03/15/24 and 04/26/24. Review of the facility policy titled Hemodialysis Care Policy last revised 08/24/23, revealed the facility was to include the following information in the dialysis communication tool shared with the dialysis provider: vital signs, pre-treatment weight unless performed at dialysis, any medication administered before treatment, time of last meal, fluid intake, any additional alerts or information. The tool was to go with the resident to treatment. The post-dialysis process was to receive report from the dialysis provider and/or review the dialysis communication tool documentation completed by the dialysis provider. Information post-dialysis will include the following: vital signs, post-treatment weight, any lab draws and/or results, any medications administered during or after treatment, any new orders, any alerts or information, monitoring the dialysis site for bleeding, monitor for dizziness, any meal/and or fluids consumed at dialysis.